Michelle H., *et al.* v. McMaster

PROGRESS REPORT: SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES

October 1, 2022 - March 31, 2023

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Michelle H., et al. v. McMaster and Leach
Progress Report for the Period
October 1, 2022 – March 31, 2023

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I. Introduction

This report covers the progress of the South Carolina Department of Social Services (DSS) in meeting the requirements of the Final Settlement Agreement (FSA)[1] entered in *Michelle H., et al. v. McMaster and Leach*, for the period October 1, 2022 through March 31, 2023.[2] Approved by the United States District Court on October 4, 2016, the FSA includes requirements for the care and treatment of the approximately 3,700 children in foster care in South Carolina and incorporates provisions ordered in a September 2015 Consent Immediate Interim Relief Order (the Interim Order or IO).[3,4] The FSA outlines South Carolina's obligations to significantly improve the experiences of and outcomes for children removed from the care of their parent(s) or guardian(s) and placed in DSS's custody, and reflects an agreement by the State to address long-standing problems in the operation of its child welfare system. The report has been prepared by court-appointed independent Co-Monitors Paul Vincent and Judith Meltzer, with assistance from Elissa Gelber, Ali Jawetz, Sarah Esposito, and Gayle Samuels. It is presented to the Honorable Richard Gergel, U.S. District Court Judge; Parties to the lawsuit (Governor McMaster, DSS, and Plaintiffs); and the public.

The FSA was crafted by state leaders and Plaintiffs to guide a multi-year reform effort on behalf of children in DSS's custody and includes specific provisions governing: the workloads of case managers and Team Leaders;[5] visits between children in foster care and their case managers; family time, or visits between children in foster care and their parents and siblings; investigations of allegations of abuse and/or neglect of children in foster care by a caregiver; appropriate placements; and access to timely physical and mental health care. Since the development of the FSA,

[1] Final Settlement Agreement (October 4, 2016, Dkt.32-1)
[2] FSA Section III.D. requires the Co-Monitors to issue reports approximately 120 days after the close of each reporting period, or after the State produces the necessary data to the Co-Monitors.
[3] The class of children covered by the FSA includes "all children who are involuntarily placed in DSS foster care in the physical or legal custody of DSS now or in the future" (FSA II.A.).
[4] Consent Immediate Interim Relief Order (September 28, 2015, Dkt. 29)
[5] The FSA utilizes the term "supervisor" to refer to DSS staff who oversee case-carrying staff. As part of its Guiding Principles and Standards (GPS) case practice model development and work to define enhanced job expectations, DSS now utilizes the term "Team Leader," effective May 2023.

Implementation Plans for key bodies of work – which are also tracked by the Co-Monitors – have been approved and ordered by the Court.[6]

The Co-Monitors utilized a range of sources and activities to collect information for inclusion in this report, and to inform the overall assessment of the State's progress. These include, among other things, review of records in DSS's Child and Adult Protective Service System (CAPSS);[7] analysis and validation of data provided by DSS and collected by DSS and Co-Monitor staff through structured reviews; discussions with case managers and other DSS staff, private providers, and stakeholders; meetings with DSS leaders; and discussions with Plaintiffs' counsel. Appendix B includes a list of specific activities used to assess DSS's progress.

In response to a request by Plaintiffs, the Co-Monitors prepared and submitted to Parties and the Court an addendum report on August 1, 2023 regarding concerns about increasing placement instability for children in DSS custody.[8] That report, entitled *Michelle H. Co-Monitors' Supplemental Report Regarding South Carolina's Placement Crisis* (hereafter, "Supplemental Report")," summarizes the current crisis of Class Members facing severe instability, factors that may be contributing to it, steps DSS is currently undertaking to address it, and, with input from DSS and Plaintiffs, the Co-Monitors' recommendations for additional immediate, short-, medium-, and long-term strategies for consideration. The report includes data provided by DSS on emergency placements and overnight stays in DSS offices, as well as information compiled through interviews with DSS staff, private providers, and other stakeholders. Given that some of the information in that report would have typically been included in the Co-Monitors' bi-annual progress reports, there are references throughout this report to data and findings already covered in detail therein. Appendix D contains the full Supplemental Report.

In order to make this report as useful as possible to the Court, Parties, and public, the Co-Monitors have also included information about developments beyond March 31, 2023 (the end of the monitoring period), as well as references to data DSS provided

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[6] See court orders approving Workload, Placement, and Health Care Plans (February 27, 2019, Dkt. 109) and Visitation Plan (April 3, 2019, Dkt. 115). To see all Implementation Plans and Addendums for the *Michelle H.* Final Settlement Agreement, go to: https://dss.sc.gov/child-welfare-reform/

[7] CAPSS is DSS's State Automated Child Welfare Information System (SACWIS).

[8] Michelle H. Co-Monitors' Supplemental Report Regarding South Carolina's Placement Crisis (August 1, 2023, Dkt. 288-1)

directly to the Court on July 28, 2023 (DSS's Data Submission to the Court) where applicable.[9]

II. Areas of Improvement and Areas of Challenge

Committed leadership and an influx of resources from the General Assembly in July 2022 has translated into sustained or additional progress in some key areas during this monitoring period (October 2022 – March 2023) and beyond. There has been a continued decline in the number of children being brought into foster care as DSS has increasingly emphasized the importance of supporting families in ways that allow them to remain together. For children who are separated from their families, DSS has continued to prioritize placement with family members or other important people in children's lives (kin and fictive kin) – one quarter of all children in DSS custody were placed with kin at the end of March 2023. In the Out-of-Home Abuse and Neglect (OHAN) unit, responsible for investigating allegations of abuse or neglect of children in foster care, investigative practices around contact with core witnesses and appropriateness of decisions improved significantly. In acknowledgement of its sustained performance at or above the FSA requirements in those areas for multiple periods, in July 2023, the Court formally approved a joint request from Parties to grant DSS "Maintenance of Effort" status with respect to timely initiation and completion of OHAN investigations (FSA IV.C.4(d), (e), and (f)), as well as appropriateness of decisions not to investigate referrals of abuse or neglect (FSA IV.C.2),.[10,11]

DSS has continued to make progress on hiring Team Leaders and case managers, and filling staff vacancies in all program areas. Though the ongoing placement instability crisis has put significant strain on DSS staff, turnover has begun to decline from its peak last year, with the greatest reduction in turnover in the Foster Care program area. DSS has also filled the newly allocated and much-needed additional Health Care Quality Improvement Coordinator positions statewide.

[9] Letter from J. Michael Montgomery Providing Information Requested in May 15, 2023 Order (July 28, 2023, Dkt. 283)
[10] August 3, 2023 Order (Dkt. 290)
[11] FSA IV.E.1-5 allows specific obligations to be designated for Maintenance of Effort status when Defendants have achieved substantial compliance as reflected in the monitoring report, and entails that the Co-Monitors shall "reduce the level of monitoring over that item to a level sufficient to identify any significant deterioration of performance."

Despite these successes, a severe shortage of services and supports throughout the state has limited DSS's ability to meet the needs of the children in its care. As discussed in detail in the Co-Monitors' Supplemental Report, the placement instability crisis has reached new extremes, with children sleeping overnight in DSS offices daily, or being moved through numerous "emergency placements" while waiting for stable placement to be found. Ten percent of the 5,177 children who were in DSS custody at any point between October 1, 2022 and March 31, 2023 experienced an emergency placement or slept overnight in a DSS office at least once during that time. In addition, many Class Member children are still experiencing high levels of instability, regardless of whether specific placements are categorized as "emergency" in nature. Of these 5,177 children, 17 percent (872 children) were moved through three or more placements between October 1, 2022 and March 31, 2023.

This placement instability crisis has also siphoned energy from DSS leadership's focus on implementing its Guiding Principles and Standards (GPS) case practice model with fidelity.[12] Individualized and strength-based engagement, functional assessment, and trauma-informed and family-centered planning are vital for DSS to achieve safety, permanency, and well-being for children in their custody. Though staff training includes an introduction to the GPS model, DSS practice does not yet have the depth required to translate the learning into meaningful changes in the way children and families experience the child welfare system. Barriers to addressing underlying needs and individualized service planning for children and families must be understood and addressed for *any* changes to take hold in a meaningful way.

DSS leadership and staff have been expending significant effort to stem the harms the placement instability crisis has caused to children in custody, their family members, and DSS staff. But DSS cannot meet the needs of these children nor comply with its FSA obligations without the partnership of *all* state Defendants, who must effectively collaborate to promote children's safety, permanency, and well-being, and the development of a robust array of services and supports for families. Included in the Supplemental Report are the Co-Monitors' recommendations for concrete steps the State can and should take in this regard. The Co-Monitors look forward to working closely with the Governor's office, South Carolina state agencies and other stakeholders to support DSS in this effort over the coming months.

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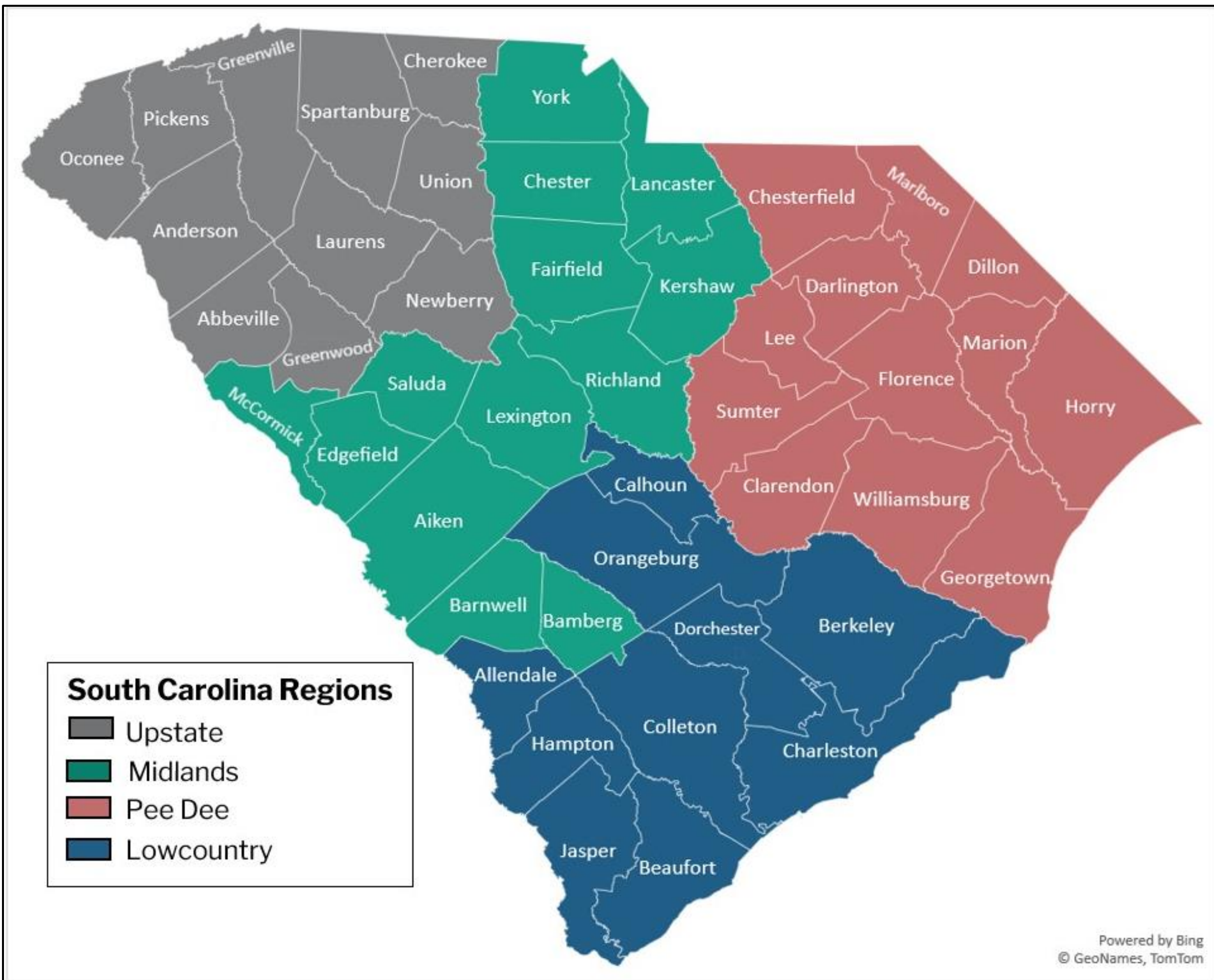
[12] DSS's GPS case practice model was designed in recognition of the need for a culture that 'engage[s], encourage[s], honor[s], and support[s] families.' To see the GPS case practice model, go to: https://dss.sc.gov/media/2746/gps-practice-model-final.pdf

III. Background Information

For a detailed summary of South Carolina DSS's structure and mission, please view prior monitoring reports, available here. The FSA pertains to children who have been involuntarily removed from the custody of their parents or guardians due to a finding of abuse or neglect and taken into the custody of DSS. These children reside in foster care or "out-of-home" care. DSS is responsible for caring for children on a temporary basis, preferably while children remain with their siblings and reside with family members (kin) or someone else known to the family (fictive kin), and working to ensure they can return home to their parents or guardians (reunification). When reunification is not possible, DSS must pursue another permanent, long-term plan, such as guardianship (living permanently with relatives without filing for termination of parental rights)[13] or adoption. DSS is structured to deliver services through regional and county offices; the state's 46 counties are divided into four regions – Midlands, Upstate, Pee Dee, and Lowcountry (see Figure 1). Some important DSS functions are located regionally, including adoptions offices, Child Health and Well Being Teams, and Child Placement Teams.

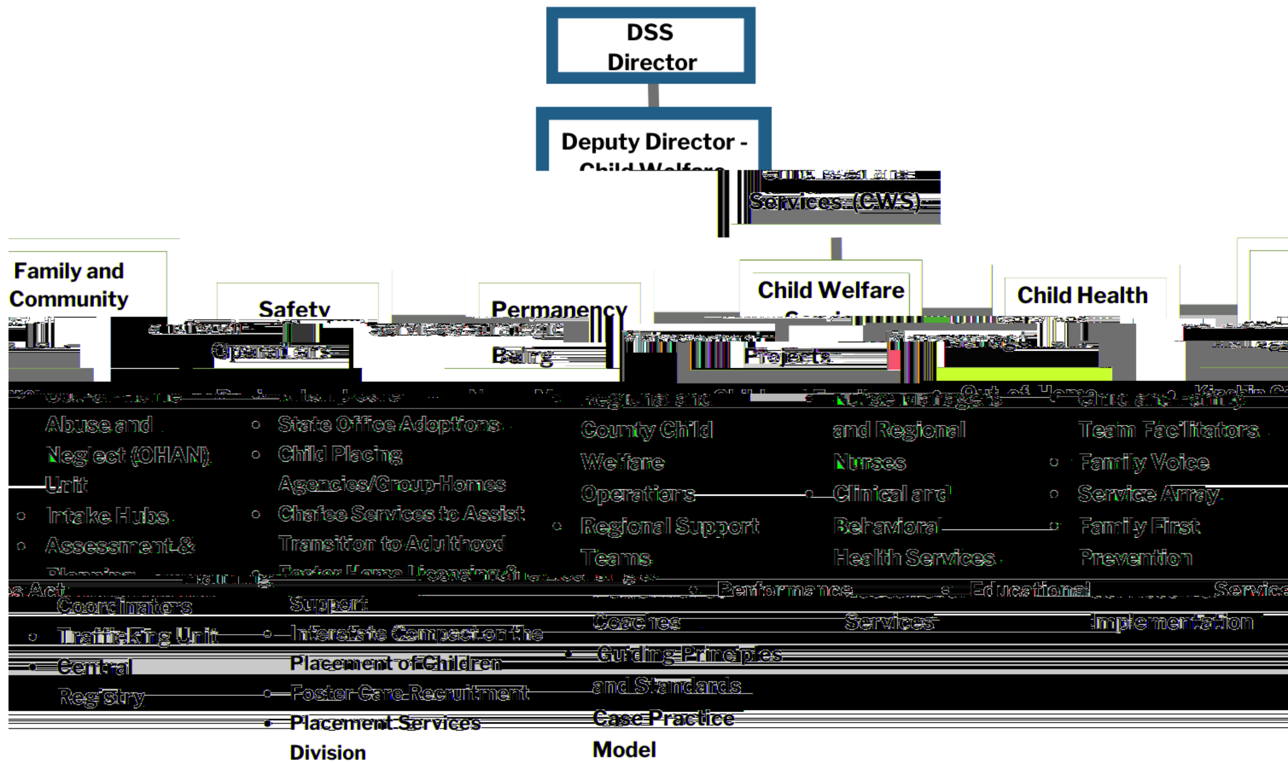
[13] On May 16, 2023, Governor McMaster signed S0380 (Rat #32, Act #25) into law, which amended the definition of "legal guardian" to establish a program by which kin legal guardians can receive equivalent benefits to adoption subsidies if DSS demonstrates that termination of parental rights (TPR) is not in the child's best interest or adoption is otherwise not appropriate. For more information, go to: https://www.scstatehouse.gov/sess125_2023-2024/bills/380.htm. See, *infra* note 94.

Figure 1: South Carolina Counties by Region



DSS's foster care work is part of its Child Welfare Services Division, overseen by Deputy State Director of Child Welfare, Emily Medere. The Child Welfare Services Division is organized into five primary areas of focus: Safety Management; Permanency Management; Child Welfare Services Operations; Child Health and Well-Being; and Family and Community Services and Strategic Projects. Figure 2 depicts this structure, and the general responsibilities encompassed in each area of work.

Figure 2: DSS Child Welfare Services Division Organizational Chart



Source: Graphic provided by DSS, as of 09/07/2023

Foster Care Budget and Financing

The federal Children's Bureau, within the Administration for Children and Families, distributes funds to states for defined child welfare functions and services through mandatory spending programs. The largest of these programs is authorized under Title IV-E of the Social Security Act and operates as an "open-ended" matching fund source, meaning states are entitled to receive reimbursement for a portion of every dollar spent on behalf of an "eligible" child.[14] The child's eligibility depends on the income level of the parent(s) from whose custody the child was removed. Even if a child's case is found to be eligible for reimbursement pursuant to Title IV-E, reimbursement is only allowed for specific portions of certain eligible expenses.[15] Approximately 46 percent of children in foster care currently meet Title IV-E eligibility requirements (referred to as the state's Title IV-E penetration rate).[16]

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[14] The Title IV-E program was established by HR. 3434 Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272).

[15] Section 474(a)(3)(A),(B),(C),(D), and (E) of the Social Security Act

[16] In February 2018, the federal Family First Prevention Services Act (FFPSA) was passed to promote placement of children in family foster care settings as opposed to congregate care settings, and to allow states to use federal IV-E funding to provide evidence-based prevention services in the

As detailed in the Supplemental Report, nearly all children in foster care are eligible for medical insurance through Medicaid, another important source of revenue for state child welfare systems.[17] States paying for Medicaid services included in federally approved state plans and waiver programs receive federal matching funds for state expenditures at a state's Federal Medical Assistance Percentage (FMAP) rate. In South Carolina, this rate for Federal Fiscal Year (FY) 2023-2024 is 69.53 percent.[18,19] This means that for every dollar South Carolina spends on a Medicaid-reimbursable service for a child or eligible family member in the current fiscal year, the federal government reimburses the state almost 70 cents. This is both a considerably higher rate than the reimbursement received under Title IV-E and one that can be applied broadly, as the Medicaid reimbursement is not limited to services for children who meet the Title IV-E eligibility requirement. States that have responsibly maximized the use of federal Medicaid matching dollars have been able to increase – sometimes vastly – funding available for the support of children in foster care.[20] Medicaid can be used to cover non-direct health care services, such as mental health services, and services as part of therapeutic foster care.

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community to reduce the need for out-of-home placement. FFPSA prevents federal reimbursement of congregate care facilities that do not meet the new criteria for a Qualified Residential Treatment Program (QRTP), which include: a trauma-informed treatment model, on-site registered or licensed nursing and clinical staff, inclusivity of family members in treatment planning, offering aftercare support 6 months post-discharge, and accreditation by a select group of bodies. (Family First Prevention Services Act, Publ. L. No. 115-123, H.R.253. (2017)). In February 2022, the Children's Bureau approved South Carolina's 5-year Family First Prevention Services plans. If statutory requirements are met, this will enable the state access to federal funding to help families stay together and prevent entry into foster care. DSS has been working with community and agency partners on developing implementation strategies. The agency has not yet begun to make IV-E claims under the Family First Prevention Services Act (FFPSA), and is currently using 100% federal funding received through the Family First Transition Act (FFTA) grant. To see South Carolina's Family First Prevention Services plan, go to: https://dss.sc.gov/media/3284/south-carolina-dss-title-iv-e-prevention-plan.pdf

[17] DSS has estimated that there are approximately 30 children at any point in time who are ineligible for Medicaid due to their immigration status. South Carolina Department of Social Services Foster Care Health Plan – Care Coordination Addendum (April 3, 2019, Dkt.120, p. 23), located at: https://dss.sc.gov/media/1962/2-25-2019-approved-health-plan-addendum.pdf

[18] Kaiser Family Foundation. State Health Facts. Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier.https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Multiplier%22,%22sort%22:%22desc%22%7D

[19] The Families First Coronavirus Response Act (FFCRA) authorized temporarily increased federal funding to states through a higher FMAP, increasing the rate for recent years to almost 77 percent (Section 6008 of P.L. 116-127). The increased support was phased down in each subsequent fiscal quarter after March 31, 2023, and will end entirely as of January 1, 2024 (Section 5131 of P.L. 117-328).

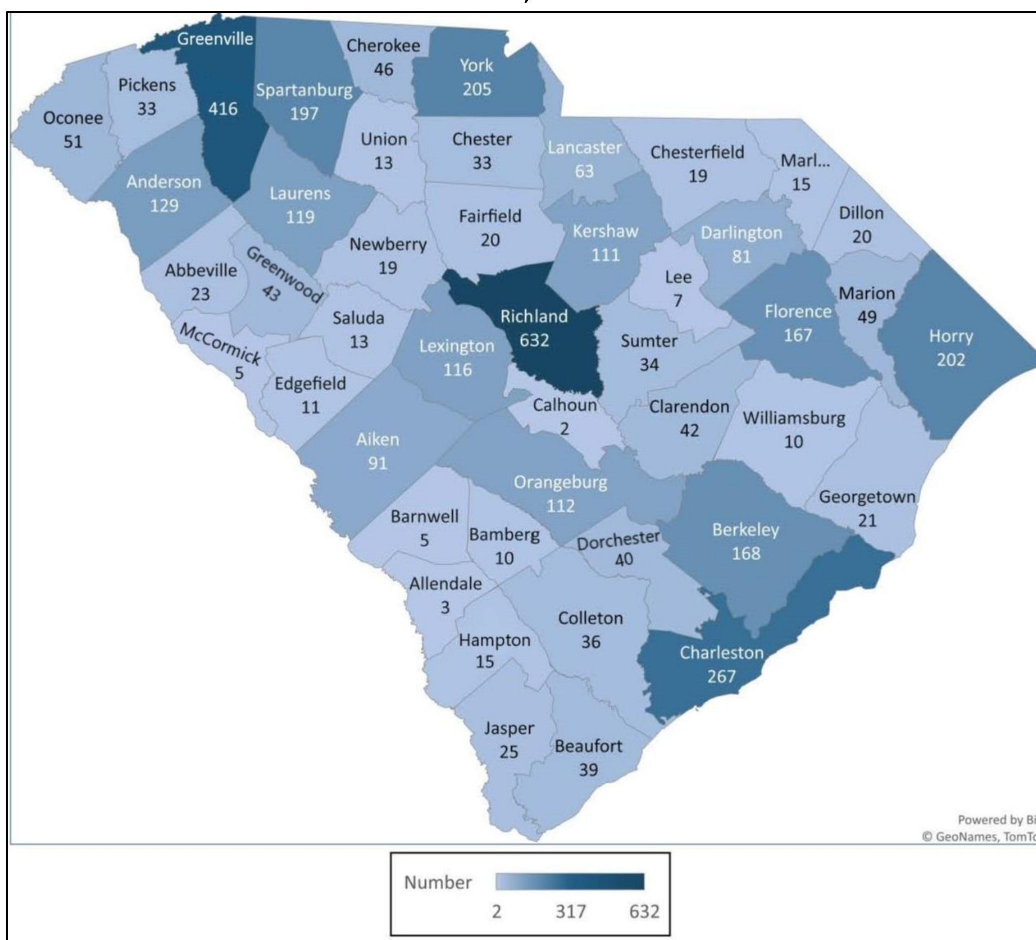
[20] For a detailed discussion of a range of strategies in four states (Arizona, New Jersey, Massachusetts, Michigan) that utilized Medicaid as a primary source of funding in the development of services and supports for children in foster care, go to: https://www.chcs.org/media/Making_Medicaid_Work.pdf. See also: https://www.chcs.org/resource/advancing-child-welfare-and-medicaid-alignment-opportunities-for-collaboration/

For details on the general process for budget allocation through the General Assembly, see prior monitoring reports. Details regarding DSS's budget for FY2023-2024 are included in Section IV. *Fiscal Resources*.

Population and Demographics of Children in Foster Care

Between October 1, 2022 and March 31, 2023, 5,177 children were in foster care at some point. On March 31, 2023, the last day of the monitoring period, there were 3,778 children in foster care across the state.[21] The map in Figure 3 shows the number of children from each county in foster care on that day.

Figure 3: Number of Children in DSS Custody by County as of March 31,2023[22] N=3,778



Source: CAPSS data provided by DSS

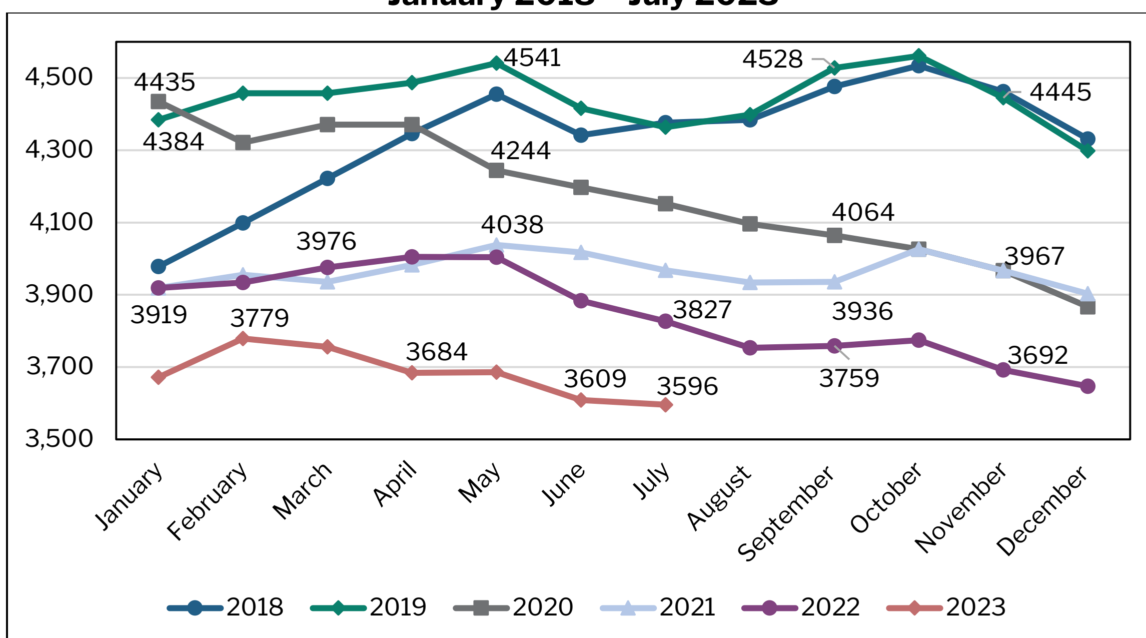
[21] This includes 33 children who resided in other institutional settings on March 31, 2023 and may not match the data in Section VIII. *Placement*.

[22] To see this map with current data, go to: http://reports.dss.sc.gov/SSRSReportServer/Pages/ReportViewer.aspx?/Foster+Care

DSS regularly publishes real-time data about children in out-of-home care on its public website.[23] Demographic data on age, race, and gender are available, as well as information about where children are placed and how long they have been in out-of-home care.

According to DSS's Data Submission to the Court, as well as the DSS data dashboard on its public website, there has been a reduction in the foster care population since the end of the monitoring period, as depicted in Figure 4.[24,25]

Figure 4: Population of Children in DSS Custody
January 2018 – July 2023



Source: Data from DSS data dashboard, 8/18/23

Though the number of children entering (1,480) and exiting (1,408) foster care between October 2022 and March 2023 remained relatively stable, the number of children served in foster care has steadily declined since the onset of the COVID-19 pandemic.[26] The two largest declines in children served occurred between April and September 2020, and April and September 2022, as seen in Figure 5.

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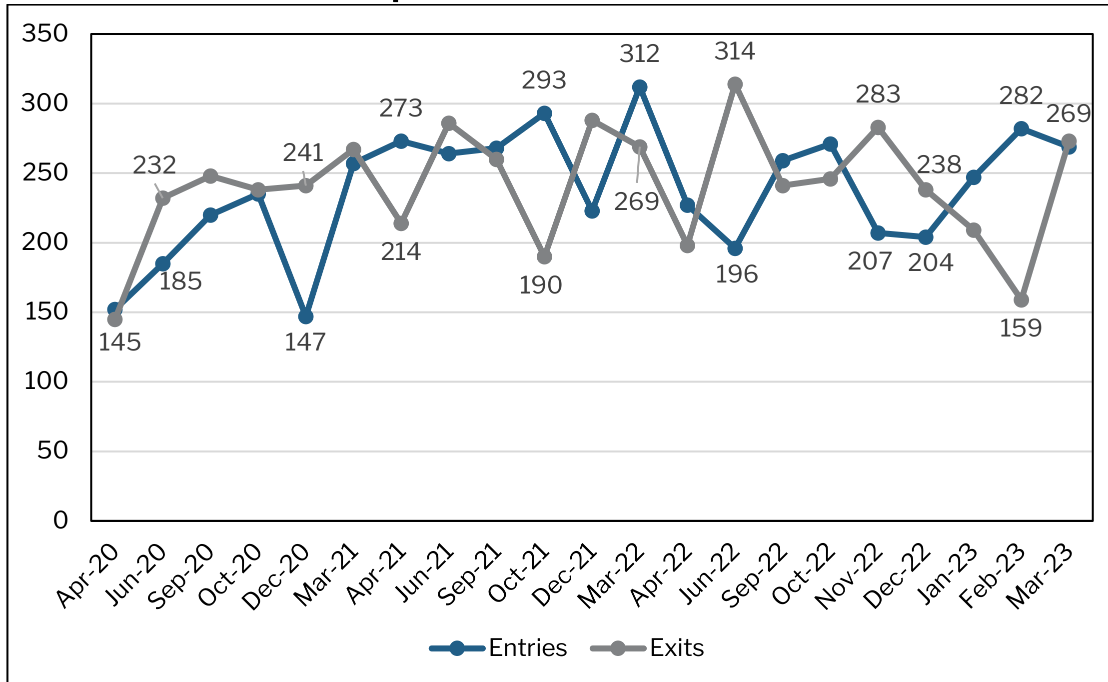
[23] To see DSS's data dashboard, go to: https://dss.sc.gov/about/data-and-resources/foster-care-dashboard/

[24] See *supra* note 9 at 26-27.

[25] Foster care population data included herein is sourced from DSS's data dashboard and includes some children who are not Class Members. More information can be found at https://reports.dss.sc.gov/ReportServer/Pages/ReportViewer.aspx?/Foster+Care

[26] These data may include children in foster care who do not fall within the definition of Class Members as per the FSA.

Figure 5: Foster Care Entries and Exits
April 2020 – March 2023



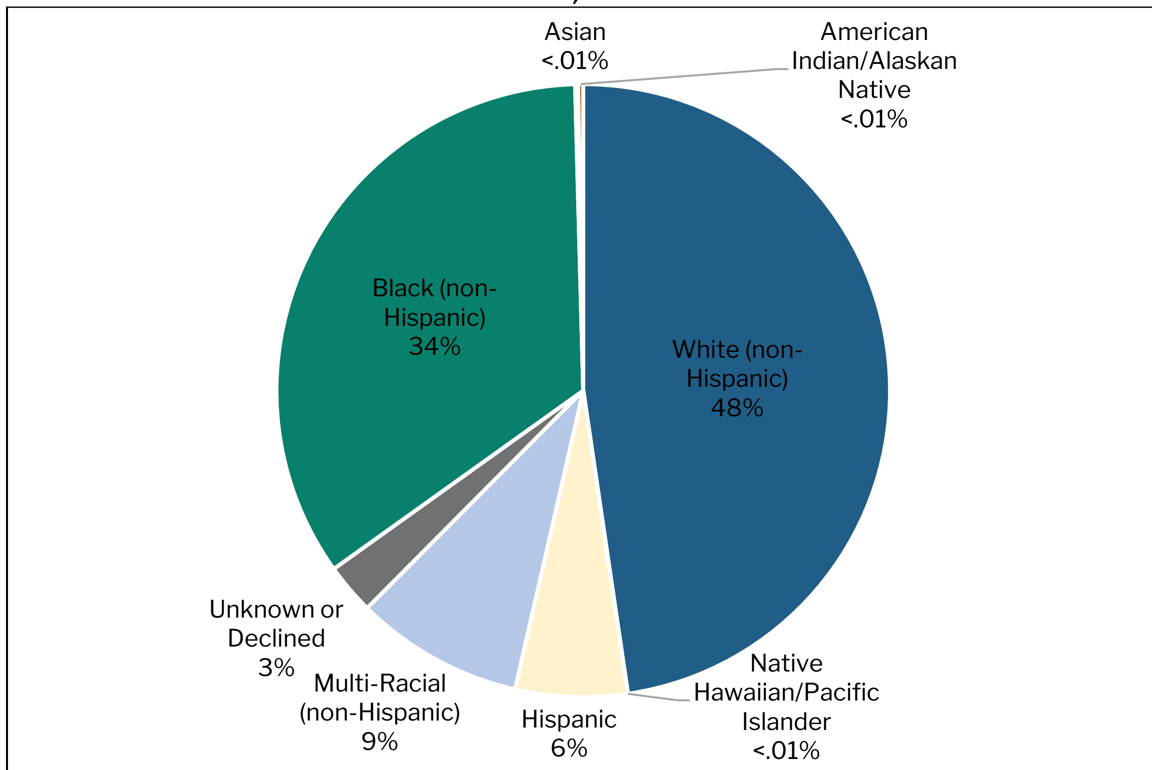
Source: CAPSS data provided by DSS

As shown in Figure 6, 48 percent of children in foster care are identified as White and 34 percent of children in foster care are identified as Black. Though Hispanic is an ethnicity and not a race, to be inclusive of this population in analysis of race data, the Co-Monitors calculated the Hispanic category as those children who were marked as a "Yes" for Hispanic ethnicity, which make up six percent of children in foster care.[27,28] These demographics have remained consistent for multiple monitoring periods.

[27] In accordance with federal guidelines, DSS does not record Hispanic or Latinx as a category in race data published on its public dashboard but does capture Hispanic ethnicity as a category in placement data. To be inclusive of this population in analysis of race data, the Co-Monitors calculated the Hispanic category as those children who were marked as a "Yes" for Hispanic ethnicity, including 13 children who were indicated as both Black and Hispanic, 57 children who were indicated as both Multiracial and Hispanic, and 133 children who were indicated as both White and Hispanic.

[28] To see DSS's current race data, go to:http://reports.dss.sc.gov/SSRSReportServer/Pages/ReportViewer.aspx?/Foster+Care

Figure 6: Population of Children in DSS Custody by Race as of March 31,2023
N= 3,778[29]



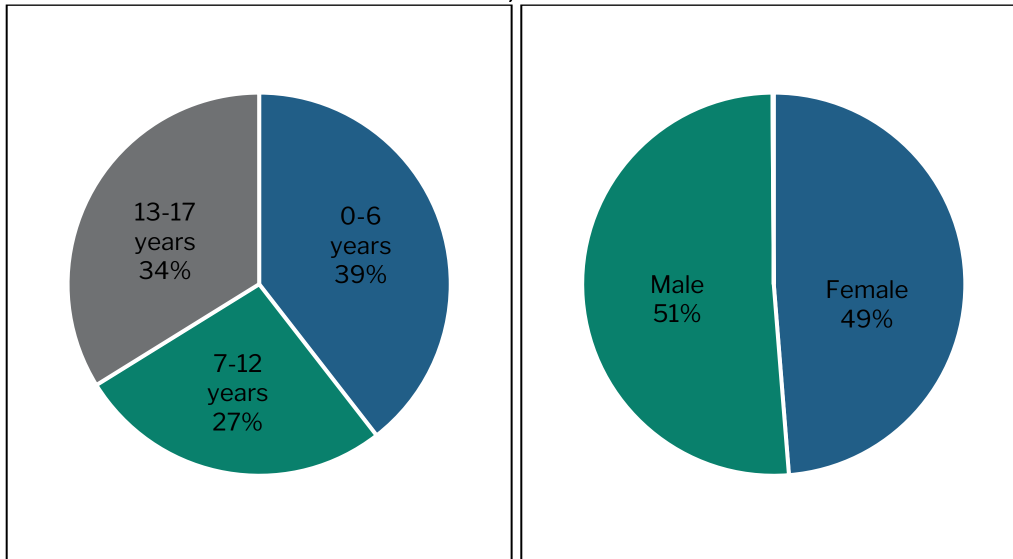
Source: CAPSS data provided by DSS

In terms of age and gender, Figure 7 reflects that about one-third (34%) of children in foster care are adolescents (ages 13 to 17), 27 percent of children in foster care are between the ages of seven to 12, and 39 percent of children are ages six and under. Slightly less than half of children in foster care are reported to be female (49%).[30] These demographics have remained consistent for multiple monitoring periods. DSS reports that on September 26, 2022, the Department introduced additional options to CAPSS to more accurately capture information regarding children's gender identity and sexual orientation. DSS expects data in this area to improve as case managers more consistently enter relevant information into CAPSS.

[29] This includes 33 children who resided in other institutional settings on March 31, 2023 and may not match the data in Section VIII. *Placement*.

[30] CAPSS data provided by DSS indicate that on March 31, 2023, the gender identity of 3 children (<.01%) in foster care was unknown.

Figure 7: Children in DSS Custody by Age and Reported Gender as of March 31,2023
N= 3,778[31]



Source: CAPSS data provided by DSS

In the coming months, the Co-Monitors plan on working with DSS to obtain and better understand data related to the circumstances under which children enter, re-enter, and exit foster care. These data could be vital to understanding where prevention and transition services are most needed, and to identifying opportunities to stabilize placement or prevent re-entry. Particular attention can also be paid to the needs of children aging out of foster care.

[31] This includes 33 children who resided in other institutional settings on March 31,2023 and may not match the data in Section VIII. *Placement*.

IV. Fiscal Resources

Funding obligations associated with the *Michelle H.* lawsuit have been fully appropriated by the General Assembly through Fiscal Year (FY) 2022-2023.[32] For Fiscal Year 2023-2024, DSS was appropriated funding to continue its child welfare reform efforts. This includes $13.7 million in state general funds to increase provider rates and support for KinGAP, a guardianship assistance program that enables children to exit the foster care system into legal guardianship with their kinship caregiver.[33] It also includes $1.3 million in state general funds for Adult Protective Services (APS), Economic Services and agency-wide efforts; $1.3 million in state general funds for technology and data privacy updates; and $14.2 in additional non-recurring state general funding. Moving forward, DSS will continue to focus efforts on requesting funding for child welfare reform as additional needs are identified.

[32] For a more in-depth discussion of the FY2022-2023 budget, please refer to the *Michelle H. et al. v. McMaster and Leach* Progress Report for October 1, 2021 – March 31, 2022, Section IV. *Fiscal Resources*, available at: https://cssp.org/wp-content/uploads/2022/10/10-5-2022-MP11-Progress-Report.pdf.

[33] To see the full FY2023-24 General Assembly Appropriation go to: https://www.scstatehouse.gov/sess125_2023-2024/appropriations2023/ta23ndx.php

V. Staffing and Caseloads

The infusion of resources for hiring in July 2022 has resulted in a gradual reduction in caseloads in some areas. At the end of March 2023, 58 percent of Foster Care case managers had caseloads within the required limit, up from 51 percent in September 2022; at least 96 percent of Team Leaders[34] were within required limits in terms of number of case managers they oversaw (not accounting for the cases they were directly carrying).[35,36]

The allocation and hiring of a significant number of newly funded positions in the FY2022-2023 budget to child welfare functions for Non-Class Members (the "front end" of DSS's system), such as Child Protective Services and Family Preservation, is intended to support continued reductions in the number of children separated from their families and taken into foster care. Though the impact of these positions on foster care caseloads cannot be seen immediately, this important investment is also likely to contribute to further reductions in caseloads over time.

The hiring of additional staff is intended to allow case managers the time and capacity to better serve children and families. As reported in the Supplemental Report, though, the placement instability crisis has increased the demands on case managers throughout the state. Some staff have reported working extremely long days, spending significant time driving children to and from emergency placements and appointments. The time and focus on children living out of offices or awaiting placements has hindered case managers' ability to serve other children and families on a path to reunification or adoption, extending their time in foster care (and on a case manager's caseload). One case manager said, "We're raising children in this office, but we have other children on our caseload. I was in the office for an entire month with a kid so I had to do virtual visits with the other children on my caseload, which is not acceptable."

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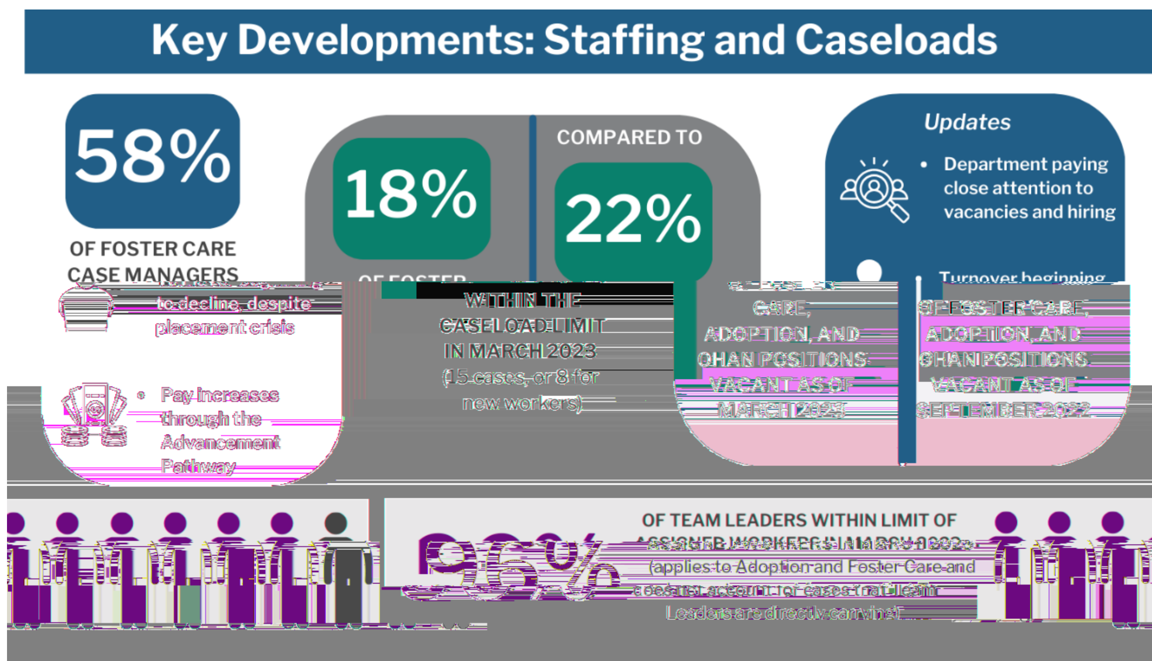
[34] See, *supra* note 5.

[35] As described below, workload limits for Team Leaders require that they oversee no more than five case managers in foster care and adoptions; OHAN Team Leaders are required to oversee no more than six investigators.

[36] Data initially produced to the Co-Monitors reflected an increase in the number of Team Leaders carrying direct cases in addition to supervising staff during each month between October 2022 and March 2023, compared to prior monitoring periods. DSS is in the process of further validating and assessing these data, and is working with the Co-Monitors to ensure future data submissions in this area accurately reflect Team Leader workloads.

The placement instability crisis has also highlighted the need for mentorship and training of staff in engaging families, assessing children's underlying needs, teaming, and service tailoring. The Co-Monitors observed several days of the Child Welfare Certification Training in March and April 2023, and spoke with the training team about their efforts to make curriculum improvements that focus more on quality of practice.

Despite the pressures on staff caused by the placement instability crisis, turnover has begun to decline from its peak in 2022. DSS leadership remains hopeful that outcomes and experiences for families will improve as it implements many of the initiatives and changes already underway, as well as some of those that have been recommended in the Supplemental Report.



Staffing and Caseload Updates

In DSS's Data Submission to the Court, the Department provided updates on hiring, recruitment, turnover, and retention strategies; pay increases through the Advancement Pathway; and training curriculum rollout for Team Leaders.[37] As reflected therein, staff turnover has continued to steadily decline, from 9.2 percent in Quarter 3 of 2022 (from July to September) to 8.2 percent in Quarter 1 of 2023 (from January to March), with a predicted drop to 7.2 percent in Quarter 2 of 2023

[37] See, *supra* note 9.

(from April to June) according to preliminary data. DSS continues to track turnover carefully.

As reflected in DSS's Data Submission to the Court, the vacancy rate for all child welfare staff has not significantly changed since it was last reported in March 2023 (hovering around 18 percent), however frontline case manager positions are 88 percent staffed, frontline Team Leader positions are 96 percent staffed, and Team Coordinator positions are 100 percent staffed statewide as of July 20, 2023.

DSS continued to fill new Regional Support Team positions, to be deployed to counties with a need for additional support due to spikes in caseloads or staff turnover to assist with visits, transportation to appointments, searches for family members, or other tasks. Regional Support Teams have already begun to provide support to Pickens County, Upstate Adoptions, Laurens County, and York County. As of May 2023, only two of 20 case manager positions on the Regional Support Teams had been filled, but as of August 2023, 16 of 20 positions were filled, as well as all four Team Leader positions.

DSS's Data Submission to the Court also highlights that, as of June 30, 2023, the eligibility requirements for pay increases through the Child Welfare Professional Advancement Pathway have been changed to allow more staff to qualify. Prior to this, only one case manager and five Team Leaders had been approved for Level 2 of the advancement pathway.[38]

Staffing and Caseloads Performance Data

The FSA requires that *'[a]t least 90% of Workers and Worker supervisors shall have a workload within the applicable Workload Limit"* (FSA IV.A.2.(b)) and that *'[n]o Worker or Worker's supervisor shall have more than 125% of the applicable Workload Limit"* (FSA IV.A.2.(c)). The Workforce Implementation Plan set the final target to be reached by DSS in March 2021. Caseload standards differ by case manager type – specifically Foster Care and Adoptions, and investigations of allegations of abuse and neglect of children in foster care (OHAN).[39] Approved caseload standards are included in Table 1.

[38] See *supra* note 9 at 69.
[39] DSS has many staff with "mixed" caseloads that include different case types and both Class and Non-Class Members. On December 21, 2017, the Co-Monitors provisionally approved DSS's proposal

Table 1: Caseload Standards by Worker Type

Worker Type	Caseload Standard	Caseload Standard for New Workers*	More than 125% of Standard	More than 160% of Standard	More than 170% of Standard	More than 180% of Standard
Case Managers						
Foster Care Case Manager	One case manager to 15 children (1:15)	No more than eight children (1:8)	More than 18 children or Non-Class cases	More than 24 children or Non-Class cases	More than 25 children or Non-Class cases	More than 27 children or Non-Class cases
Adoptions Case Manager[40]	One case manager to 15 children (1:15)	No more than eight children (1:8)	More than 18 children	More than 24 Children	More than 25 children	More than 27 children
OHAN Investigator	One investigator per eight investigations (1:8)	No more than four investigations (1:4)	More than 10 investigations	More than 12 Investigation s	More than 13 investigations	More than 14 investigations
Team Leaders						
Foster Care Team Leader	One Team Leader to five case managers (1:5)	N/A	More than six case managers			
Adoptions Team Leader	One Team Leader to five case managers (1:5)	N/A	More than six case managers			
OHAN Team Leader	One Team Leader to six investigators (1:6)[41]	N/A	More than seven investigators			

Source: Approved DSS Workforce Implementation Plan (February 2019)
* Employed less than 6 Months since completing Child Welfare Pre-Service Certification Training

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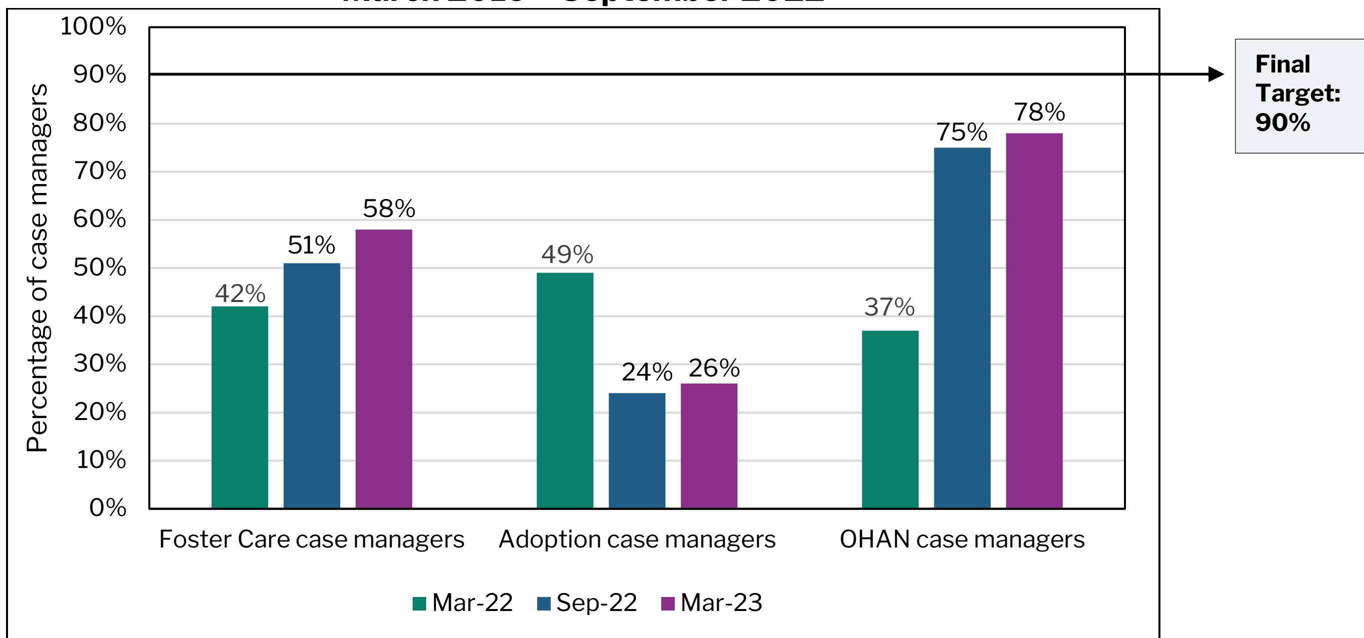
to calculate caseloads for foster care case managers with mixed caseloads by adding the total number of foster care children (Class Members) they serve to the total number of families (cases) of Non-Class Members also served. The following types of cases are currently counted by family (case): Child Protective Services (CPS) investigations; family preservation; other child welfare services; and those involving a child subject to the Interstate Compact on the Placement of Children (ICPC). This methodology is only applied to Foster Care case managers with mixed caseloads and is not applied to Adoptions case managers.

[40] Prior to 2019, DSS's workforce was structured so that case management responsibilities remained with the Foster Care case manager, even when an Adoptions case manager was assigned, until a placement agreement was signed. As a result, the approved caseload standard for Adoptions case manager was 1:17. In 2019, DSS began transitioning case management responsibility to Adoptions case manager once children became legally eligible for adoption. This was completed in January 2020; thus, Adoptions case manager caseload performance is assessed at a standard of 1:15.

[41] The Co-Monitors approved the higher caseload standard for OHAN Team Leaders in recognition of the fact that the OHAN investigators they supervise have lower caseload standards than other direct service case managers.

To assist in assessing progress over time, Figure 8 shows performance data on caseloads by case manager type for prior and current monitoring periods. As of March 31, 2023, compared to six months prior, the percentage of case managers with caseloads within required limits has improved for all three case manager types, though performance for Adoption case managers is significantly lower than it was a year ago (March 2022).

Figure 8: Percentage of Case Managers with Caseloads Within the Required Limits, by Case Manager Type March 2019 – September 2022

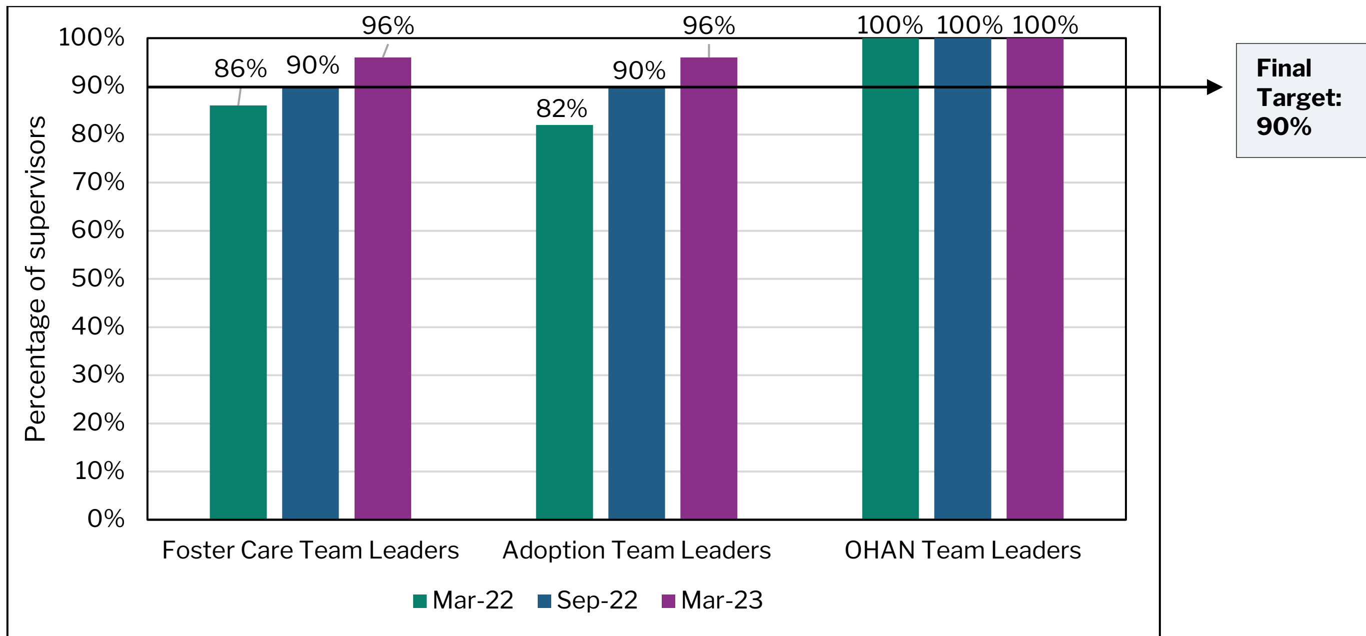


Source: CAPSS data provided by DSS

As shown in Figure 9, for the second time in March 2023, at least 90 percent of Team Leaders were within required limits in terms of the number of case managers they supervise. This is the result of focused efforts to prioritize filling all Team Leader vacancies so that appropriate support is in place for case managers. However, Team Leaders' workloads may be higher than is reflected in the data, as initial data submitted by DSS show that Team Leaders are continuing – at an increasing rate – to be directly responsible for case. DSS has identified situations in which it may be

necessary for Team Leaders to be directly responsible for a case(s) for a short period of time.[42,43]

Figure 9: Percentage of Team Leaders with Assigned Case Managers Within the Required Limits, by Team Leader Type March 2019 – March 2023



Source: CAPSS data provided by DSS

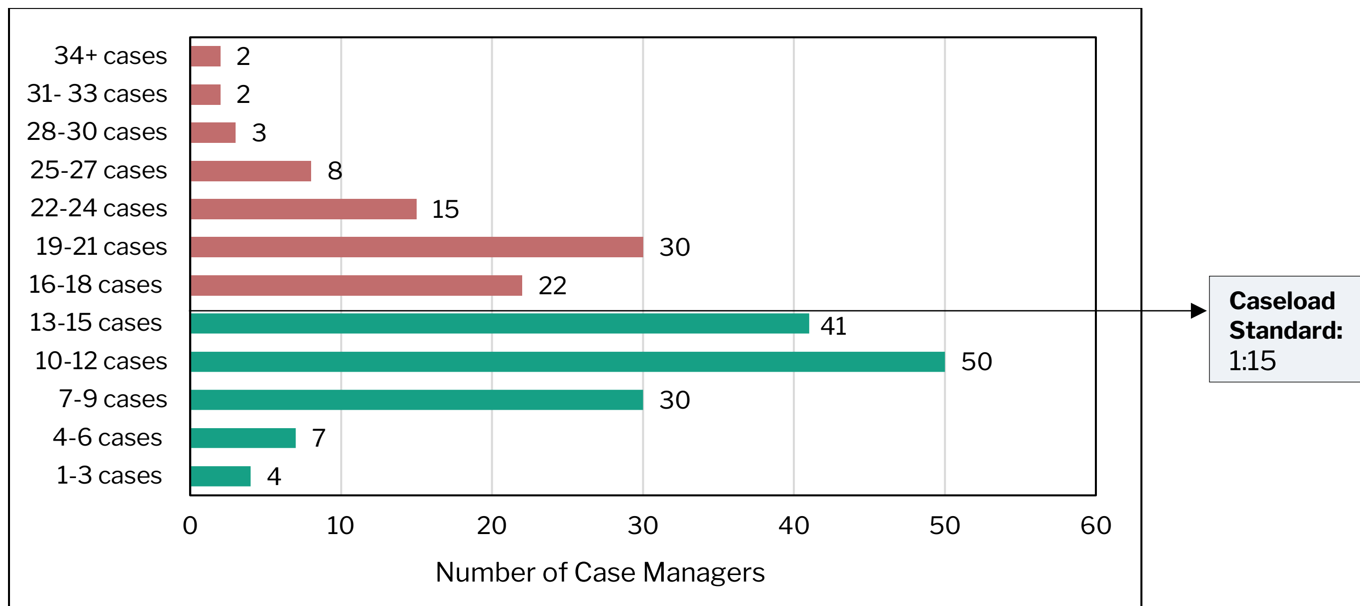
[42] These include circumstances in which a case manager is promoted to Team Leader and may temporarily retain case management for up to 45 days if a case is nearing closure; there are complexities regarding the case that need to be addressed; or an important legal event will occur within the timeframe. When cases are being transferred from one case manager, office, unit, or program area to another, the case may be temporarily assigned to the receiving Team Leader for up to 5 days until the Team Leader assigns the case to the receiving case manager. DSS has also identified that Team Leaders sometimes carry cases when a case manager leaves the agency and creates a vacancy that takes some time to fill or when case managers are on extended leave. While the Team Leader is directly managing, or "carrying" a case, they are responsible for all required case duties, including visits with the child; monitoring the child's safety, placement, well-being, case plan, and service delivery; ensuring the child is visiting with their siblings and/or parent; and other activities as necessary. For these circumstances, DSS requires Regional Director approval for Team Leaders to carry cases for more than 5 days; documentation be shared with Accountability, Data, and Research (ADR); and a description of the cases the Team Leader will carry, the circumstances leading to the Team Leader carrying cases, and a specific plan and timeline be created to address the issue. The Co-Monitors approved this process in April 2021, and DSS began tracking and reporting these data in May 2021.

[43] See, *supra* note 36.

Foster Care Case Managers

The data presented above include a compilation of all Foster Care case managers – those newly hired as well as those hired more than six months prior to completing training. Figure 10 provides the number of cases assigned only to the 214 Foster Care case managers on March 31, 2023 who had completed Child Welfare Pre-Service Certification Training more than six months prior (case managers who are not new). The Figure shows the distribution of cases for the 132 case managers with caseloads within the standard and the 82 case managers with caseloads above the standard. As shown in the Figure, as of March 31, 2023, six case managers who were not new were responsible for more than 30 cases each (double the caseload standard).

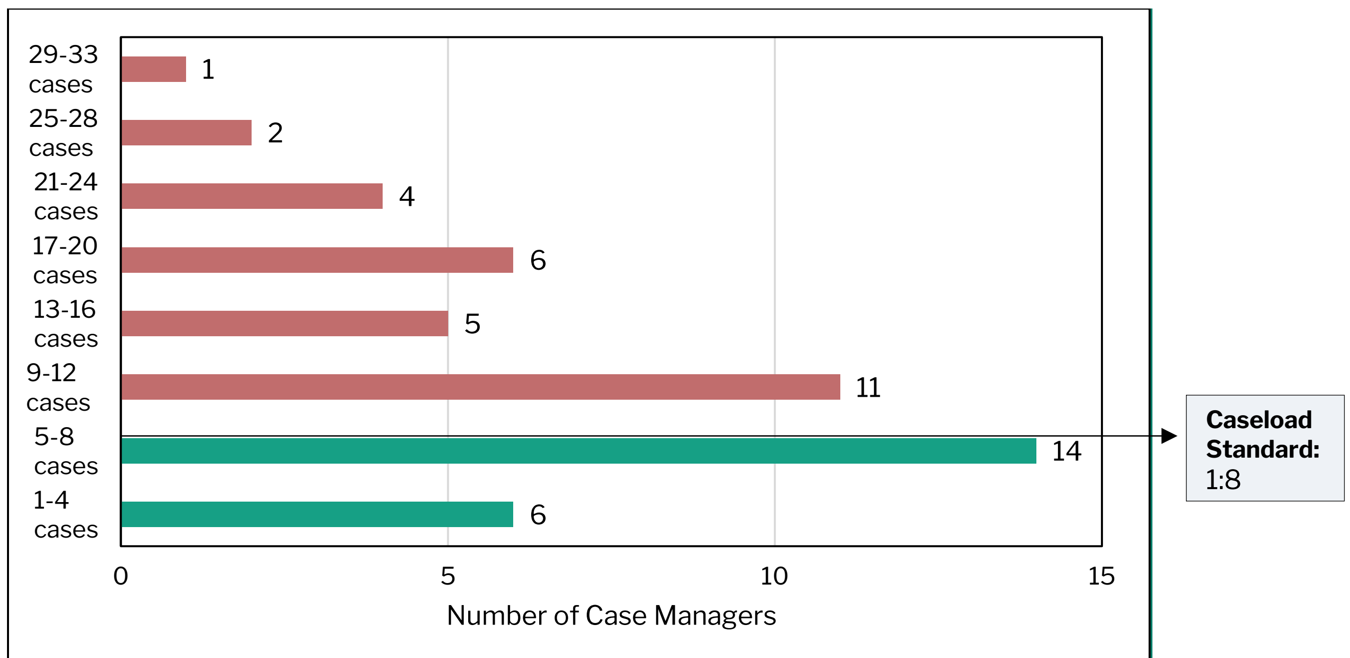
Figure 10: Number of Cases Assigned to Not New Foster Care Case Managers
March 2023
N = 214



Source: CAPSS data provided by DSS

Graduated caseload standards are an important retention strategy and necessary to allow new staff the time to develop their skills. Figure 11 reflects the number of cases assigned to the 49 new Foster Care case managers on March 31, 2023 who had not completed certification training more than six months prior (new case managers). Less than half (41%, or 20 of 49) of new case managers had caseloads within the standard. As of this date, over a quarter (27%, or 13 of 49) of new case managers were responsible for 17 or more cases (approximately double the caseload standard).

Figure 11: Number of Cases Assigned to New Foster Care Case Managers March 2023 N = 49



Source: CAPSS data provided by DSS

Data on Foster Care case manager caseloads by region as of March 31, 2023 are shown in Table 2. DSS offices are divided among four regions, which differ in terms of geographical size, the number of children and families served, and the number of assigned and onboarded case managers. Performance has improved in most regions as compared to March 2022 (12 months prior), but compared to the prior monitoring period (September 2022), Midlands and Pee Dee have maintained approximately the same levels of compliance, and performance in the Lowcountry declined. Compared to September 2022, performance in the Upstate improved from 65 percent to 87 percent of caseloads within the required limit.

Table 2: Foster Care Case Managers with Caseloads Within the Required Limit by Region September 30, 2021 – March 31, 2023

Region	Foster Care Caseloads within Required Limit on March 31, 2022	Foster Care Caseloads within Required Limit on September 30, 2022	Foster Care Caseloads within Required Limit on March 31, 2023
Lowcountry	37% N=22/60	50% N=22/44	40% N=17/42
Midlands	24% N=20/82	27% N=21/78	30% N=23/77
Pee Dee	56% N=30/54	67% N=35/52	67% N=39/60
Upstate	55% N=49/89	65% N=54/83	87% N=73/84

Source: CAPSS data provided by DSS

VI. Case Manager Visits with Children and Family Time: Children's Visits with Their Parents and Siblings

Upon agreement of all Parties, beginning in the October 2021 through March 2022 monitoring period, the Co-Monitors suspended reviews of three statistically valid samples of records and reporting on all FSA measures related to visits between case managers and children (FSA IV.B.3) and time children spend with their family members, their parents (FSA IV.J.2) and siblings who are also in foster care and placed separately (FSA IV.J.3). Parties agreed that these reviews would be paused for at least four monitoring periods, or until DSS's internal data suggests there has been substantial increase in performance.[44,45]

The placement instability crisis has made it difficult for DSS leadership and case managers to increase their focus on improving practice to ensure that all visits occur as needed and required. As described in the Supplemental Report, already overburdened staff in many county offices have had to carry out their ongoing responsibilities while acting around the clock as direct care providers for the children living in DSS offices. They have also had to spend time transporting children to and from emergency placements, many of which are hours away from the DSS office and only willing to accept a child for a few hours each night. When children are moved to longer term placements, they are often placed far from their families and communities, making it difficult for families to connect and spend time with each other and for case managers to facilitate essential visits. On July 10, 2023, 67 percent of children were placed outside their home counties. According to recent analysis by the University of South Carolina Center for GIScience and Geospatial Big Data ("the Center"), approximately one-quarter of placements (26%, or 1,011 of 3,867 placements) are more than 60 miles from the county office of management. The Center also calculated distance between placements and parent addresses, and found that 30 percent of placements (1,036 of 3,366 placements) were more than 60 miles from the caregiver(s) with whom reunification was sought.[46]

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[44] Currently, the Co-Monitors plan for a review of performance as of March 2024.

[45] For more information on the agreement to pause reviews related to visitation, refer to *Michelle H., et al. v. McMaster and Leach* Progress Report for the Period October 1, 2021 – March 31, 2022, Sections VI. *Case Manager Visits with Children* and IX. *Family Time: Visits with Parents and Siblings,* located here.

[46] See, *supra* note 9 at pp 66-69.

DSS has reported ongoing efforts to train staff, stressing the importance of time children spend with their family. However, substantial progress will not be feasible until the placement instability crisis is addressed.

Case Manager Visits Updates

Parties agreed that a case manager's documentation in CAPSS of a contact with a child should reflect each of the Department's policy and practice expectations for a visit and that CAPSS documentation would be assessed qualitatively to determine that a visit that conforms to policy expectations has been held for monitoring and reporting performance. However, due to the lack of substantial progress in this area, and subsequent pause of reviews, these policy and practice expectations have not been assessed for this monitoring period.

Documentation from five statistically valid samples of DSS records of Class Members between 2019 and 2021 shows that case managers had contact with the overwhelming majority, if not all, of the children in the sample, and that these contacts predominantly occurred where the child resides.

At this time, the FSA requirement that at least 90 percent of children receive a monthly face-to- face visit by their case managers during a 12-month period and that at least 50 percent of those visits occur where the child resides, can only be reported with quantitative data from CAPSS. Quantitative data provided by DSS continue to show these outcomes. For example, data show that 92 percent of possible visits occurred as of May 2023, and 62 percent of those occurred in the child's home.[47]

Family Time: Visits with Parents and Siblings Updates

DSS's Data Submission to the Court included monthly internal reports on the number of parent-child and siblings visits, as well as updates on training and coaching of staff regarding expectations for visits. The submission details DSS's efforts to increase direct documentation by foster parents and providers of visits in the Child and Adult Information Portal (CAIP) of visits of which they are aware and/or facilitate. DSS also reported on the progress of implementing SafeMeasures®, a nationally recognized

[47] See, *supra* note 9 at 57-58.

web-based system for data aggregation, reporting, and analysis developed by Evident Change[48] that will provide real time data dashboards for case managers and leadership. DSS reports progress in implementing Safe Measures. Reports on sibling and parent-child visits have been completed and are being vetted. The sibling visit report will soon be published. However, the parent-child visit report, which includes more variables, requires additional vetting and adjustments for finalization.

[48] To read more about Evident Change, go to: https://evidentchange.org/analytics/safemeasures/

VII. Intakes and Investigations of Alleged Abuse/Neglect in Out-of-Home Care

Staff of DSS's Out-of-Home Abuse and Neglect (OHAN) unit conduct investigations of allegations of abuse and/or neglect of children in foster care screened by Intake Hub staff and deemed to warrant investigation. Investigation tasks are expected to be completed with quality and in a timely manner.

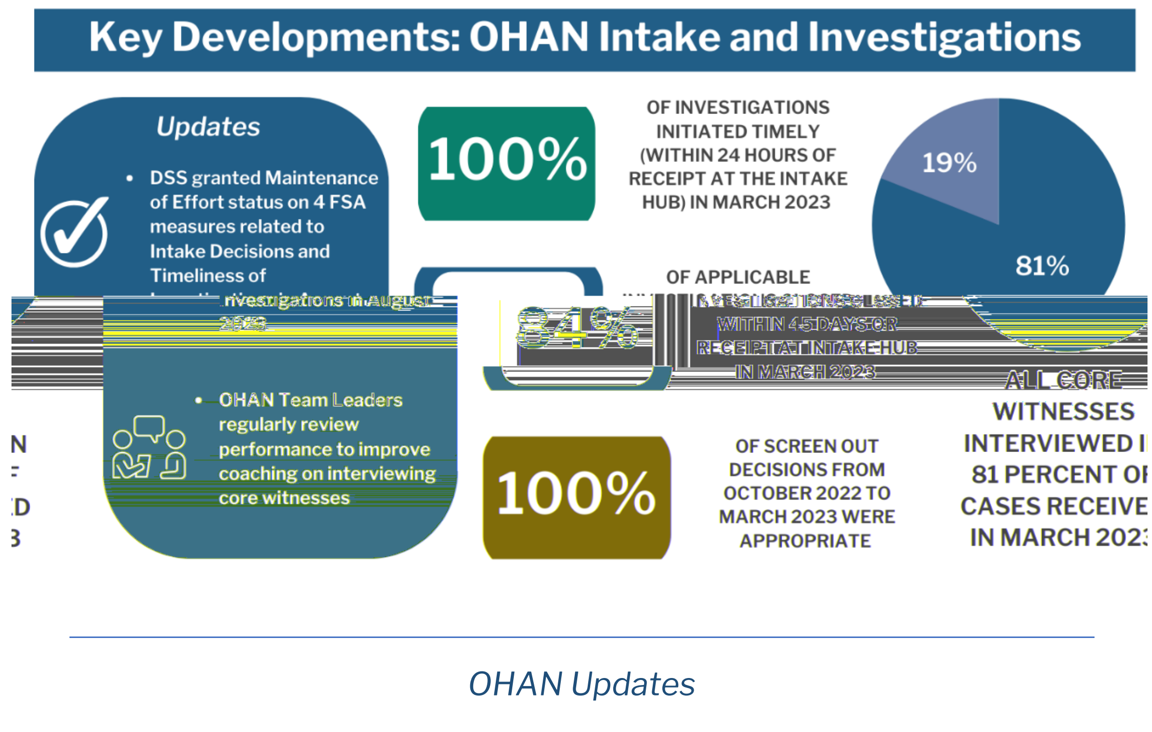
Since 2017, results of case record reviews have reflected improvements in the overall quality of OHAN documentation and practices. The Co-Monitors reported DSS's performance on decisions not to investigate a referral of abuse or neglect about a Class Member were above the target of 95 percent for two consecutive monitoring periods.[49] Similarly, since 2018, DSS has been meeting each of the three targets for timely completion of OHAN investigations.[50] The Co-Monitors designated these subsections of the FSA as eligible for Maintenance of Effort status.

On July 28, 2023, DSS, while acknowledging there is still work left to do, joined Plaintiffs in filing a motion seeking the Court's approval for Maintenance of Effort status for four subsections of the FSA related to OHAN: Intake – Decision Not to Investigate; Timely Completion of Investigation Within Forty-five (45) Days of Initiation; Timely Completion of Investigation Within Sixty (60) Days of Initiation; and Timely Completion of Investigation Within Ninety (90) Days of Initiation. The Court granted this motion on August 3, 2023.[51]

DSS will continue to provide data on decisions not to investigate an OHAN report on a quarterly basis.[52] Through twice-yearly OHAN case records reviews, DSS and Co-Monitor staff will gather and review data on timeliness of the completion of OHAN investigations.

[49] FSA IV.C.2 requires that at least 95% of decisions not to investigate a referral of abuse or neglect about a class member must be made in accordance with South Carolina law and DSS policy.
[50] FSA IV.C.4(d), (e), and (f): Timely Completion of Investigations Within Forty-Five, Sixty, and Ninety Days, respectively.
[51] Court Order approving Maintenance of Effort for FSA IV.C.2 and FSA IV.C4(d), (e), and (f). (August 3, 2023, Dkt.290)
[52] FSA V.E.2 states that a designation of Maintenance of Effort means the Co-Monitors "shall reduce the level of monitoring over that item to a level sufficient to identify any significant deterioration of performance and not continue at the level of monitoring prior to a designation of 'Maintenance of Effort.'"

An increased number of investigator and Team Leader positions, focused and consistent supervision, improved information gathering and assessments, and improved engagement by OHAN staff with children and other core witnesses during investigations are important contributors to the continued success in OHAN practices.



OHAN Updates

The OHAN Implementation Plan[53] set interim benchmarks and timelines and contains strategies to improve OHAN practice and achieve the targets required by the FSA.[54] The OHAN unit has benefitted from strong, consistent leadership. DSS has increased staffing for OHAN, revised training for Intake and OHAN, implemented processes to improve timely initiation of investigations, communication with licensing and Foster Care Team Leaders.

Staffing

DSS reports that as of July 13, 2023, five of six Team Leader positions were filled with a sixth person in the hiring process. Thirty of the 33 investigator positions were filled, with one of the 30 investigators participating in training. Three people were in the

[53]The OHAN Implementation Plan is available at: https://dss.sc.gov/media/1967/michelle-h-2017-approved-ohan-section-of-august-9-implementation-plan-su.pdf

[54] DSS committed to achieving these FSA targets by March 2021.

hiring process at that time. Since the start of the lawsuit in 2016, the number of OHAN investigators has increased from seven to 33 and the number of Team Leaders has grown from two to six.

Training

Child Welfare Pre-service Certification Training is required for all child welfare staff. According to DSS, all Intake Hub staff complete an intake certification process which includes a module specific to OHAN reports.

All OHAN staff are expected to complete new investigator training within two weeks after completing Child Welfare Pre-Service Certification Training. The new investigator training includes OHAN policy, practice, and procedural expectations, two days of shadowing an investigator, and one day of OHAN-specific CAPSS training. DSS reports that certified employees who transfer to OHAN from other areas of the Department typically receive new investigator training within their first week.

New Processes Partnering OHAN Investigators

In July 2023, OHAN implemented a process of a second investigator accompanying the assigned investigator in cases involving multiple children or alleged perpetrators. DSS views this practice as providing support for the assigned investigator and creating opportunities for new investigators to learn from experienced investigators.

Integrating a Safety Assessment Tool

The Family Advocacy and Support Tool (FAST) has been integrated into OHAN investigation practice to assess child safety and risk and assist with determining the appropriateness of a recommendation for a child be moved from a placement. An outcome of this assessment is a staffing between the OHAN investigator, OHAN Team Leader, Foster Care case manager, and Foster Care Team Leader in cases where it is warranted to request that a child move to another placement.

Providing Information in Writing to Alleged Perpetrators

Alleged perpetrators currently receive information in writing upon the completion of an OHAN investigation regarding findings. However, in response to requests from providers for written documentation of allegations, DSS reports developing and implementing an OHAN Case Initiation and Allegation letter for alleged perpetrators.

OHAN Intake

Since November 2019, DSS's Intake Hub have been responsible for screening all reports alleging abuse and/or neglect of children, including allegations involving children in foster care settings.[55] Screening decisions are made utilizing a Structured Decision Making (SDM)® intake tool.[56] Decisions to either accept a report for investigation or take no further action on the report ("screen out") are based upon information received by the Intake Hub to determine if the allegations would, if substantiated, meet the state's statutory definition of abuse or neglect.[57] All screening decisions are reviewed and approved by a Team Leader prior to being finalized.

The FSA requires that *'[a]t least 95% of decisions not to investigate a Referral of Institutional Abuse or Neglect about a Class Member must be made in accordance with South Carolina law and DSS policy"* (FSA IV.C.2.).

Reports involving a Class Member that were not approved for investigation by DSS's Intake Hub staff from October 1, 2022 to March 31, 2023 were reviewed by Co-Monitor staff, in collaboration with DSS, to determine the appropriateness of the screening decision.[58] During this timeframe, DSS determined an investigation was not warranted for 34 applicable reports. Upon review, Co-Monitor staff, in collaboration with DSS, determined that the decision to not investigate for each of the 34 reports was appropriate. Figure 12 shows that performance on this measure is above the final target of 95 percent. As explained above, this requirement has been met and is now in Maintenance of Effort status. DSS will continue to provide information to Co-Monitors on this measure on a less frequent basis, quarterly instead of monthly.

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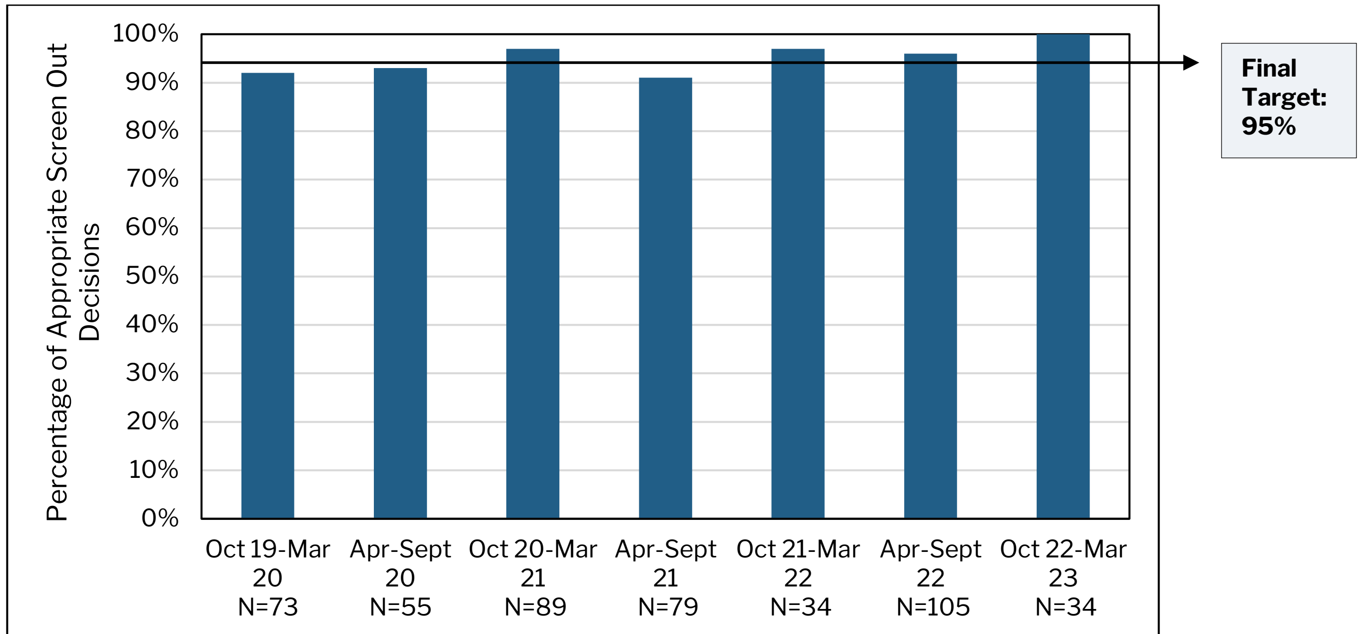
[55] In addition to the Intake Hub call center, DSS maintains a child abuse and neglect online reporting system accessible through their website. Guidance provided on the site indicates that it is designed to receive non-emergency reports of suspected abuse and/or neglect of a child or adult, and that it should not be used to report suspected abuse and/or neglect against a child in foster care. DSS has designated some Intake Team Leaders to check DSS's online portal every two hours for reports.

[56] For more information on SDM, see https://evidentchange.org/assessment/structured-decision-making-sdm-model/child-welfare/ (retrieved Jan. 26, 2023)

[57] SC Code § 63-7-20.

[58] This review includes examining information entered into CAPSS, and listening to recordings of reports, when available.

Figure 12: Appropriateness of Decision Not to Investigate Report of Institutional Abuse and/or Neglect October 2019 – March 2023



Source: Monthly review data, Co-Monitor and DSS staff

OHAN Investigations

Allegations of abuse or neglect of children in DSS custody screened by DSS's Intake Hub as appropriate for investigation are assigned to OHAN staff.[59,60] The FSA and OHAN policy require face-to-face contact with the alleged victim child(ren) within 24 hours of the report to Intake to assess for safety and risk, and the investigation is to be completed within 45 days.[61] OHAN policy requires that the investigator must conduct a safety assessment of the child, including a private interview; collaborate with the child's case manager or law enforcement to make arrangements for medical treatment or examinations, as needed; interview core witnesses to inform the investigation; review documents and records related to the incident; and assess the risk of further maltreatment to all children within that setting.[62]

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[59] SC Code § 63-7-1210; SC DSS Child Welfare Policies and Procedures Manual, Chapter 16: Special Topics: Out of Home Abuse and Neglect (effective May 19, 2022).

[60] Allegations of abuse or neglect by a foster parent of their biological or adopted child are investigated by child protective service case managers/investigative staff in local county offices.

[61] SC DSS Child Welfare Policies and Procedures Manual, Chapter 16: Special Topics: Out of Home Abuse and Neglect (effective May 19, 2022).

[62] Ibid.

FSA measures that relate to OHAN investigations include – timely initiation (two measures),[63] contact with core witnesses (one measure), investigation determination decisions (one measure), and timely completion (three measures, each now in maintenance status). Performance data below were collected during a record review of 43 investigations involving Class Members conducted by DSS and Co-Monitor staff in June 2023. The investigations were assigned to OHAN in March 2023.

Timely Initiation of Investigations

The FSA requires that *'[t]he investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations"* (FSA IV.C.4.(a)). FSA Section IV.C.4.(b) requires that *'[t]he investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim within twenty-four hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors."* [64] The Co-Monitors measure performance for both FSA IV.C.4.(a) and (b) using the same methodology and timeframes – the time between receipt of a report by the Intake Hub and face-to-face contact with the alleged child victim must be within 24 hours.

Of the 43 applicable OHAN investigations in March 2022, contact was made with all alleged victim children within 24 hours in 39 (91%) investigations and in an additional

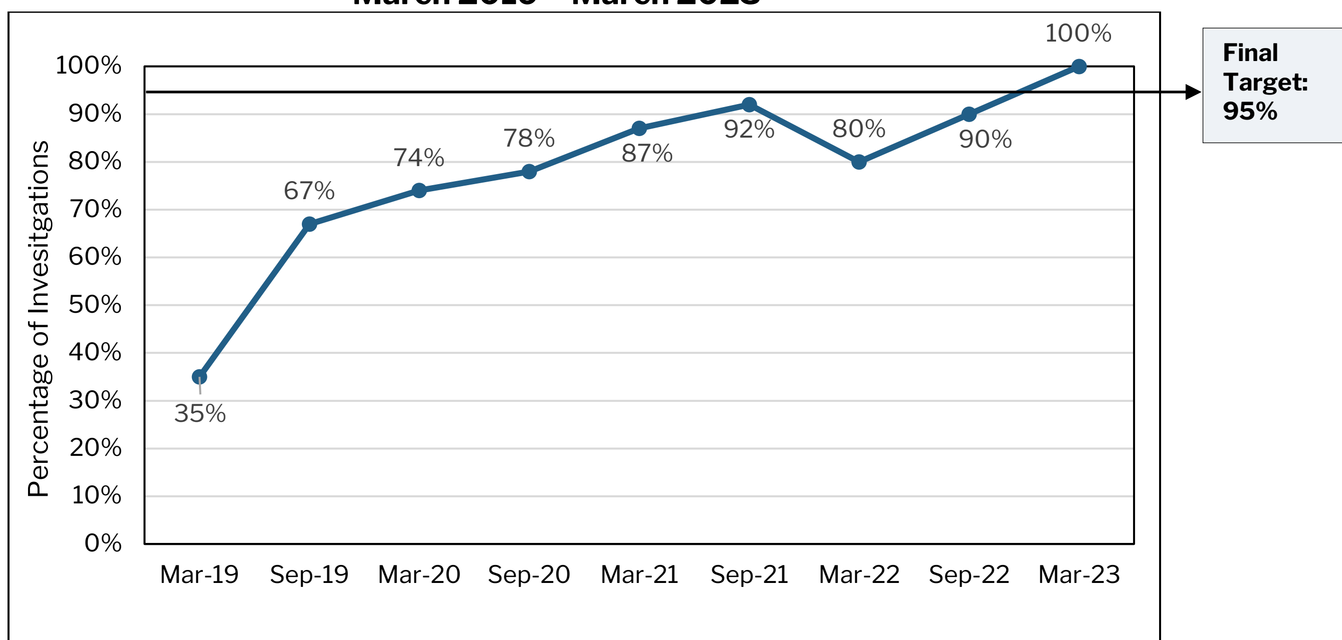
[63] The Co-Monitors' interpretation of the FSA requires that investigations be initiated within 24 hours of receipt of the report by DSS, not within 24 hours of the decision to accept the report, and that initiation is completed by making face-to-face contact with the alleged victim child(ren). As a result, the performance for both FSA measures IV.C.4.(a) and (b) are measured using the same methodology and timeframes - the time between receipt of referral/report and face-to-face contact with alleged child(ren) victim must be within 24 hours.

[64] The Co-Monitors approved the following efforts as "good faith efforts" for timely initiation which must be completed and documented, as applicable, to contact with an alleged victim child(ren) within 24 hours: investigator attempted to see child(ren) at school or child care facility; investigator attempted to see child(ren) at doctor's visit or hospital; for child(ren) moved to an out-of-state location in order to receive specialized treatment, investigator attempted to interview by Skype or other electronic means; investigator attempted to see child(ren) at the police department; investigator attempted to attend forensic/Child Advocacy Center (CAC) interview; investigator attempted to see child(ren) at therapist's office; investigator contacted the assigned Foster Care case manager(s) and/or Team Leader(s); investigator attempted to contact the parent/guardian of the victim child(ren) if the child(ren) has returned home; and investigator attempted to contact the child at all foster care placements where the child may temporarily be placed in the first 24 hours. Additionally, the following extraordinary circumstance exceptions to timely initiation were approved by the Co-Monitors: child was returned to biological family prior to report and family refuses contact; child is deceased; law enforcement prohibited contact with child(ren); facility restrictions due to child's medical requirements; natural disaster; and child missing despite efforts to locate (efforts should include all applicable good faith efforts).

four (9%) investigations, all applicable good faith efforts were made to contact each of the alleged victim children;[65] 100 percent of investigations were initiated in a timely manner.

Current performance shows an increase from the prior period and meets the final target of 95 percent (see Figure 13).[66]

Figure 13:Timely Initiation of OHAN Investigations March 2019 – March 2023



Source: Case Record Reviews completed by U of SC CCFS (up to Sep-21), DSS, and Co-Monitor staff

Contact with Core Witnesses during Investigations

The FSA requires that *'[c]ontact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors"* (FSA IV.C.4.(c)).[67]

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[65] There were 3 instances of children considered to be on "runaway" status and a child who had returned home with a closed case and could not be found to participate in the investigation.

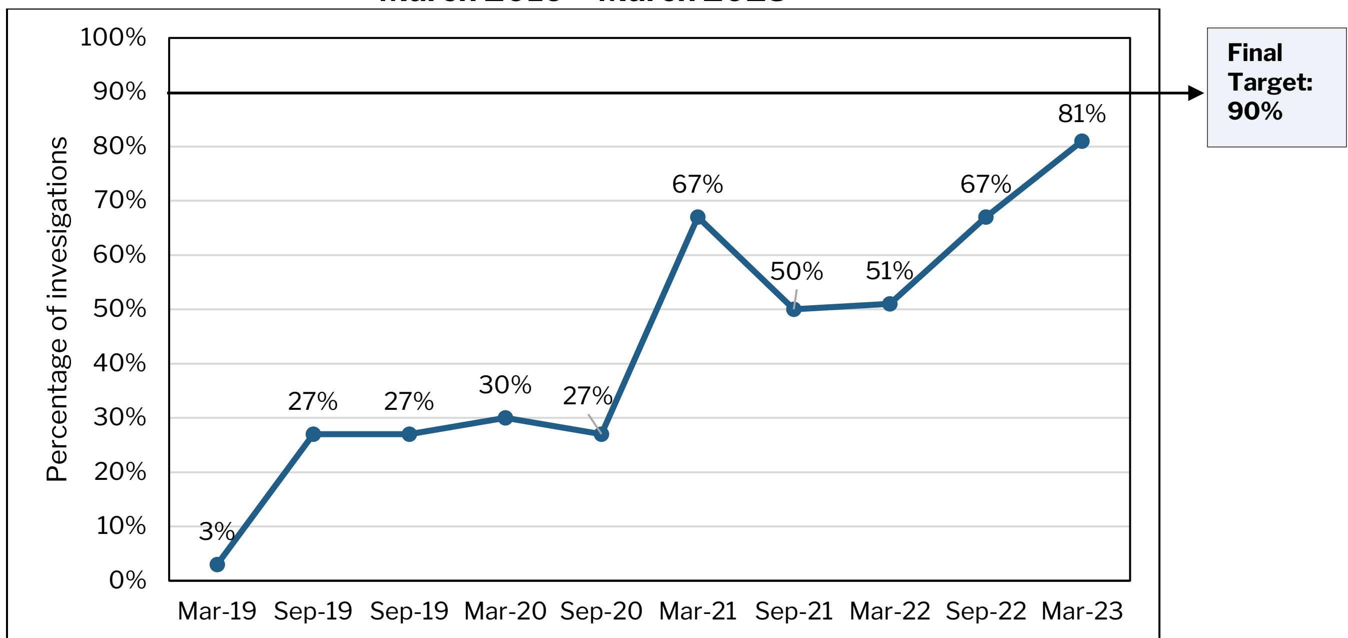
[66] Pursuant to FSA V.E.1-3, the Co-Monitors identify that this provision may be eligible for "Maintenance of Effort" designation by the Court.

[67] The following are exceptions, approved by the Co-Monitors, to the requirement that the investigator contact a core witness during an investigation: witness refused to cooperate; witness advised by counsel or law enforcement that interview could not occur (e.g., due to pending charges, lawsuit); witness is deceased; unable to locate or identify witness; and medical conditions prevented witness from cooperating. In all instances, the exception must be supported by documentation of the exception reason and best efforts to engage the witness.

A core witness is defined as an individual who is pertinent to the investigation because they witnessed or have knowledge of the alleged actions and can shed light on the allegations and the actions of the alleged perpetrators. Core witnesses may differ from investigation to investigation, but in all cases include: reporter(s), alleged perpetrator(s), alleged child victim(s), child's DSS case manager, other child(ren) and/or adult(s) in the home, and, when involved, law enforcement. If the allegations involve an institutional setting, all other adults and children relevant to the investigation are also considered core witnesses.[68]

Of the 43 applicable reports involving Class Members accepted in March 2023, 35 (81%) reflected contact with all necessary core contacts during the investigation. Current performance is a significant increase from the past two periods. This is likely a reflection of improved documentation and supervision by Team Leaders who engage in regular reviews of records for quality improvement on this measure. Performance for March 2023 remains below the final target of 90 percent (see Figure 14).

Figure 14: Contact with All Necessary Core Witnesses During OHAN Investigations March 2019 – March 2023



Source: Case Record Reviews completed by U of SC CCFS (up to Sep-21), DSS, and Co-Monitor staff

[68] This definition of core witnesses was proposed in DSS's OHAN Implementation Plan, which was approved by the Co-Monitors and consented to by Plaintiffs.

Data presented in Table 3 shows the frequency of OHAN investigator contact with each type of core witness in the 43 investigations reviewed.

Table 3: Interviews with Necessary Core Witnesses During OHAN Investigations by Type of Core Witness March 2023 N=43

Core Witness	Applicable Investigations	Contact/Interview with All	Contact/Interview with Some	Contact/Interview with None
Alleged Victim Child(ren)	43[69]	43 (100%)	-	-
Reporter	40[70]	39 (98%)	-	1 (2%)
Alleged Perpetrator(s)	43	43 (100%)	-	-
Law Enforcement	15	12 (80%)	-	3 (20%)
Alleged Victim Child(ren)'s Case Manager(s)	43	39 (91%)	2 (5%)	2 (5%)
Other Adults in Home or Facility[71]	20	17 (85%)	2 (10%)	1 (5%)
Other Children in Home or Facility[72]	20	15 (75%)	3 (15%)	2 (10%)
Additional Core Witnesses	43[73]	34 (79%)	8 (19%)	1 (2%)

Source: Case Record Review completed in December 2022 by DSS and Co-Monitor staff

Data in Figure 15 show the frequency of contact within all categories of core witnesses in March 2023 compared to the prior review in September 2022. Improvements are noted in the frequency of contact with all core witness types, except law enforcement and other children in the foster home or facility. In some investigations, OHAN staff are unable to reach law enforcement for a conversation but may obtain an official report. Co-Monitors have agreed to track and report the

[69] In 3 investigations the investigator was unable to locate the child, whose status was considered "runaway" and in 1 investigation a child had returned home with a closed case and could not be contacted despite efforts.

[70] In 3 investigations, the reporter was anonymous; in 4 investigations, the investigator was unable to locate the reporter despite efforts.

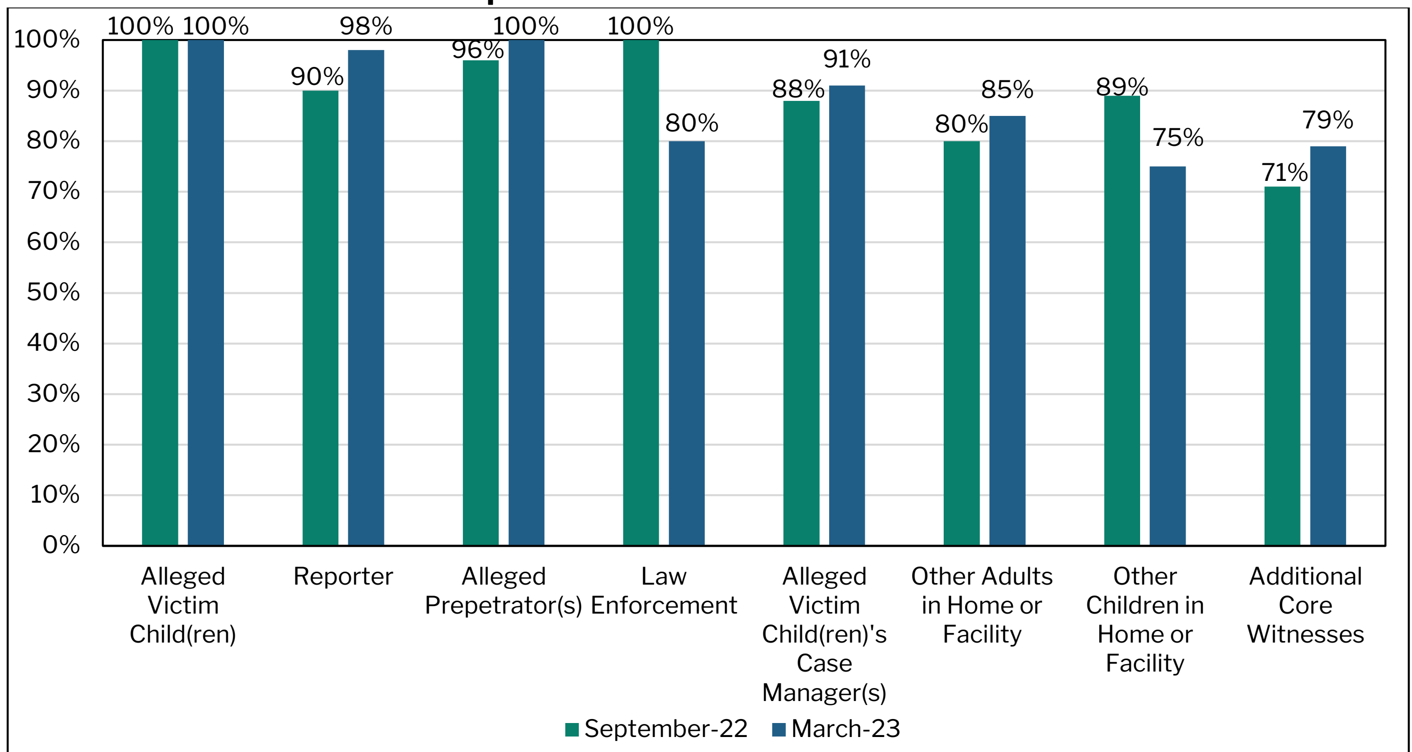
[71] For investigations involving foster homes, in addition to speaking with the alleged perpetrator(s), the investigator should speak with all other adults in the household. For investigations involving institutions, the investigator should speak with all other adults who were involved in or who have knowledge of the allegations.

[72] For children who are placed in foster homes, in addition to speaking with all alleged victim children, the investigator should speak with all non-victim children in the home to inform the investigation, including other children in foster care and biological or adopted children in the home. For investigations involving institutions, as facilities can have many children placed there, investigators should speak with all other children who were involved in or who have knowledge of the allegations.

[73] Additional core witnesses identified by reviewers in 43 investigations included: DSS licensing staff, medical and behavioral health providers, school or daycare personnel, and Guardian Ad Litem (GAL).

receipt of a written report and conversations with law enforcement during the investigation.

Figure 15: Contact with Necessary Core Witnesses During OHAN Investigations September 2022 and March 2023



Source: Case Record Reviews completed by U of SC CCFS (up to Sep-21), DSS, and Co-Monitor staff

Investigation Decisions

According to DSS policy at the conclusion of an investigation, a decision to *indicate* or *unfound* is made based upon the totality of the information collected, with the preponderance of the evidence as standard of proof of the facts.[74]

Section IV.C.3. of the FSA requires that *'[a]t least 95% of decisions to 'unfound' investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected."*

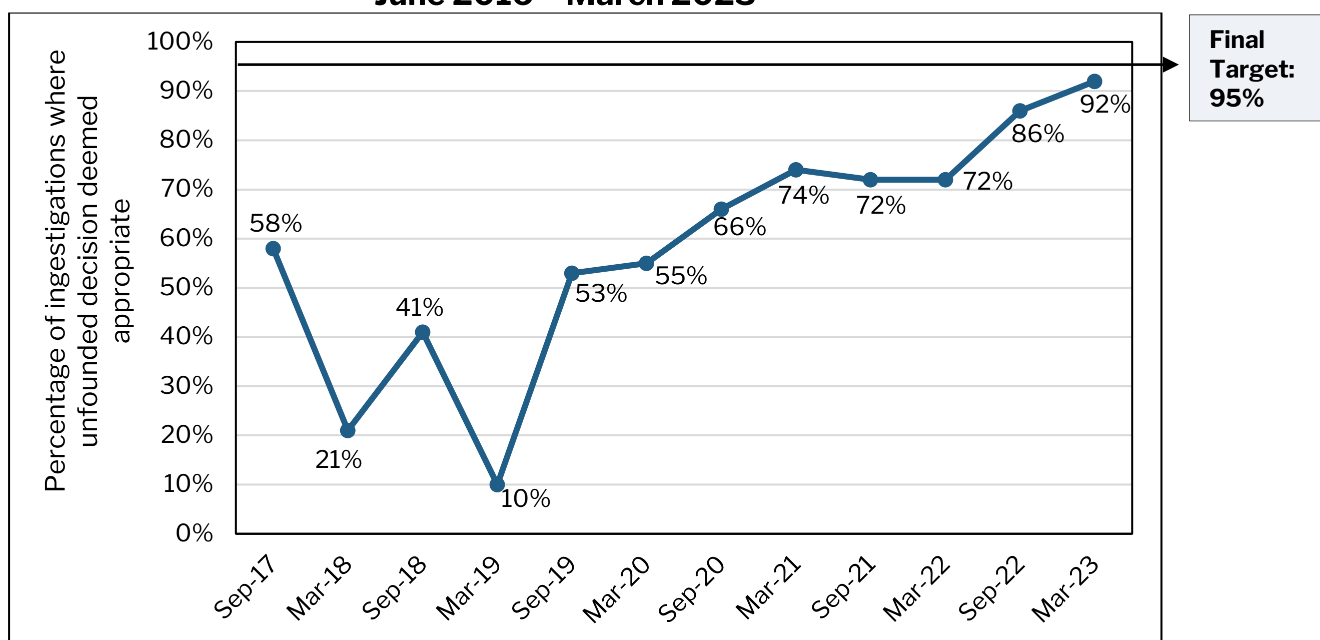
Of the 43 investigations reviewed, the final decision was to *unfound* the allegations in 38 investigations. Reviewers agreed that the decision to *unfound* the investigation

[74] SC DSS Child Welfare Policies and Procedures Manual, Chapter 16: Special Topics: Out of Home Abuse and Neglect (effective May 19, 2022).

was appropriate in 35 (92%) of the investigations.[75] In each investigation in which the reviewer did not agree with the decision to *unfound*, the disagreement was due to the reviewer determining that the investigator did not collect all critical information necessary to make an accurate finding in the investigation, including, for example, not interviewing a witness with relevant information, or not clarifying conflicting information gathered during the investigation.

Performance in this area continues to increase. However, performance remains below the final target of 95 percent.

Figure 16: Decision to Unfound OHAN Investigations Deemed Appropriate June 2016 – March 2023



Source: Case Record Reviews completed by U of SC CCFS (up to Sep-21), DSS, and Co-Monitor staff

Timely Investigation Completion

The FSA includes three measures for timely completion of investigations (FSA IV.C.4(d),(e)&(f)), recognizing that some investigations may take longer than 45 days as policy requires. The FSA and OHAN policy provide that the OHAN Director or Director's Designee may authorize an extension of up to 15 days for "good cause" or

[75] As part of the Co-Monitors protocol for all case reviews that are conducted, if a safety concern is identified and documentation does not reflect it was addressed, DSS is immediately notified for appropriate follow-up.

compelling reasons.[76] Good cause means that, through no fault of the investigator, sufficient reason exists for delaying the investigation decision.[77] DSS met and maintained the required final target levels for each measure assessing timely completion of OHAN investigations since September 2018. These measures are in Maintenance of Effort status and will be tracked twice yearly by the Co-Monitors through case record reviews.

Completed within 45 Days

In seven of the 43 investigations reviewed, the investigator requested and received an extension for an additional 15 days to complete necessary investigative tasks. Thirty-six (84%) of investigations were completed within 45 days (see Figure 18). Current performance meets the final target for this measure.

Completed within 60 Days

All (100%) of the 43 investigations were completed within 60 days of opening. Performance meets the final target for closure within 60 days.

Completed within 90 Days

Since all investigations were closed within 60 days, performance toward 90-day closure is also 100 percent, and performance meets the final target for this measure.

Figure 17 shows performance for timely closure of investigations from September 2018 to March 2023.

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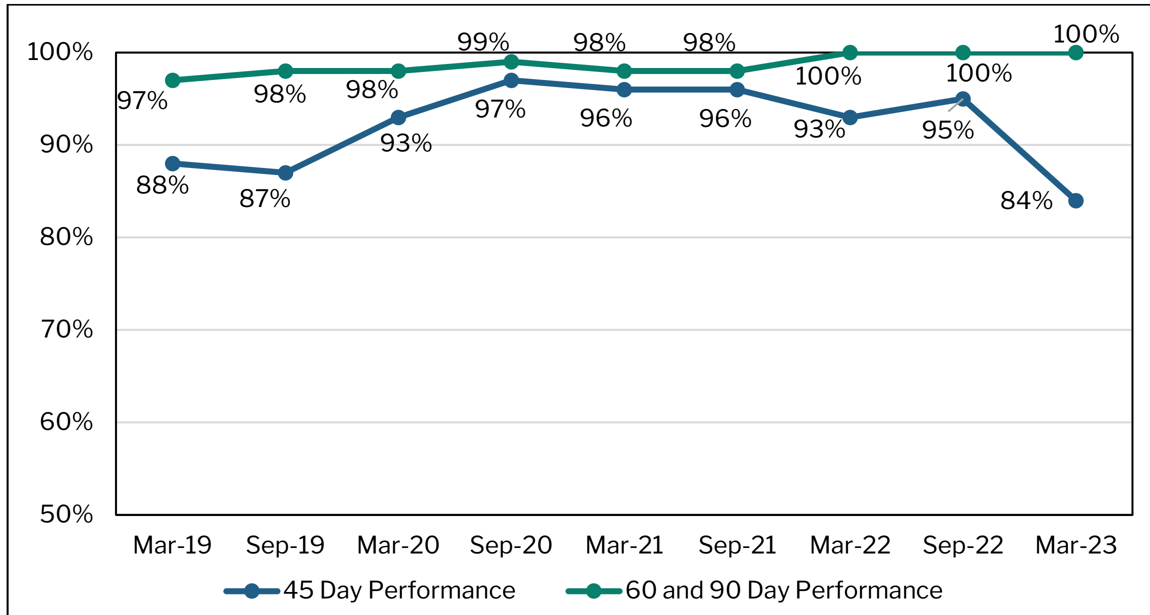
[76] SC DSS Child Welfare Policies and Procedures Manual, Chapter 16: Special Topics: Out of Home Abuse and Neglect effective (May 19, 2022).

[77] Examples of good cause may be one of the following: awaiting critical collateral information (e.g. medical report, x-rays, toxicology, video); awaiting forensic interview/findings; awaiting critical information from another jurisdiction (e.g. central registry check); critical new information was received from witness that requires follow-up; awaiting action by law enforcement; or child has been too ill or traumatized to speak with investigator.

Figure 17: Timely Completion of OHAN Investigations
March 2018 – March 2023



FSA Final Targets:
45 Day – 60%
60 Day – 80%
90 Day – 95%

Source: Case Record Reviews completed by U of SC CCFS (up to Sep-21), DSS, and Co-Monitor staff

VIII. Placements

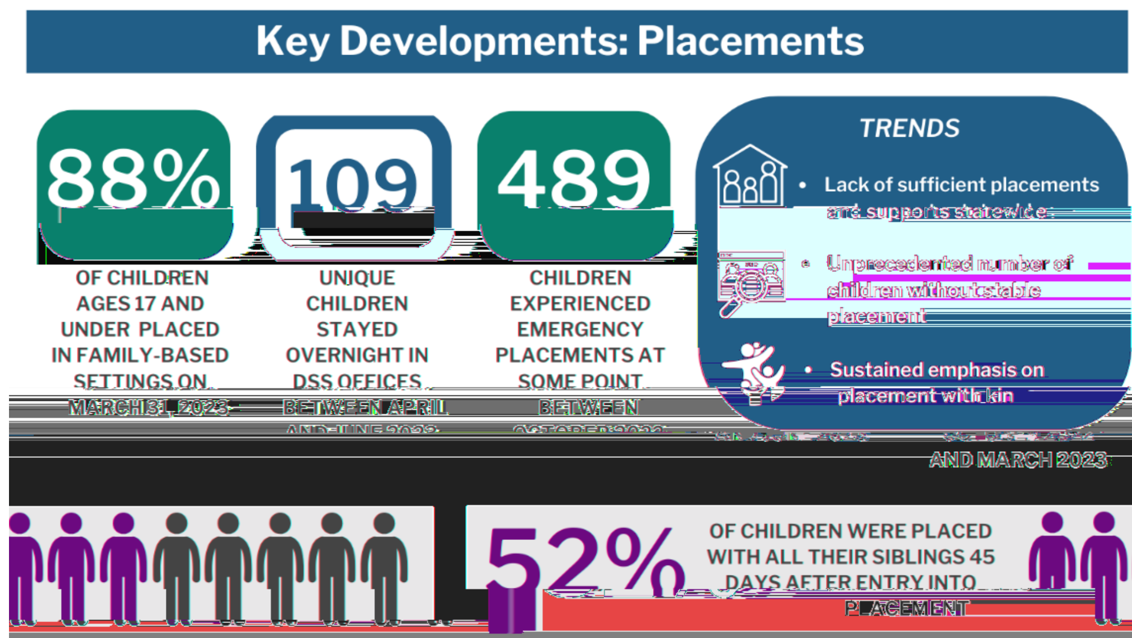
The Co-Monitors' August 1, 2023 Supplemental Report focuses on the current placement instability crisis faced by Class Members and includes detailed information on overnight stays in DSS offices and emergency placements that occurred during the monitoring period, as well as a more recent analysis of children who stayed overnight in DSS offices between April and June 2023. The Supplemental Report describes the impact of the placement instability crisis on all involved – children, families, kin, foster parents, group home staff, private providers, DSS frontline staff and leaders – who are strained, tired, and operating with less patience than they were prior to April 2021 when reports of children staying overnight in DSS offices began to escalate.

As presented in that report, the placement instability crisis is a symptom of the severe shortage of services and supports for children and families throughout South Carolina, as well as other contributing factors. These include the lingering impact of the COVID-19 pandemic on family stress and foster parent recruitment; efforts by the state to appropriately reduce the number of non-therapeutic group care placements; slow implementation of Qualified Residential Treatment Programs (QRTPs); limited access to intensive residential treatment for a small number of youth who need a higher level of care; and the compounding failures of other child- and family- serving systems that have resulted in children entering foster care.

The placement instability crisis has also detracted from DSS leadership's focus on integrating its Guiding Principles and Standards (GPS) case practice model into its work with children and families, as discussed above.[78] Individualized and strength-based engagement, functional assessment, and trauma-informed and family-centered planning are vital for DSS to achieve safety, permanency, and well-being for children in their custody. The Co-Monitors look forward to meeting with the DSS

[78] DSS's GPS case practice model was designed in recognition of the need for a culture that 'engage[s], encourage[s], honor[s], and support[s] families.' To see the GPS case practice model, go to: https://dss.sc.gov/media/2746/gps-practice-model-final.pdf

Continuous Quality Improvement (CQI) subgroup on GPS, which meets quarterly to identify gaps in GPS implementation.



Placement Updates

Recommendations for Addressing the Placement Instability Crisis

DSS cannot effectively succeed in their mission of supporting children's safety, permanency, and well-being, and strengthening families, without more readily available supports and treatment services for families and their children from other public agencies who have the responsibility to fund and provide such services and supports. The State defendants must implement a broader system of care that can intervene earlier and effectively when families experience crises and need help.

The Supplemental Report contains a summary of current strategies DSS is using to address the placement and services crisis, as well as recommendations from the Co-Monitors for additional strategies that DSS can implement immediately and in the near term to reduce the harm currently being caused to children and their families. Many of these recommendations must be done in conjunction with other state agencies, such as the Department of Health and Human Services (DHHS), the Department of Mental Health (DMH), the Department of Juvenile Justice (DJJ), the Department of Disability and Special Needs (DDSN), the Department of Education

(DE), and the Department of Children's Advocacy (DCA) – as well as private providers. The recommendations include, among others:

1. *'DHHS should expand Home- and Community-Based Services through Medicaid: Medicaid is critically important and extensively used in jurisdictions throughout the country to provide intensive in-home and community-based services. While services must always be individualized, there are some services that are foundational to any family-serving system that can be financed through Medicaid, including: intensive care coordination (ICC) and high-fidelity wraparound,[79] intensive in-home mental health treatment services,[80] therapeutic foster care, and peer mentoring, among other things.[81] Medicaid allows states flexibility in tailoring services or coverage for a specific population, and, as such, have been an essential tool in the development of services and supports for children in foster care for decades. As the Co-Monitors have long-recommended, DSS and DHHS should work together, employing a consultant with Medicaid expertise if needed, to consider the many ways in which jurisdictions throughout the country have utilized Medicaid, including 1915(c) and (i) Home- and Community-Based Services (HBCS) Waivers and quickly begin building an array of*

[79] ICC is "a robust, comprehensive form of case management services, designed specifically for children and youth with significant mental health needs," and should include: assessment and service planning; help with access to and coordination with services, including crisis services, support for meeting basic needs, family advocacy, and progress monitoring. (Lav, Jennifer and Lewis, Kim *Children's Mental Health Services: The Right to Community-Based Care* (April 1, 2018) (citing Joint Centers for Medicare and Medicaid Services (CMS) and Substance Abuse and Mental Health Services Administration (SAMHSA) Informational Bulletin, Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions (May 7, 2013), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf). ICC is often provided through a "wraparound" model, which is a structured approach to individualized family- and youth-driven care coordination. (Center for Health Care Strategies, *Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs: State and Community Profiles 5 (*July 2014*),* https://www.chcs.org/media/ICC-Wraparound-State-and-Community-Profiles1.pdf; *see* Jennifer Schurer Coldiron et al., *A Comprehensive Review of Wraparound Care Coordination Research*, 1986-2014, 26(5) Journal for Child and Family Studies 1245 (2017).

[80] Intensive in-home mental health treatment services are comprehensive, collaborative interventions provided to improve child, youth, and family functioning and to prevent the need for out-of-home placement, placement disruption, inpatient hospitalization, or residential treatment. Multisystemic Therapy, Intensive Family Preservation Services, Homebuilders, Functional Family Therapy are examples of such interventions, amongst many others. (Barbot, B., Bick, J., Bentley, M.J., Balestracci, K., Woolston, J., Adnopoz, J.A., & Grigorenko, E. (2016) *Changes in mental health outcomes with the Intensive In-Home Child and Adolescent Psychiatric Service: A multi-informant, latent consensus approach.* International Journal of Methods in Psychiatric Research.*; see* Stroul, B, et al. *The Evolution of the System of Care Approach*. University of Maryland Institute for Innovation and Implementation.https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf)

[81] Center for Health Care Strategies. *Lessons From Other Fields: What are Promising Practices for Using Medicaid State Plan Amendments and Waivers to Address the Needs of Children and Youth in Foster Care?* Casey Family Programs. Retrieved from: https://www.casey.org/media/20.07-KM-LFOF-Medicaid-waiver-authorities_fnl.pdf

services in South Carolina not already covered and/or provided in the state under or outside of the Medicaid State Plan.[82]" (Supplemental Report, pp. 25-26)

2. *'Expand and Improve use of Pre-Removal Child and Family Team Meetings (CFTMs) and Risk of Placement Disruption CFTMs: DSS leadership and staff report that convening a CFTM prior to a child's removal into foster care has been effective throughout the state at keeping families together and identifying kin and other family resources. These CFTMs should be mandated before or upon placement, with regularity and in accordance with the GPS case practice model. [The Co-Monitors] recommend DSS engage technical assistance (TA) support in the form of external expert consultation around the assessment of underlying needs and innovative problem-solving strategies with families, including use of flexible funds that could meet the needs of families to avoid family separation. This work can begin in Richland, Spartanburg, and Greenville, and extend to counties that reach a designated level of overnight and emergency placements. Consideration should be given to the initial CFTM being in-person rather than virtual, unless it impedes the participation of the parent or child. Intensive TA support should be made available to these counties to craft individualized services and solutions." (Supplemental Report, p. 22)*

3. *'Increase the Availability and Accessibility of Flexible Funds: Simple guidelines for use and access of flexible funds should be immediately available to staff, along with brief training to fiscal staff (which can be integrated into TA work described above). Successful implementation will require funds to be available to children experiencing instability in placement, to support families to prevent placement into foster care, and to speed up reunification. Funds should be used for things that are not currently funded through other state and federal funded programs and available for concrete supports and non-traditional services and supports to meet needs identified by children and their families. As described above, flexible funds should be available to the child and family team without unnecessary layers of approval. This need for*

[82] For example: New York's Bridges to Health (B2H) 1915 (c) waiver allows for the provision of a broad range of services to children in foster care who have intellectual or developmental disabilities to help them live in a home- or community-based setting. Services include immediate crisis response, help with daily activities, intensive in-home supports, family and caregiver supports and services, healthcare coordination, respite care, skill building, and employment support. Wisconsin utilizes a 1915 (c) waiver to access Medicaid funding to reimburse foster care providers who care for children with higher level needs at an increased rate. Arizona has used a 1115 waiver since 1982 to implement a Comprehensive Health Plan for children in foster care, based on a partnership with the Arizona Department of Health Services, Division of Behavioral Health Services, and a single MCO. Oregon was recently granted a 1115 waiver to, among other things, address social determinants of health using non-medical services, with children in foster care as one target population. North Carolina has used a 1115 waiver to implement evidence-based interventions to address social determinants of health through its "Healthy Opportunities Pilots" program, which focuses on housing instability, transportation insecurity, interpersonal violence, and toxic stress for a limited number of managed care enrollees who meet needs-based criteria.

flexible funds was identified as a high priority in the planning work underway in the [Small Test of Change] STOC counties (Greenville, Anderson, and Spartanburg)." (Supplemental Report, p.23)

In addition to developing concrete services, DSS must also embrace a different approach to identifying and understanding children's underlying needs within its own assessment and placement processes. The Co-Monitors commend DSS on its work with an external consultant who is providing technical assistance support on a small number of complex cases around the assessment of underlying needs and innovative problem-solving strategies with families. This is a first step toward integrating the GPS practice model with fidelity throughout the system. The Co-Monitors have recommended that external consultants be assigned to the three STOC counties – Spartanburg, Anderson, and Greenville – discussed below, to provide in-person coaching to local staff and state-level Family and Community Services staff who will need the capacity to train the larger DSS workforce.

The Co-Monitors are also encouraged by the Department's ongoing efforts to engage private providers as partners in developing and implementing change strategies. Since the outset of this lawsuit, the provider community has been ready and willing to contribute and adapt as needed to assist DSS in its efforts to better support children and families. Private providers are often not only the providers of placement, but the clinical experts serving children with high needs. Breakdowns in communication, lack of involvement in CTFMs, lack of accurate clinical assessment of child and family needs, and the dearth of needed supportive services inhibit their ability to appropriately meet the needs of families. The effectiveness of many of the recommendations included in the Supplemental Report, as well as initiatives in which DSS is currently engaged, depend on enhanced, meaningful, and ongoing partnership with these providers, in addition to collaboration with other state agencies.

DSS convened a strategic session with private providers, state agency partners, and other stakeholders on October 9 and 10, 2023, to discuss ways to disrupt the placement instability crisis in South Carolina. The convening was an important initial step. By focusing not just on the immediate need for placements, but on the root causes underlying the current placement instability crisis, the convening was a breakthrough in broadening participants' thinking. Meeting participants began to appreciate the comprehensive, collaborative work that will be needed to bring about meaningful progress, including changes in people's attitudes about families and their strengths and needs. DSS also used the convening as an opportunity to share new data analyses about foster care placement instability – the result of vast

improvements in internal data capacity since the inception of this lawsuit – which helped guide the discussions. DSS reports that is using the information and feedback from the convening to create a blueprint for future actions, and mechanisms for accountability for all parties. Rapid follow-up will be essential.

A full list of Co-Monitor recommendations for addressing the placement instability crisis can be found in the Supplemental Report (Appendix D).

Small Tests of Change (STOC)

In an effort to serve teenagers who may enter DSS custody due to status offenses, parent-child conflict, and/or allegations of behavioral issues, DSS has committed to implementing "small tests of change" in three counties in the state: Spartanburg, Anderson, and Greenville. The goal is to work with community partners to develop strategies to increase the percentage of children placed in or near their home communities and improve outcomes for older youth, who are currently experiencing significant placement instability in South Carolina. The STOC Design Team met for a two-day retreat in June 2023 to brainstorm priorities and solutions, and each county will begin implementing strategies discussed over the coming months. As referenced in the Supplemental Report, the STOC work presents an important opportunity to align with other multi-agency efforts to meet the needs of older children in state custody and their family members through the development of community-based and intensive in-home services. This work will also incorporate the findings and recommendations from *Children Concurrently Involved with SCDJJ and SCDSS: Joint Review Findings*, described in further detail below.[83] To date, DSS has committed to making a limited amount of flexible funding available that can be used to tailor supports to meet the unique needs of children and families as determined by the Child and Family Team. An update on STOC progress will be included in the next monitoring report.

[83] The joint review findings can be found here: https://cssp.org/wp-content/uploads/2022/10/FINAL-Children-Concurrently-Involved-with-SC-DJJ-and-DSS-Joint-Review-Findings-002.pdf

Placement of Children in Family-Based Settings

The FSA contains several provisions related to the placement of children in the most family-like, least restrictive environments necessary to meet their needs. Overall, the FSA requires that "*at least 86 percent of Class Members be placed outside of congregate care on the last day of the reporting period*" (FSA IV.E.2.).

On March 31, 2023, 88 percent (3,280 of 3,745) of Class Members were placed outside of a congregate care placement and in family-based settings.[84] Performance continues to meet the final FSA target for children residing in family-based placements. According to DSS's Data Submission to the Court, which includes data beyond the monitoring period, the percentage of children in family-based placements has remained consistent at 88 percent through May 2023.[85] This measure captures strictly the type of setting in which children are placed at a given point in time, and does not reflect stability or the long-term nature of that placement. Children without long-term placement who are being shuffled through emergency placements are included in this calculation as residing in family-based placement.

The FSA also includes placement standards specific to certain age groups of children, requiring that '*[a]t least 98% of the Class Members twelve (12) years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting Period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file*" (FSA IV.E.3.).

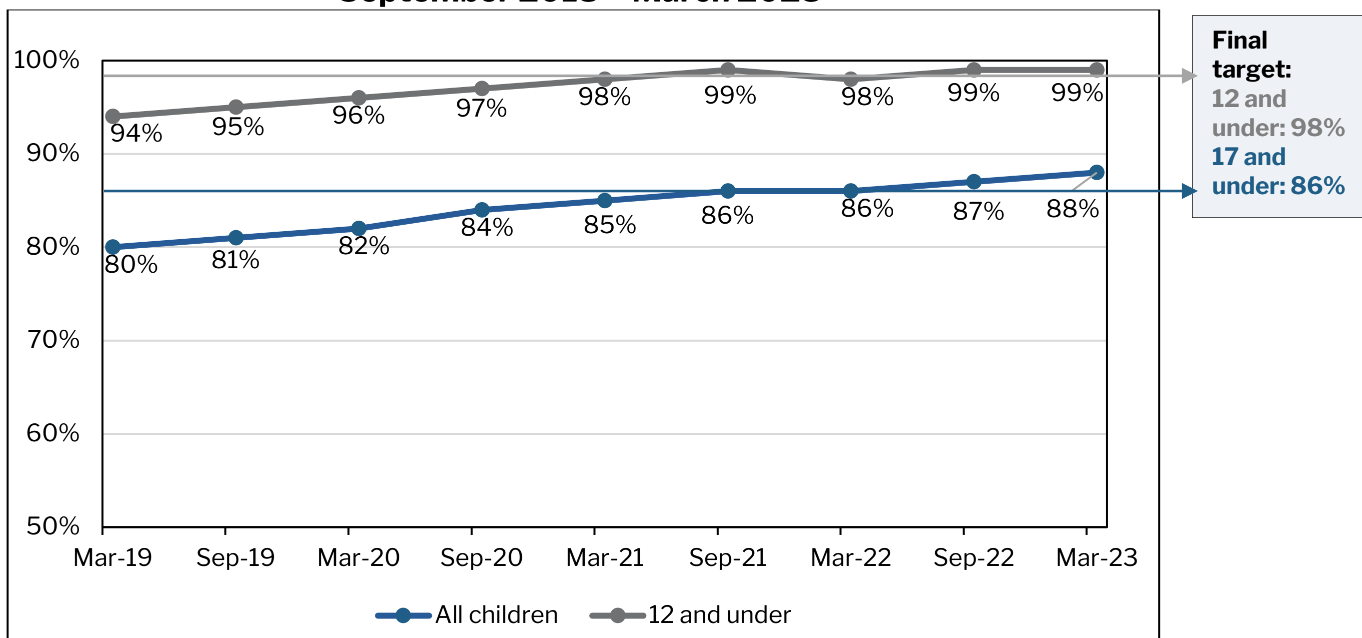
As reflected in Figure 18, as of March 31, 2023, 2,447 of 2,491 Class Members ages 12 and under resided outside of a congregate care placement, in a family-based setting. Ten children ages six and under resided in congregate care pursuant to a valid

[84] 33 children resided in other institutional settings and were removed from the universe. Specifically, DSS reports that 20 children were incarcerated in correctional or juvenile detention facilities, 12 children were hospitalized, and 1 child was in a Department of Disability and Special Needs (DDSN) Residential Facility.

[85] See, *supra* note 9 at 1-3.

exception,[86] resulting in performance of 99 percent.[87] As shown in the figure, performance on this measure continues to meet the final target.[88]

Figure 18: Trends in Placement of Children Outside of Congregate Care September 2018 – March 2023



Source: CAPSS data provided by DSS

The data in Figure 18 do not capture children's experiences over the entirety of their time in foster care and do not include children who resided in other institutional settings, such as hospitals or correctional facilities. Approximately 17 percent of all children in foster care and three percent of children ages 12 and under experienced congregate care at some point during the monitoring period. This is a significant improvement from March 2019 when these data were first reported; at the time, 23 percent of all children in foster care and eight percent of children ages 12 and under spent some time in congregate care during the prior six months.

DSS is also required to prevent, with exceptions approved by the Co-Monitors, '*the placement of any Class Member age six (6) and under in any non-family group*

[86] The Co-Monitors have approved exceptions for placing children ages 7 to 12 in a congregate care facility, but DSS did not submit any exceptions for children in this age group for this monitoring period.
[87] 9 additional children ages 12 and under were hospitalized on the last day of the monitoring period and are excluded from the calculations.
[88] Pursuant to FSA V.E.1-3, the Co-Monitors identify that this provision may be eligible for "Maintenance of Effort" designation by the Court. Defendants have achieved compliance with the obligations set forth in FSA IV.E.3., as reflected in the March 30, 2023, October 3, 2022, and March 23, 2022 monitoring reports.

placement (including but not limited to group homes, shelters or residential treatment centers)" (IO II.3.(a) & FSA IV.D.2.).[89,90]

Of the 26 children ages birth to six who resided in congregate care facilities during the monitoring period, all were placed there pursuant to an agreed upon exception.[91]

Children ages 13-17 are still far more likely than younger children to be placed in congregate care. On March 31, 2023, 420 (33%) of 1,255 children ages 13 to 17 resided in congregate care. As reported in DSS's Data Submission to the Court, this percentage remained consistent at 33 percent through May 2023.[92] Comparable to the prior two monitoring periods, slightly less than half (44%, or 799 of 1,803) of children ages 13 to 17 in foster care at any time between October 1, 2022 and March 31, 2023 were placed in a congregate care setting at some point during the period. DSS has continued to work to reduce this occurrence; this performance represents a significant change from March 2019 when these data were first reported (at the time, 64 percent of children ages 13 to 17 spent some time in congregate care during the prior six months).

Distribution of Placement Types

Figure 19 shows the breakdown for all placement types for children in foster care, both family-based and congregate care, on the last day of the monitoring period

[89] On March 15, 2016, the Co-Monitors approved DSS's plan, including acceptable exceptions (due to medical necessity, placement with parents, or placement with siblings), and DSS issued a directive outlining the procedure to be used by staff to reduce the placement of young children in congregate care, and ensure the appropriate placement of children ages 6 and under in family placements (IO II.3.(a) & FSA IV.D.2.). The procedure requires approval of a Regional Director prior to the placement of any child under the age of 7 in a non-family-based setting.

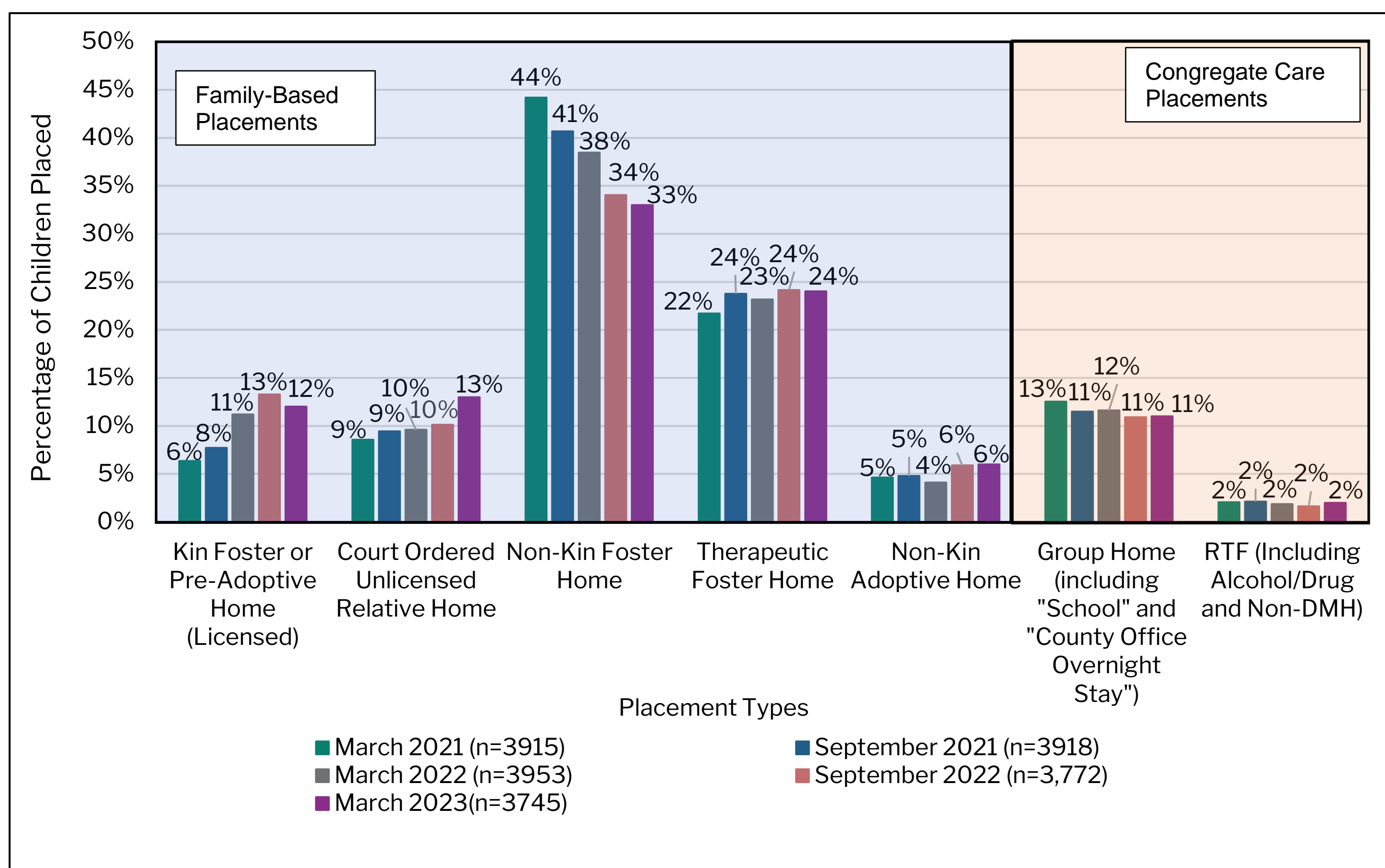
[90] The following are exceptions, approved by the Co-Monitors, to the requirement that children ages 6 and under be placed outside of congregate care: the child requires a degree of clinical and/or medical support that can only be provided in a group care setting and cannot be provided in a family-like setting, and the placement is a facility that has the capacity and specialized treatment to meet those needs; the child is the son or daughter of another child placed in a group care setting; or the child coming into care is in a large sibling group and all efforts to secure foster home and Therapeutic Foster home placements have been completed and have not produced a home. In that the last instance, placement in a facility that can accommodate the sibling group together and maintain daily contact between siblings is an allowable exception. This exception is time-limited for up to 90 days and can be extended for time-limited increments after considering and documenting the best interests of the children and pursuing and documenting intensive efforts to identify and support an appropriate placement or placements.

[91] Of the 26 children, 3 were placed with siblings for less than 90 days, 21 were placed in a treatment facility or group care setting with their mothers, and 2 were placed in a psychiatric hospital for which a clinical need was identified.

[92] See, *supra* note 9 at 2.

between September 2020 and March 2023. On March 31, 2023, 12 percent (455 of 3,745) of children resided in licensed relative foster homes, a continued improvement from the prior period. As reflected in the figure, when combined with court-ordered unlicensed relative placements, this means a quarter of children (26%, or 955 of 3,745) were placed with relatives. As of March 31, 2023, 62 percent (2,325 of 3,745) of children were placed in foster or adoptive homes with non-relatives, including: 1,237 children (33%) placed in non-kin foster homes, 882 children (24%) placed in therapeutic foster homes, and 206 (6%) placed in non-kin adoptive homes. Most children in congregate care placements continue to reside in group homes (406 children, or 11%),[93] while 56 children (2%) are in residential treatment facilities (RTFs).

Figure 19: Percentage of Children in Family-Based and Congregate Care Placements, September 2020 – March 2023

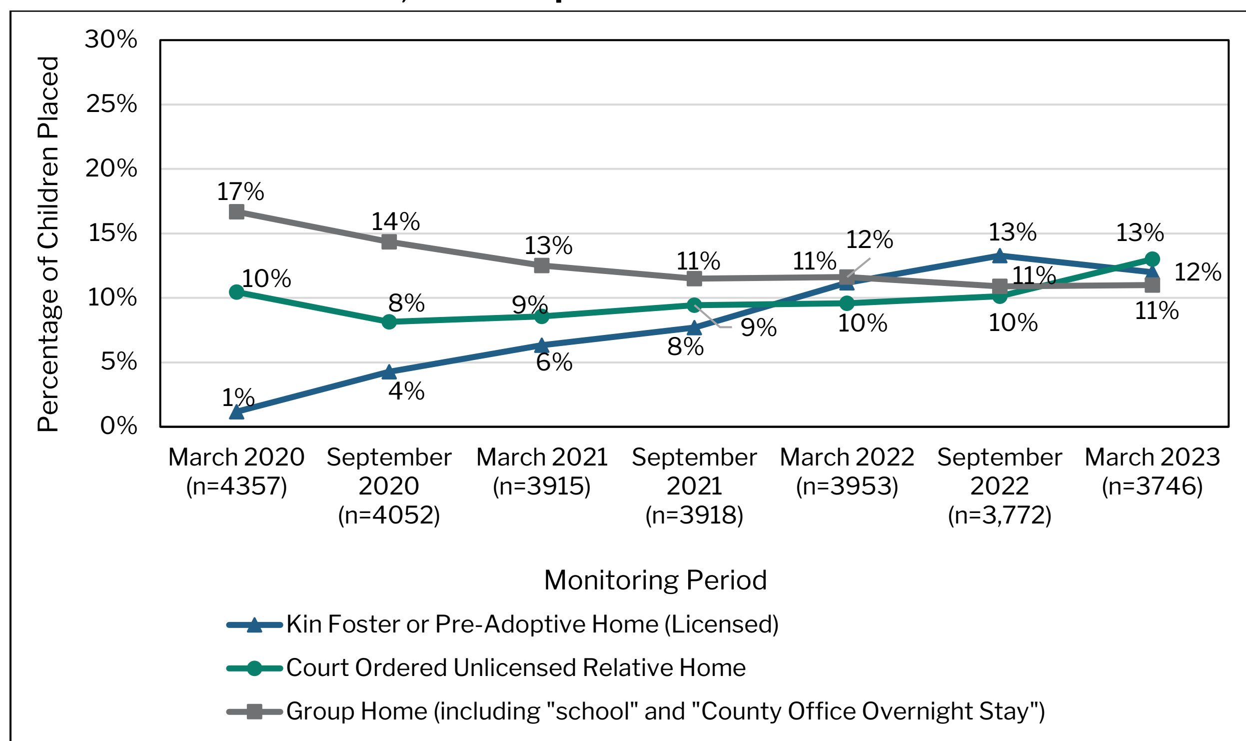


Source: DSS Data

[93] This includes 3 children who slept overnight in a DSS county office on the last day of the monitoring period. These are not licensed or appropriate foster care placements.

Figure 20 depicts placement types between March 2020 and March 2023. As shown, the percentage of children placed in licensed kin homes has increased while the percentage of children placed in group homes has decreased. This continues to be a positive trend, and a result of DSS's efforts to place children outside of congregate care and with kin whenever possible.

Figure 20: Percentage of Children Placed in Licensed Relative Homes, Unlicensed Relative Homes, and Group Homes March 2020 – March 2023



Source: DSS Data

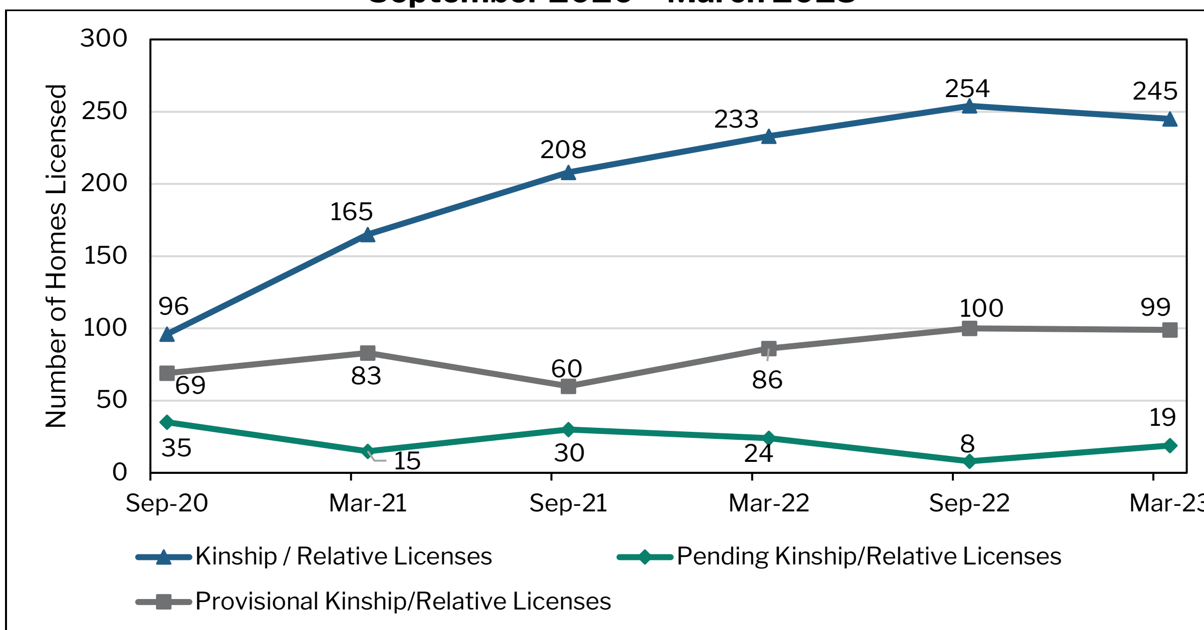
Kin Placement and Licensure

After shifting its focus exclusively to the licensing of kin homes in July 2020, DSS re-initiated direct licensing of foster homes for adolescents, youth who identify as LGBTQ+, and large sibling groups in May 2023. DSS continues to dedicate staff to recruiting and licensing kin, and has continued to prioritize the placement of children with kin.[94] However, as seen in Figure 21, the number of licensed kin has plateaued, at a time when there has been a reduction in the number of overall licensed foster

[94] See, *supra* note 13. South Carolina enacted legislation to support a KinGAP program in May 2023, which would allow for permanent placement of children with approved or licensed kin, with financial assistance in the same manner as adoption assistance payments are provided for children adopted from foster care.

homes.[95] According to DSS's Data Submission to the Court, the number of provisional kin licenses ranged from 99 to 114 for each month between March 2023 and June 2023.[96] DSS reports that it offers licensing as an option to all kin caregivers, and shares the benefits of licensure, including eligibility for full foster care maintenance payments.

Figure 21: Kinship Licensing Trends
September 2020 – March 2023



Source: Data provided by DSS

In the coming monitoring period, the Co-Monitors plan on working with DSS to collect and assess information on the placement of children with kin, including timelines for and barriers to placement and licensing and the frequency of re-placement and/or re-entry into foster care after placement with kin. These data can further inform DSS's understanding of how efforts to place and stabilize children with kin can be enhanced and what supports and services are most essential in making these placements feasible, stable, and successful.

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[95] The Children's Bureau published a final rule effective November 27, 2023 that requires the same rates of foster care maintenance payments for both licensed (or otherwise approved) relatives and licensed non-relatives, and allows Title IV-E matching funds to be used for implementation. For more information, go to: https://www.federalregister.gov/documents/2023/09/28/2023-21081/separate-licensing-or-approval-standards-for-relative-or-kinship-foster-family-homes

[96] Provisional licensure allows a child to be placed in the kin home before the full foster parent licensure process has been completed.

Emergency Placements and Overnight Stays in DSS Offices and Hotels

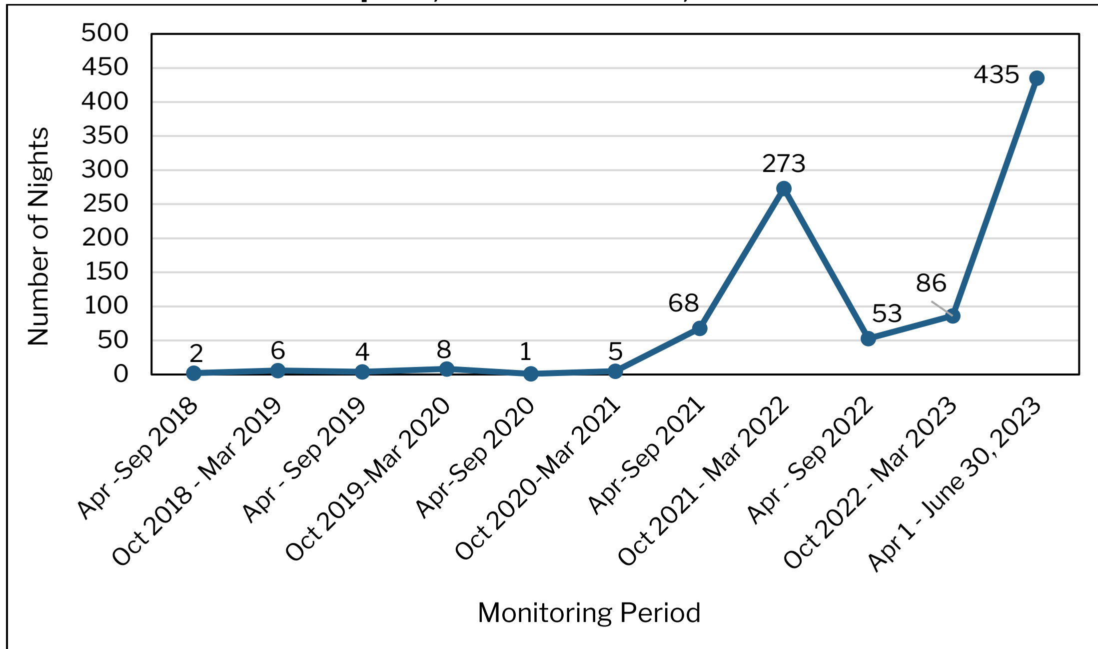
The FSA requires that by November 28, 2015, *'DSS shall cease using DSS offices as an overnight placement for Class Members, and shall cease placing or housing any Class Members in hotels, motels and other commercial non-foster care establishments. For any Class Members moved out of such DSS Offices or Hotels, DSS shall provide for their appropriate placement. In the extraordinary event that a child stays overnight in a DSS office, Defendants shall immediately notify the Co-Monitors, who shall provide a report to Parties as appropriate, including whether or not, in their view, the incident should be reported to the Court as a violation which would preclude Defendants' ability to achieve compliance on this provision"* (FSA IV.D.3.).

Between October 2022 and March 2023, 53 unique children stayed overnight in DSS offices for a combined total of 86 nights. Over three-fourths (79%) of these overnights occurred during February (19 nights) and March (49 nights). Since the end of the monitoring period, the number of children sleeping in offices has continued to increase exponentially, with the number of children sleeping overnight in DSS offices reaching levels higher than the six-month period that led to the Overnight Plan, jointly agreed upon with Plaintiffs on March 23, 2022.[97] Between April 1 and June 30, 2023, 109 unique children spent a combined total of 435 nights in a DSS office.[98]

[97] Overnight Stay Plan (March 23, 2022, Dkt. 236)

[98] These data have been updated by DSS and include one additional overnight office stay than was reported in the Supplemental Report.

Figure 22: Overnight Stays in a DSS Office
April 1, 2018 – June 30, 2023

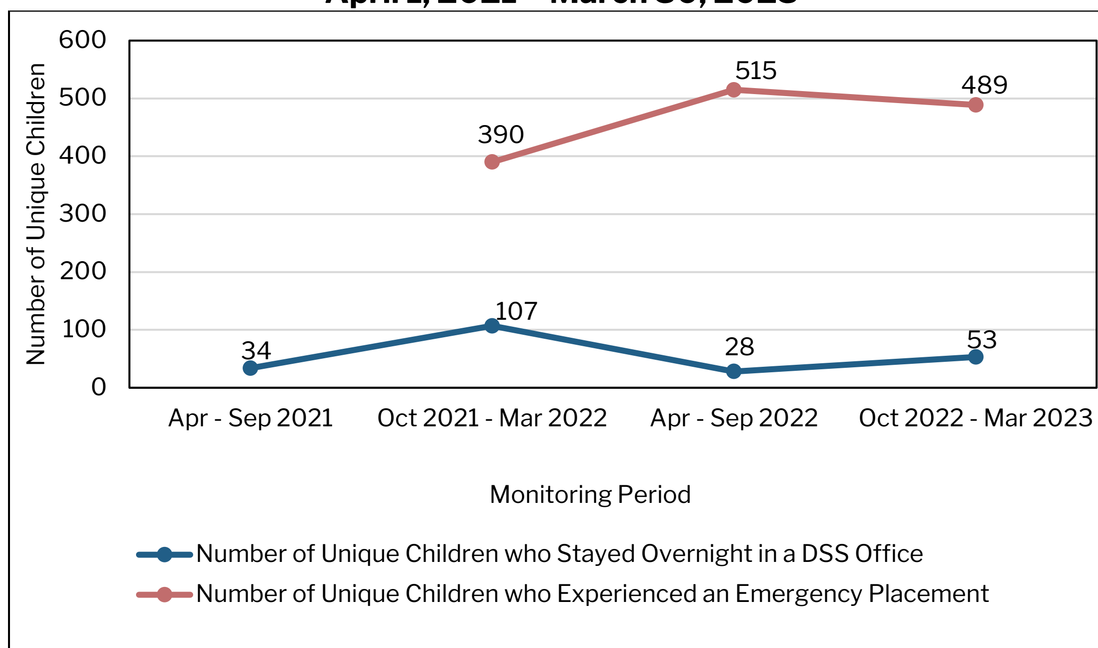


Source: Data provided by DSS

In response to the increase in children sleeping in offices overnight because placements could not be found, DSS increased its efforts to ensure that every child has a bed each night. As discussed in more detail in the Supplemental Report, this has resulted in children being increasingly moved between short-term emergency placements, after spending the day in DSS offices. As DSS has acknowledged, these placements are not fundamentally different from overnight stays in DSS offices, particularly when – as has been reported to the Co-Monitors – many of these children only arrive to emergency placements after dinner and are picked up and returned to the DSS office before breakfast the following morning. While at emergency placements, children are sometimes barred from bathing, eating meals, and accessing their phones, and may not be provided with their medication. While the FSA focuses on the length of time children spend in a particular emergency placement, children experience even more instability when they are moved *between* multiple emergency placements and DSS offices or other holding places, remaining in each for only a day or two at a time.

Though DSS data collection in this area is still developing,[99] DSS reports that between October 1, 2022 and March 31, 2023, 489 unique children experienced at least one of the 1,479 emergency placements over the course of 7,400 nights. The number of unique children has slightly decreased from the prior period, when 515 unique children experienced an emergency placement over the course of the period, but there was a significant increase in the number of nights, up from 4,915 to 7,400 (see Figure 24).[100]

Figure 23: Children who Stayed Overnight in a DSS Office or Experienced an Emergency Placement April 1, 2021 – March 30, 2023

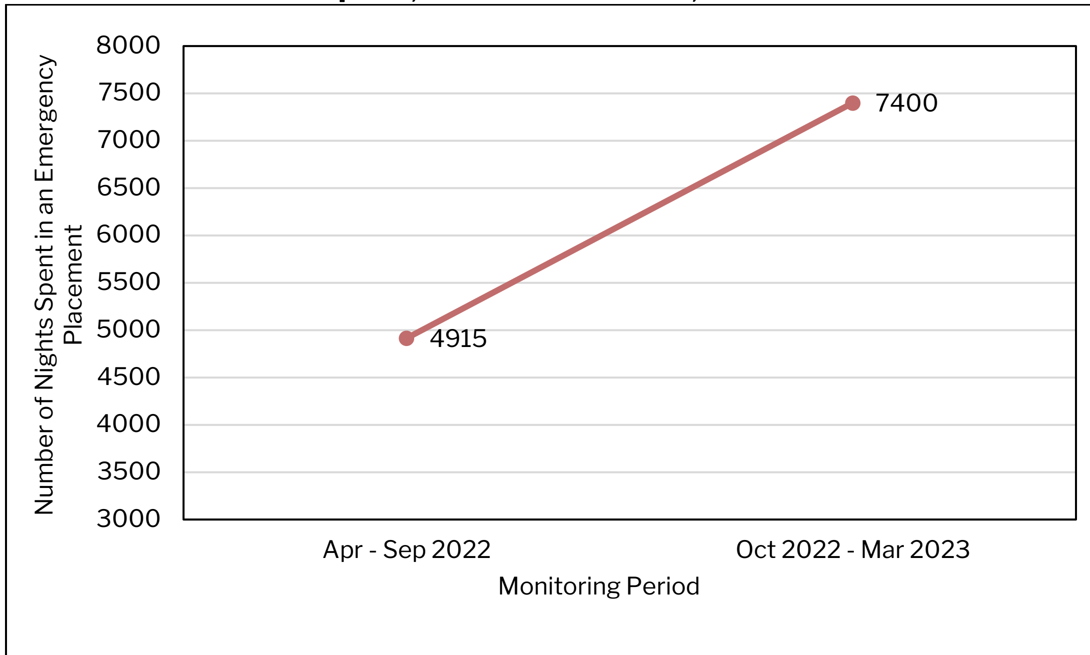


Source: Data provided by DSS

[99] DSS reports inconsistent data entry of emergency placements into CAPSS between October 2021 and March 2022. As technological processes continue to be enhanced, data may be updated in subsequent reports. DSS reports having made several process refinements during this monitoring period to improve the accuracy and consistency of data entry.

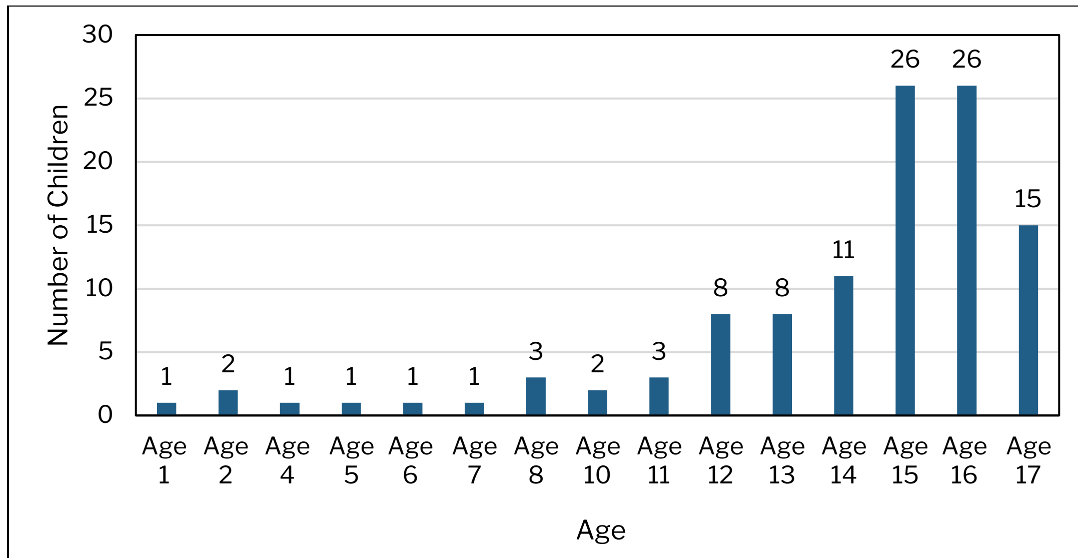
[100] Recent reports on emergency placements are likely more accurate than those or prior periods, meaning that the precipitous rise in emergency placements may be, in part, a reflection of improvements in DSS's capacity to track these children's experiences and produce data.

Figure 24: Number of Nights Spent in an Emergency Placement April 1, 2022 – March 30, 2023



Source: Data provided by DSS

Figure 25: Number of Children Staying Overnight in DSS Offices by Age April 1 – June 30, 2023 N=109



Source: Data provided by DSS

As Figures 23, 24, and 25 show, this is not an issue only affecting a small number of "high needs" children – between October 2022 and March 2023, 10 percent of the 5,177 children who spent any time in foster care during the monitoring period experienced at least one emergency placement or slept overnight in a DSS office. These experiences also vary based on age, race, and gender:

- 33 percent (159 of 489) of the children who experienced at least one emergency placement during the monitoring period, and 28 percent (31 of 109) of the children who experienced at least one overnight stay in DSS offices between April and June, were 13 years old or younger.
- Almost half (46%, or 227 of 489) of the children who experienced at least one emergency placement during the monitoring period, and 39 percent of the children who experienced at least one overnight stay in DSS offices between April and June, were under the age of 15.
- Black girls were about 50 percent more likely to have experienced an emergency placement during the monitoring period than either non-Hispanic White girls or White boys.
- Black girls were about 33 percent more likely to have experienced an emergency placement during the monitoring period than Black boys.[101]

The FSA requires that children should not remain in an initial Emergency Placement for longer than 30 days (FSA IV.E.4.), and if they experience an additional Emergency Placement within 12 months, the subsequent Emergency Placement should not last more than seven days (FSA IV.E.5.). As mentioned above, these measures are of limited value in capturing the experiences of children, as children experiencing instability are more commonly moved between emergency placements rather than remaining in a single emergency placement for a long period of time.

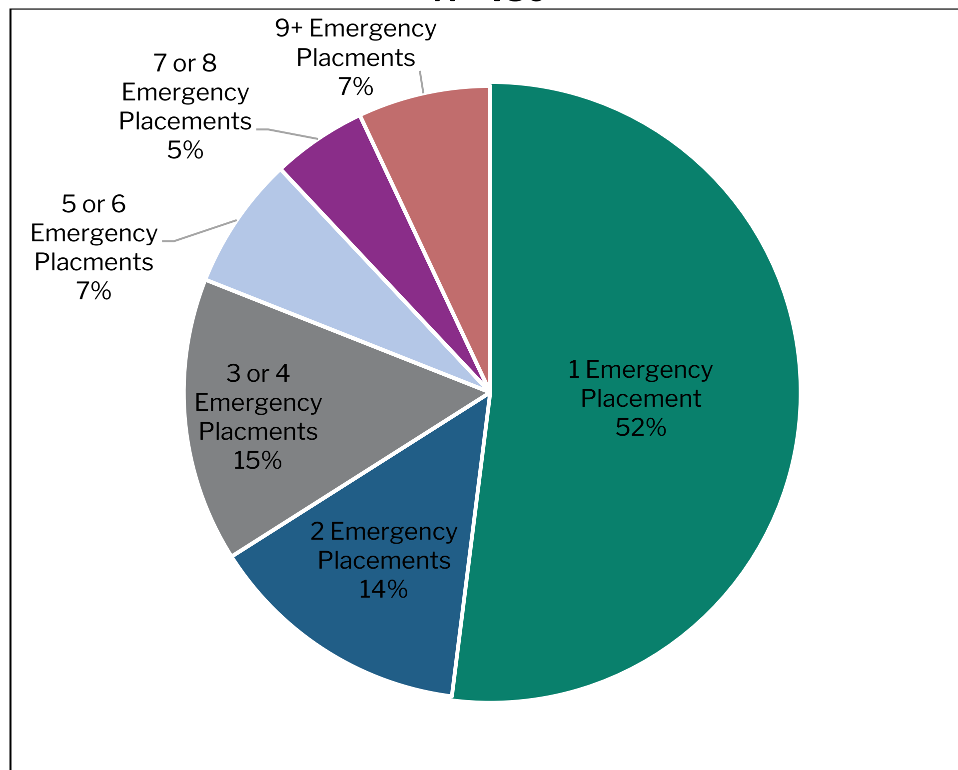
DSS reports that 19 of the 489 youth had at least one emergency placement that started and ended between October 1, 2022 and March 31, 2023, and lasted longer than 30 days. When emergency placements last longer than 30 days, CAPSS triggers a redesignation for that placement to a long-term placement rather than emergency placement. In addition, DSS reports that, of the 286 unique children who experienced more than one emergency placement in a 12-month period, 153 (53%) had at least

[101] Black girls represented 136 (28%) of the 489 children who experienced at least one emergency placement during the monitoring period. Non-Hispanic White girls represented 92 (19%) and White boys represented 90 (18%). Black boys represented 103 (21%) of the 489 children who experienced at least one emergency placement. Approximately 5% of the children who experienced an overnight stay identified as Hispanic, and an additional 8% of children identified as Multiracial.

one subsequent emergency placement during the monitoring period that lasted more than seven days.

DSS also collects data on the total number of nights spent in emergency placements across multiple placements. Over half (52%, or 257) of the 489 children who experienced emergency placements ended up staying in emergency placements for more than seven total nights. Eighty-four children (17%) experienced more than 30 nights of emergency placements. Twenty-four children (5%) experienced more than 50 nights in emergency placements. Figure 26 shows the distribution of emergency placements those 489 children experienced between October 1, 2022 and March 31, 2023.

Figure 26: Number of Emergency Placements Experienced by Class Members October 2022 – March 2023 N= 489



Source: CAPSS data provided by DSS

Placement instability has long been an issue in South Carolina, even compared to states across the country that struggle with shortages of placements and services. In CY 2021, South Carolina ranked second to last on the Adoption and Foster Care

Analysis and Reporting System (AFCARS) indicator related to placement moves.[102] Placement Instability under the FSA is an annual measure (FSA IV.F.1) – updated data will be reported in the next monitoring report.

Juvenile Justice Placements

The FSA requires that *'[w]hen Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not recommend to the family court or Department of Juvenile Justice that a youth remain in a Juvenile Justice Placement without a juvenile justice charge pending or beyond the term of their pleas or adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member. DSS shall take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea. DSS shall provide for their appropriate placement"* (FSA IV.H.1.).

The limited quantitative data available in this area has made tracking performance a challenge, and the Co-Monitors have historically had to rely significantly on anecdotal reports by stakeholders to assess performance. In November 2022, the Co-Monitors and DSS, with the Department of Juvenile Justice's (DJJ) permission and collaboration, published a report of findings from their joint comprehensive review of the experiences of children dually involved with both DSS and DJJ.[103] The full report, including key findings and recommendations can be found here.

The review was a key step in identifying some of the barriers to meeting the needs of many of the children in DSS's care who present with high levels of need. In February 2023, DSS and the Co-Monitors staff, with the support of DJJ, hosted a symposium to present the report findings and begin discussing next steps. The symposium was attended by over 100 individuals representing DSS, Parties, DJJ, other state agency partners, community members, and individuals with lived experience. As mentioned above, DSS is working with the Co-Monitors, DJJ, and its system partners to develop and test practices that address these findings, as part of the Small Tests of Change (STOC) efforts underway in Spartanburg, Anderson, and Greenville counties. The findings from the joint review should also be integrated into other efforts to reduce placement instability for older children, given that children who are dually involved with both systems often experience high levels of placement instability.

[102] For more information, go to: https://datacenter.aecf.org/data/tables/8822-children-in-foster-care-with-more-than-two-placements?loc=1&loct=1#ranking/2/any/true/2048/any/17681

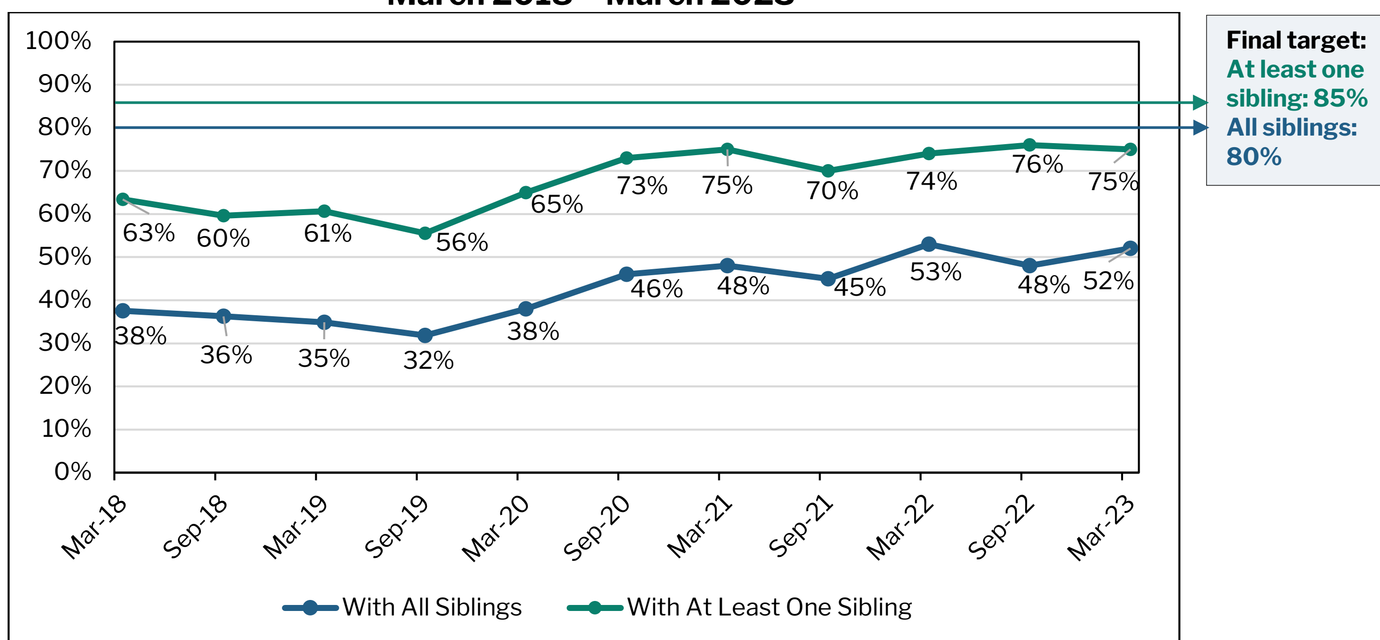
[103] More information on the joint findings about children dually involved with DSS and DJJ can be found at: https://cssp.org/wp-content/uploads/2022/10/FINAL-Children-Concurrently-Involved-with-SC-DJJ-and-DSS-Joint-Review-Findings-002.pdf

Sibling Placements

The FSA recognizes the importance of the lifelong and supportive relationships between children and their siblings and requires that *'at least 80 percent of children who enter care with or within 30 days of their siblings be placed with their siblings"* (FSA IV.G.2. & 3.). The FSA includes two targets – one for placement with *at least one* of a child's siblings (85% target) and the other for placement with *all* of a child's siblings (80% target).[104] DSS committed to achieving these outcomes by March 2021.

DSS provided data for 737 children who entered foster care between October 1, 2022 and March 31, 2023, with a sibling or within 30 days of a sibling's entry into foster care. For this cohort, 75 percent (556 of 737) of children were placed with at least *one* of their siblings, and 52 percent (382 of 737) of children were placed with *all* of their siblings 45 days after entry into care. As shown in Figure 27, this performance is roughly comparable to performance from the prior two monitoring periods. Performance does not meet the final targets.

Figure 27: Sibling Placements for Children Entering Placement March 2018 – March 2023

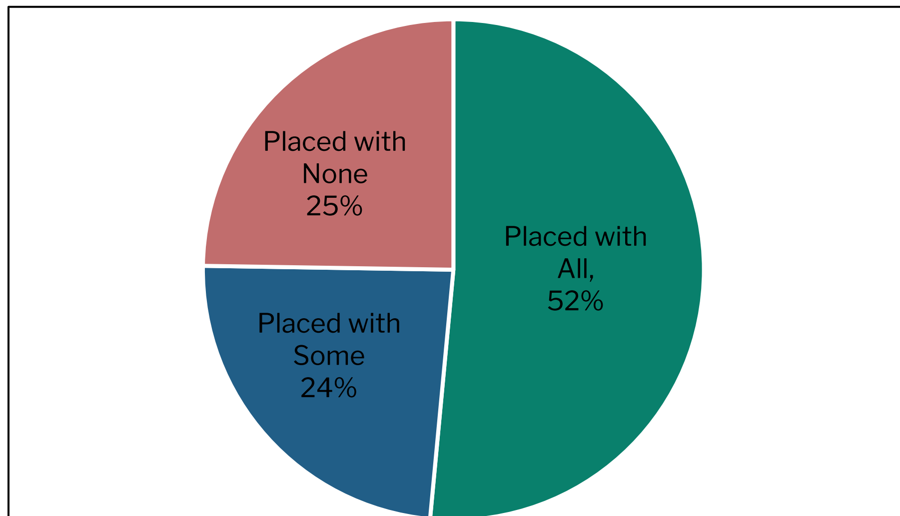


Source: CAPSS data provided by DSS

[104] The FSA allows for exceptions to this requirement, including when there is a court order prohibiting such placement or if the placement is determined not to be in the best interest of 1 or more siblings. Exceptions to placement of children with their siblings have been approved, though not applied during this monitoring period; therefore, actual performance may be higher than reported. DSS will develop a process for review and approval of exceptions in a future monitoring period.

Figure 28 further shows the breakdown of sibling placements during this monitoring period. Twenty-five percent (181 of 737) of all children entering care with siblings were not placed with *any* siblings 45 days after entry, which is also roughly comparable with the prior two monitoring periods.

Figure 28: Sibling Placements for Children Entering Placement October 2022 – March 2023 N=737



Source: CAPSS data provided by DSS

Therapeutic Placements

The FSA includes requirements with respect to the assessment of children's need for therapeutic supports and placement, requiring that Class Members identified as needing diagnostic assessments for a higher level of care are referred for a staffing within a particular time period; that the recommendations for placements and services be provided within a particular time period of the staffing; that the type of care with which a child is provided matches the recommendations; and that placement occurs within a particular time period of the receipt of the recommendations.

The FSA also includes a requirement that DSS identify "*enforceable interim benchmarks with specific timelines, subject to consent by the Plaintiffs and approval by the Co-Monitors, to measure progress,*" with respect to the placement of children in therapeutic placements when determined to be needed (FSA IV.B.I.2.).[105] These

[105] "Therapeutic Level of Care" refers to the leveling system used by DSS within the therapeutic placement and services array, including but not limited to Level 1, 2, 3 foster care placements and

requirements have been long delayed as DSS has considered ways to align measurement with its placement leveling system. In the Supplemental Report, the Co-Monitors recommended that DSS consider alternatives to the current leveling approach, which is frequently based only on placement availability and a child's current behavior, rather than the child's underlying needs. The Co-Monitors also recommend that the current Interagency System for Caring for Emotionally Disturbed Children (ISCEDC) clinical assessment and eligibility process be assessed and, potentially, modified with input from private providers who utilize the results of these assessments.

Psychiatric Residential Treatment Facilities (PRTFs), as described in the Human Services Policy and Procedures Manual and The State of South Carolina, Fixed Price Bid No. 5400002885 (FSA II.S.).

IX. Health Care

DSS has continued its work towards meeting the health care needs of the children in its care. This effort was accelerated by DSS's hiring for the nursing and support positions that were included and provided for in the FY2022-2023 budget, enabling Regional Nurses to increase time spent on addressing clinical needs, rather than serving as data collectors. However, despite these efforts, health care outcomes for children in foster care have yet to significantly improve, particularly for initial comprehensive medical assessments and initial dental exams upon entering custody.

As reiterated in the Supplemental Report, the responsibility of delivering health care to children in foster care does not rest with DSS alone. It is inherently a legal responsibility of the state in accordance with federal Medicaid mandates for Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) for all Medicaid eligible children, which includes children in foster care.[106] The affirmative obligation to children to provide treatment to meet their physical, mental, and behavioral health needs is what makes EPSDT different from Medicaid for adults.[107] It continues to be critical that DSS work with its state agency partners like DHHS , DMH, and DDSN, community partners, and its private managed care organization (MCO) partner (Select Health) to develop robust, accessible, community-based services and supports across the state for children and families, including intensive in-home supports. Given the need to improve access to quality services for all South Carolina children, particularly those in foster care, it is essential that the state actively pursue ways to maximize federal Medicaid funding to meet the needs of children in foster care.

On August 23, 2018, the Co-Monitors and the Court approved a Health Care Improvement Plan[108] and, on February 25, 2019, a care coordination addendum (the "Health Care Addendum") which vested considerable responsibility for meeting the health care needs of children in state custody with Select Health, the State's Managed Care Organization (MCO) for these children.[109] It also envisioned strong collaboration by the MCO and other state agencies in delivering services, developing

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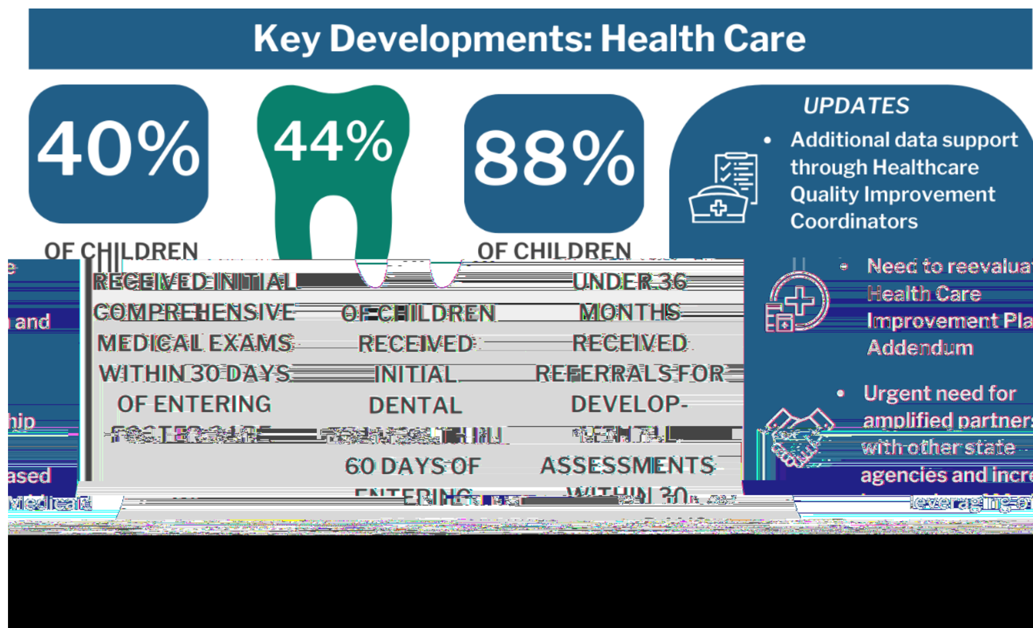
[106] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B); 1396d(r)

[107] U.S. Department of Health and Human Services, EPSDT: A Guide for States. (June 2014) p. 6 https://www.hhs.gov/guidance/sites/default/files/hhs-guidancedocuments/epsdt_coverage_guide_140.pdf

[108] To see the Health Care Improvement Plan, go to: https://dss.sc.gov/media/1980/8-23-2018-final-approved-dss-health-care-implementation-plan.pdf

[109] To see the Health Care Addendum, go to: https://dss.sc.gov/media/1962/2-25-2019-approved-health-plan-addendum.pdf

the service array needed, and collecting and tracking performance data. Progress in meeting the Plan's requirements around service expansion and care coordination has not kept pace with these expectations. The Co-Monitors believe that it is time to fully revisit the Health Care Improvement Plan, and related Health Care Addendum, and make the modifications necessary for improved performance. The Co-Monitors will initiate this work in the next period.



Health Care Updates

As referenced above, the Health Care Improvement Plan and Health Care Addendum were approved by the Co-Monitors and entered by the Court in 2018 and 2019, respectively, establishing commitments by Select Health and DHHS to a framework for care coordination involving distinct, interrelated roles for the DSS Office of Health and Well-Being, DSS case managers, Select Health Care Coordinators, and foster and biological families. The Plan and Addendum were approved with the understanding that additional detail would be determined during implementation, and the efficacy and adequacy of the model would be assessed on an ongoing basis to determine what changes or additions are needed; it has not yet been reassessed.

An infusion of funds in the FY2023 budget has allowed for a modest expansion of the Child Health and Well-Being Team formed by DSS. Under the leadership of Tim Nix, formerly Lead Clinical Specialist, the Team is comprised of ten nurses (a state-level Nurse Manager, Nurse, and Dental Nurse; three Upstate Regional Nurses; two

Midlands Regional Nurses; a Lowcountry Regional Nurse; and a Pee Dee Regional Nurse – though there are three nurse vacancies as of September 25, 2023); five Health Care Quality Improvement Coordinators (one for the Upstate, one for the Pee Dee, one for the Lowcountry, two for the Midlands); three new data and statistical analysis support positions; and two new liaison support positions who will work with Select Health and DHHS. The team also continues to have four health care data coordinators, one on each of the regional Well-Being Teams.

Beginning in spring 2023, the Regional Nurses are notified of the information entered into the medical module as part of the Family Advocacy and Support Tool (FAST) and Child and Adolescent Needs and Strengths (CANS) tool, which is intended to identify immediate health needs, as well as needs that have arisen within the prior 30 days. DSS reports this process has connected case managers to the nursing teams in a new way, but the rollout has still faced challenges due to the nurses' limited bandwidth to address the identified needs.

Despite the increased capacity of the Regional Nurses with the addition of new staff, there remain systemic barriers to ensuring that children receive the health care to which they are entitled. More than four years after the Health Care Addendum was agreed upon (and five years into the implementation of the Health Care Improvement Plan), there are ongoing challenges in defining care coordination roles and ensuring the performance of key strategies, such assessing and ensuring network adequacy with agency partners like Select Health and DHHS.

Health Care Performance Data

As noted in previous monitoring reports, the Co-Monitors and DSS have been engaged in discussions about re-assessing the approved data methodologies for health care measures given the shared goal of efficiently and effectively producing understandable, timely performance data that can be used both for public and court accountability purposes, and for day-to-day management and quality improvement. In some areas, as indicated, the data included for this monitoring period were collected by DSS's Regional Nurses from several sources and have not been independently validated by the Co-Monitors. DSS does not have the capacity to produce aggregate health care data related to initial health screens,[110] mental health

[110] DSS ADR is currently working with CAPSS IT to extract data collected from the completion of the FAST medical module to potentially utilize for this purpose.

assessments (following a screening which identified a need for such an assessment),[111] and follow-up care.[112]

Health care data reporting timelines were adjusted this period to accommodate delays in access to Medicaid administrative data. In order to provide the most up-to-date information, more recent data are included in the areas in which they were available. For example, data on periodic well-child and dental visits are reported as of May 2023. Data on initial comprehensive medical and dental visits are reported for all children who entered care between September 2022 and February 2023. All data throughout are labeled accordingly.

Comprehensive Medical Assessments

In accordance with American Academy of Pediatrics (AAP) guidelines for health care delivery to children in foster care, comprehensive medical assessments are to be performed for the purpose of "reviewing all available data and medical history about the child or adolescent;" identifying medical, developmental, and mental health conditions requiring immediate attention; and developing an "individualized treatment plan."[113]

In the DSS Health Care Outcomes, approved by the Co-Monitors on December 21, 2018, based on AAP guidelines, DSS committed that *'at least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care; at least 95% will receive a comprehensive medical assessment within 60 days of entering care*."[114] DSS committed to achieving these targets by March 2021.[115]

[111] DSS has provided data on the *total* number of children who receive mental health assessments, but those assessments are not tied to an identified need for a mental health assessment from a comprehensive medical assessment. DSS is not yet able to report data on the number of children receiving mental health assessments after the *need* for such an assessment has been identified. As a result, the Co-Monitors have not reported these data.

[112] DSS has proposed collecting additional qualitative information using a case review process to measure follow-up care, based on the instrument used for the Child and Family Services Review (CFSR), and is discussing potential approaches and review design with the Co-Monitors.

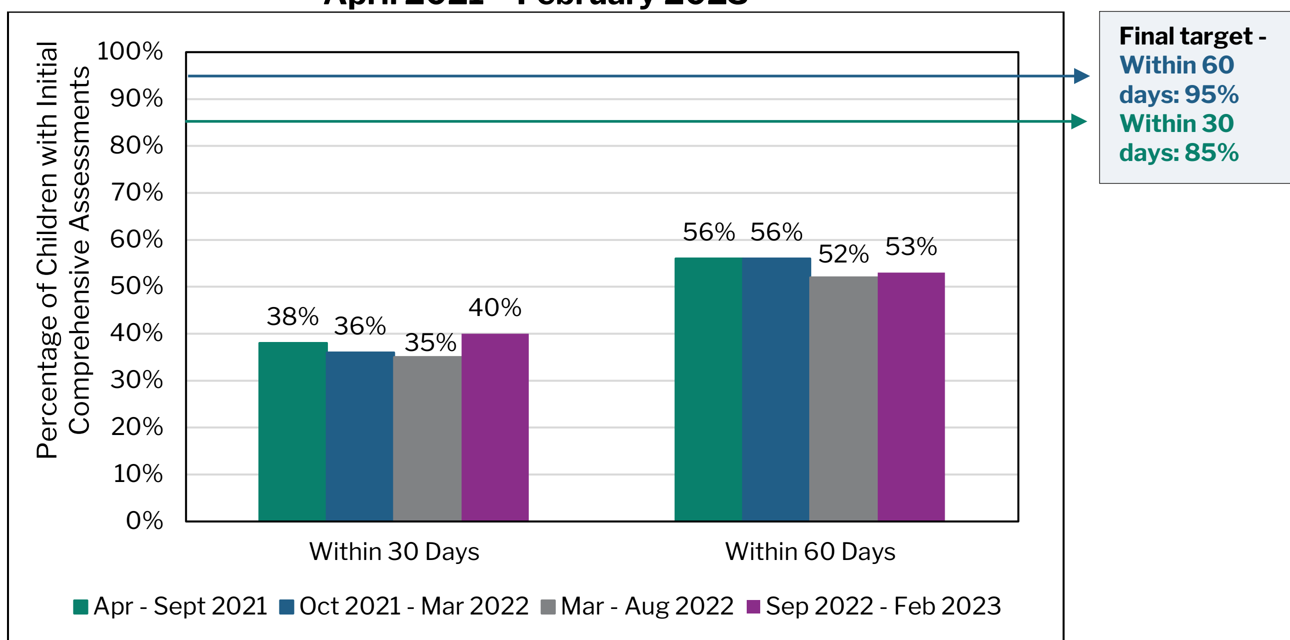
[113] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003), p. 22.

[114] The Health Care Outcomes are available at: https://dss.sc.gov/media/1958/appendix-b-final-health-care-targets.pdf

[115] The baseline performance data that were used to determine the benchmarks were in some cases extracted based upon methodologies that were different from those later approved by the Co-Monitors.

DSS reports that 40 percent (396 of 987) of children who entered foster care between September 1, 2022 and February 28, 2023, and were in foster care for at least 30 days, received an initial comprehensive medical assessment within 30 days, and 53 percent (376 of 704) of children who entered foster care in this period and were in foster care for at least 60 days received an initial comprehensive medical assessment within 60 days (see Figure 29). The 30-day performance represents an improvement from August 2022 when performance was 35 percent; 60-day performance remains unchanged. Performance remains significantly and unacceptably below the final targets of 85 percent of children receiving an initial exam within 30 days, and 95 percent of children receiving an initial exam within 60 days.[116]

Figure 29: Initial Comprehensive Medical Assessments within 30 and 60 Days April 2021 – February 2023



Source: Medicaid claims data provided by DSS

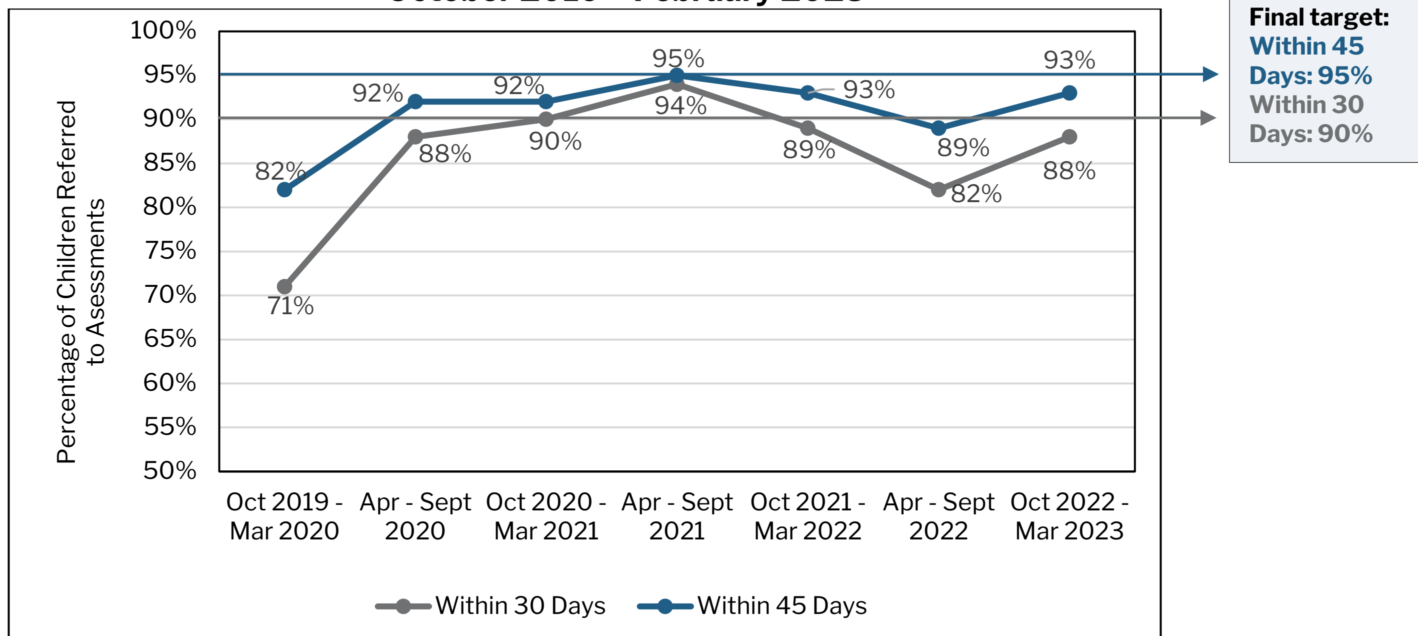
Developmental Assessments

In the DSS Health Care Outcomes, DSS committed that "*at least 90% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 30 days of entering care; at least 95% shall be referred within 45 days.*" DSS committed to achieving these targets by March 2021.

[116] DSS reports working with Select Health and DHHS to seek commitments from providers to see children in foster care for initial medical and dental care within a 30-day timeframe.

DSS reports that 88 percent (286 of 325) of children under 36 months of age who entered care between October 1, 2022 and March 31, 2023 and were in care for at least 30 days were referred to BabyNet – the state entity responsible for developmental assessments – within 30 days of their entry into care; and 93 percent (290 of 312) of children who were in care for at least 45 days were referred to BabyNet within 45 days.[117] Current performance represents an increase from the preceding monitoring period and is comparable to performance in the prior year (see Figure 30).

Figure 30: Referrals for Developmental Assessments within 30 and 45 Days October 2019 – February 2023



Source: CAPSS data provided by DSS

Initial Dental Examinations

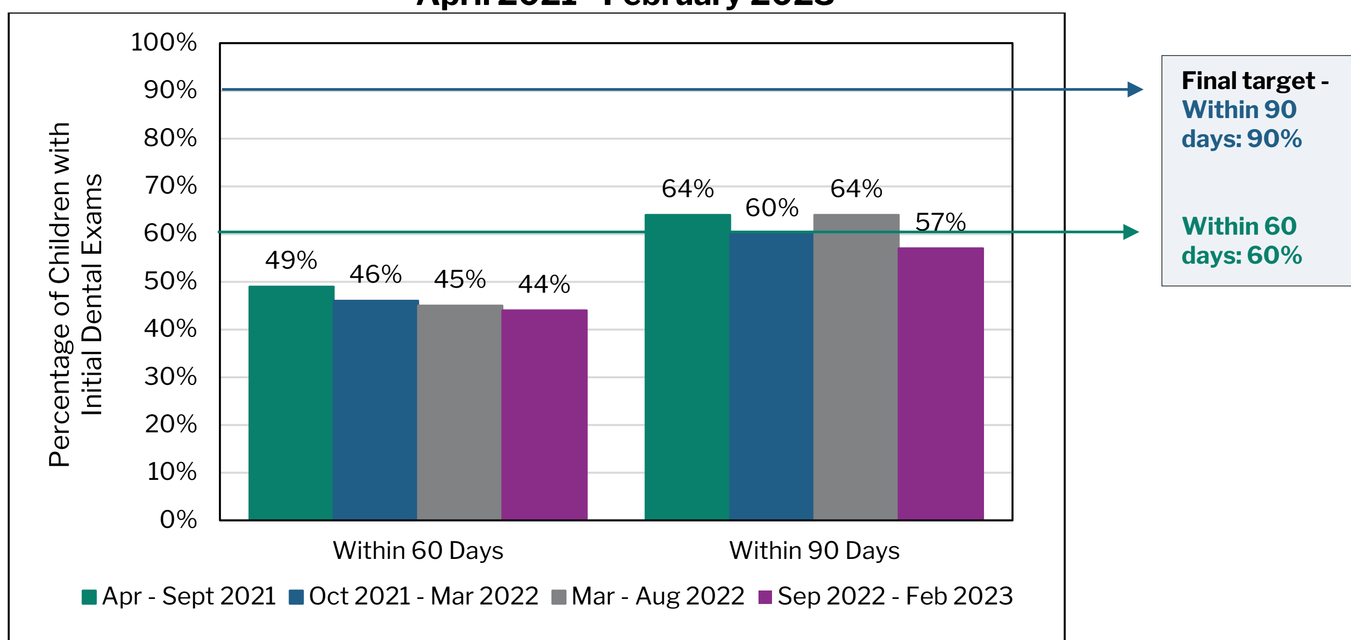
In the DSS Health Care Outcomes, approved by the Co-Monitors on December 21, 2018, DSS committed that *'at least 60% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care; at least 90% will receive a dental examination within 90 days of entering care*." DSS committed to achieving these targets by March 2021.[118]

[117] These data only measure whether a child was referred for a developmental assessment and do not capture whether an assessment occurred.

[118] The baseline performance data that was used to determine the benchmarks were in some cases extracted based upon methodologies that were different from those later approved by the Co-Monitors.

DSS reports that 44 percent (217 of 490) of children ages two and older who entered foster care between September 1, 2022 and February 28, 2023, and were in foster care for at least 60 days had a dental exam within 60 days, and 57 percent (219 of 384) of children ages two and older who remained in care for at least 90 days had a dental exam within 90 days.[119] The 60-day performance is comparable to the prior monitoring period, while the 90-day performance represents a decline from all prior periods. Performance does not meet the target for either requirement, as shown in Figure 31.

Figure 31: Initial Dental Exams within 60 and 90 Days April 2021– February 2023



Source: Medicaid claims data provided by DSS

Periodic Well-Child Visits

In accordance with AAP guidelines for ongoing health care delivery for children in foster care, periodic preventative well-child visits should be performed for the purpose of promoting "overall wellness by fostering healthy growth and development," as well as "regularly assess[ing] for success of foster care placement," and "identify[ing] significant medical, behavioral, emotional, developmental, and school problems through periodic history, physical examination, and screenings."[120]

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[119] This excludes children who had a visit within 3 months of entering care.

[120] *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2d. ed (16-17). American Academy of Pediatrics (2003), p. 30.

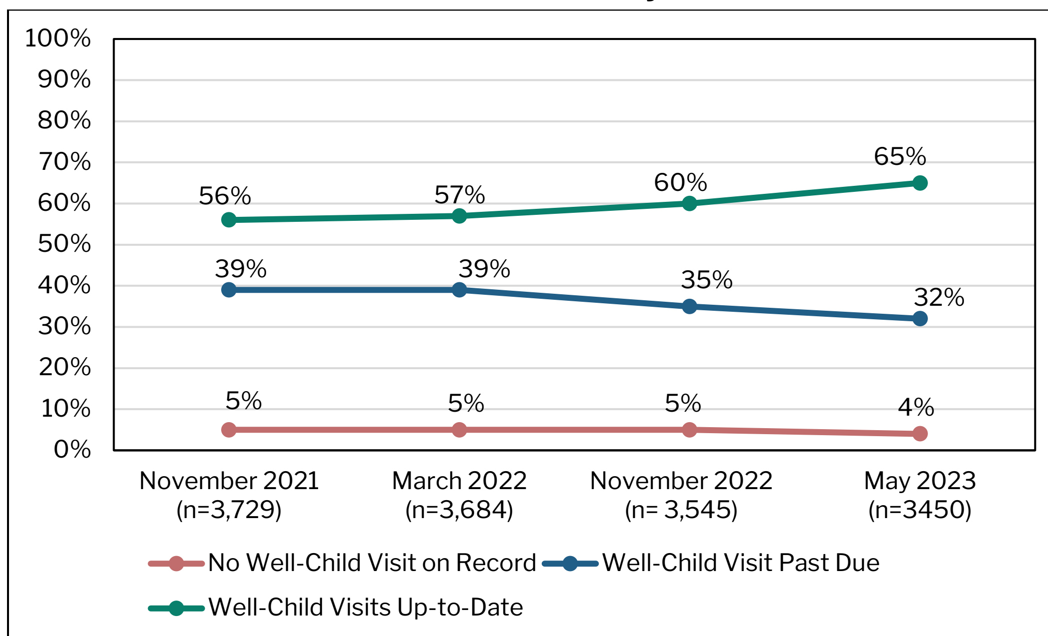
AAP guidelines for health care delivery for children in foster care recognize the increased needs of these children and youth as compared with the general population.

DSS committed to several Health Care Outcomes based on the periodicity schedule required of different age groups pursuant to AAP guidelines for children in foster care.[121,122] However, after years of providing data according to the agreed-upon methodology for calculating compliance with the periodicity schedule, DSS and the Co-Monitors have both determined that this methodology requires updating. As a result, the Co-Monitors have been reporting the health care data that DSS uses for day-to-day management and quality improvement. These data are validated by DSS Regional Nurses who review CAPSS for encounters entered by case managers and after-visit summaries completed by doctors. Data are also cross-checked with administrative data from DHHS and Select Health. DSS's ADR reviews encounters to see whether they are verified by more than one source.

DSS reports that of all children under 18 years of age who were in foster care for at least 30 days, 65 percent (2,225 of 3,450) were up-to-date on their well-child visits as of May 22, 2023, an improvement from November 2022, when 60 percent of children were up-to-date. Of the remaining children, 124 (4%) children did not have a well-child visit on record. As depicted in Figure 32, 32 percent (1,101 of 3,450) of children were past due on their well-child visits. It is important to note that, with this methodology, children become included in the data pool upon entering foster care, so there will always be some percentage of children who are past due.

[121] Bright Futures/American Academy of Pediatrics. Recommendations for Preventative Pediatric Health Care. Accessed at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf
[122] As of April 1, 2018, SC DHHS amended South Carolina's Title XIX state plan for update the medical and dental periodicity schedule to align with nationally recognized guidelines. To see the press release, go to: https://www.scdhhs.gov/communications/public-notice-final-actions-update-periodicity-schedules

Figure 32: Well-Child Visits
November 2021 – May 2023

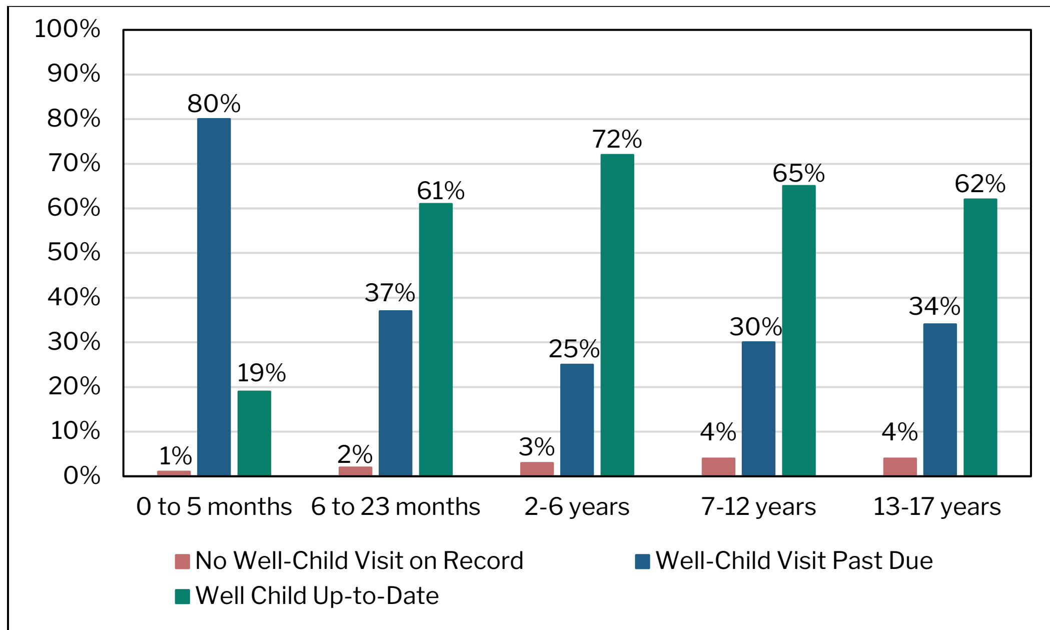


Source: CAPSS, DHHS, and Select Health data provided by DSS

These data are also reported to the Co-Monitors by age group, and data for all age groups shows improvement from the prior monitoring period. As of May 22, 2023, 19 percent of children birth to six months old were up-to-date on their well-child visits, as seen in Figure 33. In November 2022, only five percent of the youngest children were up-to-date on their well-child visits. In May 2023, only one child in this youngest age cohort had no well-child visit on record, an improvement from the prior period.

Compared to November 2022, a greater percentage of children older than six months were up-to-date on their well-child visits as well. The percentage of children ages six to 23 months who were up-to-date on well-child visits increased from 54 percent in November 2022 to 61 percent in May 2023. For children ages two to six years old, the percentage of those who were up-to-date on well-child visits increased from 67 percent in November 2022 to 72 percent in May 2023. For children ages seven to 12 years old, performance improved from 59 percent to 65 percent, and for ages 13 to 17 years old, there was a slight increase in up-to-date visits from 60 percent to 62 percent.

Figure 33: Well-Child Visits by Age as of May 22, 2023
N=3,450



Source: CAPSS, DHHS, and Select Health data provided by DSS

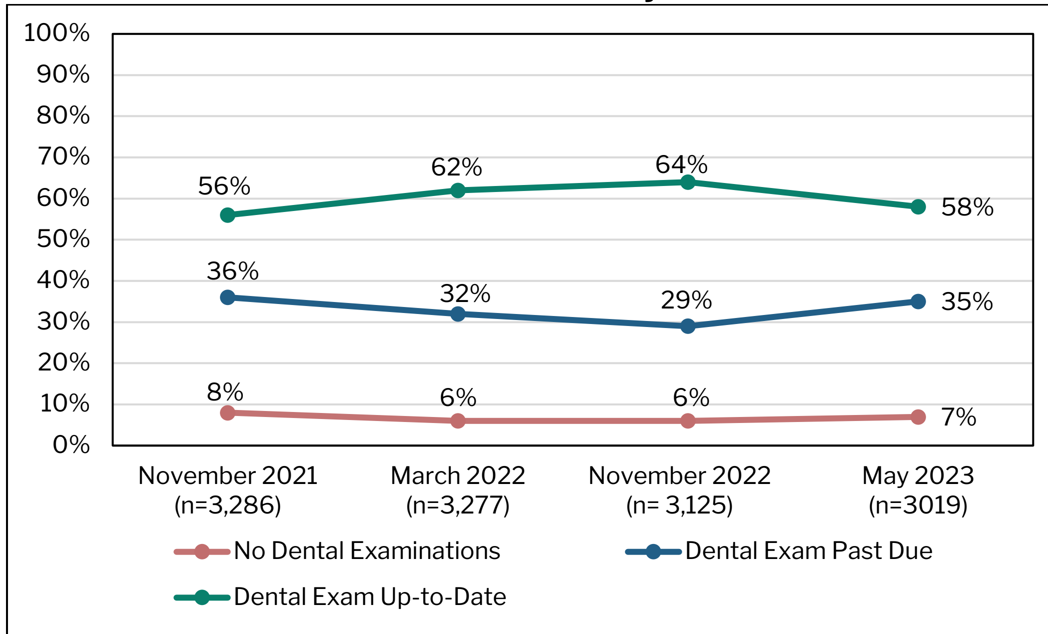
Periodic Dental Examinations

In the DSS Health Care Outcomes, DSS also committed that "*at least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually; at least 90% will receive a dental examination annually.*" DSS committed to achieving these outcomes by March 2021.

DSS reports that of the children between two and 17-years-old who were in care for at least 30 days, 58 percent (1,745 of 3,019) were up-to-date on their semi-annual dental examination as of May 22, 2023. This represents a decline from November 2022 when 64 percent of children were up-to-date on their semi-annual dental examination. As shown in Figure 34, 35 percent (1,047 of 3,019) were past due for their dental exam and seven percent of children (226 of 3,019) had no dental examination on record.[123] These data also represent slight declines in performance from the prior monitoring period. Same as above, with this methodology, children become included in the data pool upon entering foster care, so there will always be some percentage of children who are past due.

[123] These data were collected and analyzed by DSS staff for internal management purposes and have not been validated by the Co-Monitors.

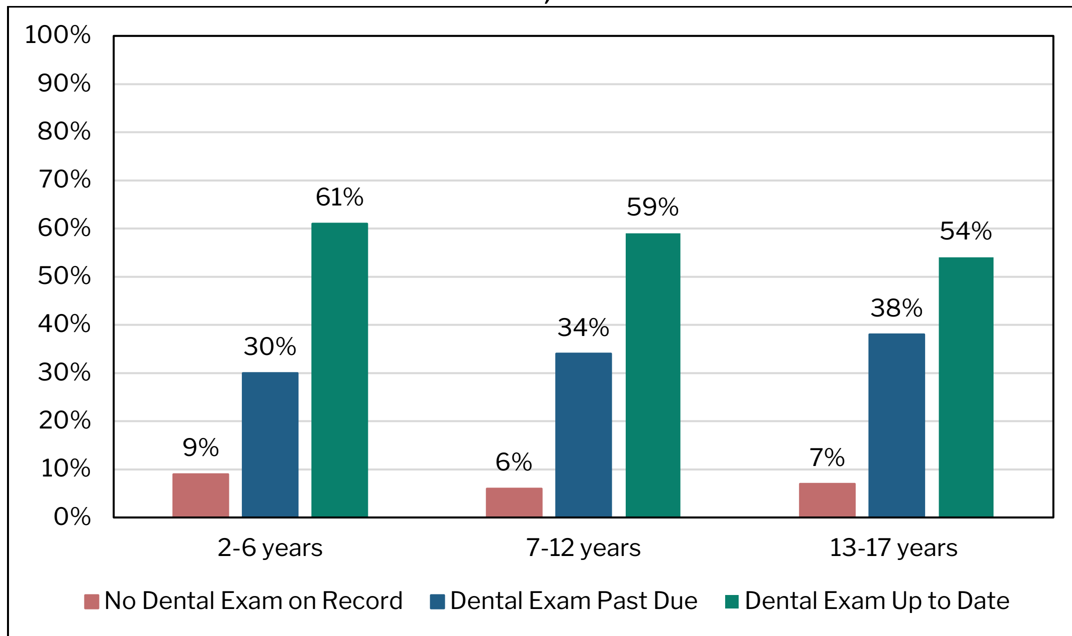
Figure 34: Periodic Dental Examinations
November 2021 – May 2023



Source: CAPSS, DHHS, and Select Health data provided by DSS

DSS also provided their internal management data for dental examinations by age group, as seen in Figure 35. These data show the largest declines among 13-17 year olds, where only 54 percent were up-to-date on dental exams, compared to 65 percent in the prior monitoring period. There were smaller declines in performance for children ages two to six years old and children ages seven to 12 years old. These data showed that 61 percent of 2-6 year olds were up-to-date on dental exams and 59 percent of 7 to 12 year olds were up-to-date.

Figure 35: Periodic Dental Examinations by Age as of May 22, 2023
N=3,019



Source: CAPSS, DHHS, and Select Health data provided by DSS

Appendix A – Glossary of Acronyms

AAP: American Academy of Pediatrics
ADR: The Office of Accountability, Data, and Research
AFCARS: Adoption and Foster Care Analysis and Reporting System
APS: Adult Protective Services
BSW: Bachelor's Degree in Social Work
CAAP: Coach Approach to Adaptive Leadership Model
CAC: Child Advocacy Center
CAIP: Child and Adult Information Portal
CAPSS: Child and Adult Protective Services System
CANS: Child Assessment of Needs and Strengths
CFTM: Child and Family Team Meeting
CFSR: Child and Family Services Review
CMS: Centers for Medicare and Medicaid Services
CPA: Child Placing Agency
CPS: Child Protective Services
CQI: Continuous Quality Improvement
CWS: Child Welfare Services
CY: Calendar Year
DCA: Department of Children's Advocacy
DDSN: Department of Disability and Special Needs
DE: Department of Education
DHHS: Department of Health and Human Services
DMH: Department of Mental Health
DJJ: Department of Juvenile Justice
DSS: Department of Social Services
EPSDT: Early, Periodic, Screening, Diagnosis and Treatment
FAST: Family Advocacy and Support Tool
FES: Family Engagement Specialist
FFCRA: Families First Coronavirus Response Act
FFPSA: Family First Prevention Services Act
FFTA: Family First Transition Act
FMAP: Federal Medical Assistance Percentage
FSA: Final Settlement Agreement
FY: Fiscal Year
GAL: Guardian Ad Litem
GPS: Guiding Principles and Standards Case Practice Model
HBCS: Home-and Community-Based Services

HRSN: Health-Related Social Needs
ICC: Intensive Care Coordination
ICPC: Interstate Compact on the Placement of Children
ILOS: In Lieu of Services and Settings
ILT: Instructor-Led Training
IO: Interim Order
ISCEDC: Interagency System for Caring for Emotionally Disturbed Children
MCO: Managed Care Organization
MSW: Master's Degree in Social Work
OHAN: Out-of-Home Abuse and Neglect Unit
OJT: On-the-Job Training
PMA: Office of Performance Management and Accountability
PRTF: Psychiatric Residential Treatment Facility
QA: Quality Assurance
QRTP: Qualified Residential Treatment Program
SACWIS: State Automated Child Welfare Information System
SAMSHA: Substance Abuse and Mental Health Services Administration
SDM: Structured Decision Making
STOC: Small Tests of Change
TA: Technical Assistance
TPR: Termination of Parental Rights
U of SC CCFS: University of South Carolina's Center for Child and Family Studies

Appendix B – Monitoring Activities

The Co-Monitors are responsible for independent validation of data and documentation to compile and issue public reports on performance with respect to the terms of the FSA. In carrying out this responsibility, the Co-Monitors and their staff have worked closely with DSS leadership and staff. The Co-Monitors use multiple methodologies to conduct their work, including verification and analysis of information available through CAPSS; review of individual electronic case records of Class Members; review and validation of data aggregated by DSS; interviews and conversations with DSS leaders and staff; and conversations with external stakeholders, including providers, advocates, and community organizations. The Co-Monitors worked with DSS to establish review protocols to gather performance data and assess current practice for some measures. The Co-Monitors engaged in in-person site visits to three county offices in the Upstate, as well as the regional adoption office. On these visits, the Co-Monitors met with case managers, Team Leaders, County Directors, and other DSS staff, including the regional placement team and CFTM facilitators. The Co-Monitors also met with a range of stakeholders throughout the monitoring period.

Other specific data collection and/or validation activities conducted by the Co-Monitors for the current period include the following:

- Review of monthly caseload reports for county Foster Care, Adoption, and Out-of-Home Abuse and Neglect (OHAN) case managers and Team Leaders (FSA IV.A.2.(b)&(c));

- Monthly review of all referrals involving allegations of abuse and neglect of Class Members not accepted for investigation by DSS's Intake Hub and OHAN (FSA IV.C.2.);

- Review of all OHAN investigation case records in CAPSS involving Class Members as an alleged victim accepted in March 2023, to assess for timely initiation, contact with core witnesses, timely completion, and appropriateness of unfounded decisions (FSA IV.C.3.&4.);

- Review of case files of Class Members identified by both DSS and stakeholders as involved with the South Carolina Department of Juvenile Justice (DJJ) to assess whether DJJ placement was in violation of the FSA (FSA IV.H.1.);

- Review of case files of Class Members ages six and under who were placed in a congregate care setting from October 1, 2022 to March 31, 2023 (FSA IV.D.2.);

- Review of a sample of case files of Class Members reported to have remained in a DSS office overnight from October 1, 2022 to March 31, 2023 (FSA IV.D.3.);

- Review of overnight stay notices and Universal Applications of Class Members reported to have remained in a DSS office overnight from April 1 to June 30, 2023 (FSA IV.D.3);

- Observation of select days of the Child Welfare Certification Training for incoming case managers and investigators, as well as a discussion with DSS training staff and curriculum developers.

- On-site visit to SC DSS for meetings with leadership and focus groups with staff.

Appendix C – Summary Table of Michelle H., et al. v. McMaster and Leach Final Settlement Agreement Performance

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
Workload Limits for Foster Care[125] 1a. At least 90% of caseworkers shall have a workload within the applicable Workload Limit. 1b. No caseworker shall have more than 125% of the applicable Workload Limit. (FSA IV.A.2.(b)&(c))	OHAN investigators: 0% within required limit. (September 2017) 100% had more than 125% of the limit. (September 2017)	OHAN investigators: 37% within the required limit Monthly range within the required limit: 24 – 47% 37% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 24 – 53%	OHAN investigators: 75% within the required limit Monthly range within the required limit: 29 – 95% 0% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 0 – 35%	OHAN investigators: 78% within the required limit Monthly range within the required limit: 77 – 89% 4% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 0 – 5%

[124] The Co-Monitors selected a random day in each month this period to measure caseload compliance for each type of case manager and Team Leader. These random dates are as follows: October 3, 2022; November 4, 2022; December 22, 2022; January 21, 2023; February 8,2023; March 31, 2023.

[125] The FSA utilizes the term "caseworker" to refer to DSS case-carrying staff and "supervisor" to refer to DSS staff who oversee case-carrying staff. As part of its case practice model development and outlining enhanced job expectations, DSS now utilizes the term "case manager" and "Team Leader," respectively. Where appropriate and for consistency with practice, this report utilizes the term case manager and Team Leader.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
Approved Workload Limits:[126,127] • *OHAN worker* - 8 investigations • *Foster care worker* – 15 children • *Adoption worker* – 15 children[128] • *New caseworker* – ½ of the applicable standard for first six months after completion of Child Welfare Certification training	Foster Care case managers: 28% within the required limit. (September 2017) 59% had more than 125% of the limit. (September 2017) IFCCS case managers:[129] 10% within the required limit. (September 2017) 77% had more than 125% of the limit. (September 2017)	Foster Care case managers: 42% within the required limit Monthly range within the required limit: 40 – 48% 35% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 33 – 41%	Foster Care case managers: 51% within the required limit Monthly range within the required limit: 43 – 51% 29% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 29 – 38%	Foster Care case managers: 58% within the required limit Monthly range within the required limit: 53 – 58% 31% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 27 – 32%

[126] These limits were approved by the Co-Monitors on December 6, 2016, after completion of the Workload Study.
[127] Caseload limits and methodologies to calculate performance for case managers with mixed caseloads, both Class and Non-Class Members, were approved in December 2017. Non-Class Members include children receiving family preservation services while remaining in the home with their parent or caregiver, Adult Protective Services (APS) cases, families involved in child protective service assessments, and children placed by ICPC. Performance for Foster Care case managers with mixed caseloads is calculated by adding the total number of foster care children (Class Members) the case manager serves to the total number of families (cases) of Non-Class Members the case manager also serves; the total number should not exceed 15 children and cases.
[128] Prior to 2019, DSS's workforce was structured so that case management responsibilities remained with the Foster Care case manager, even when an Adoption case manager was assigned, until a placement agreement was signed. As a result, the approved caseload standard for Adoption case managers was 1:17. In 2019, DSS began transitioning case management responsibility to Adoption case managers once children became legally eligible for adoption. This transition was complete in January 2020; thus, Adoption case manager caseload performance is assessed at a standard of 1:15, the same standard applied to Foster Care case managers.
[129] The IFCCS case manager and supervisor positions were eliminated as of January 2020, with staff positions and cases transferred to county Foster Care case manager and Team Leader positions and caseloads in December 2019.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
	Adoption case managers: 23% within the required limit. (September 2017) 62% had more than 125% of limit. (September 2017)	Adoption case managers: 49% within the required limit Monthly range within the required limit: 21 – 49% 34% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 34 – 62%	Adoption case managers: 24% within the required limit Monthly range within the required limit: 24 – 49% 37% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 33 – 43%	Adoption case managers: 26% within the required limit Monthly range within the required limit: 26 – 46% 38% had more than 125% of the limit. Monthly range with caseloads more than 125% of the limit: 35 – 38%
Workload Limits for Foster Care: 2a. At least 90% of supervisors shall have a workload within the applicable Workload Limit. 2b. No supervisor shall have more than 125% of the applicable	OHAN Team Leaders: 100% within the required limit. (March 2018) None were more than 125% of the limit. (March 2018)	OHAN Team Leaders: 100% within the required limit each month this period 0% had more than 125% of the limit.	OHAN Team Leaders: 100% within the required limit each month this period 0% had more than 125% of the limit.	OHAN Team Leaders:[131] 100% within the required limit each month this period 0% had more than 125% of the limit.

[131] Team Leaders' workloads may be higher than is reflected in the data, as data initially produced by DSS to the Co-Monitors show an increase in the number of Team Leaders carrying direct cases in addition to supervising staff during each month between October 2022 and March 2023, compared to prior monitoring periods. DSS is in the process of further validating and assessing these data, and is working with the Co-Monitors to ensure future data submissions in this area accurately reflect Team Leader workloads. DSS has identified situations in which it may be necessary for Team Leaders to be directly responsible for a case(s) for a short period of time. See, *supra* note 36.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
Workload Limit. (FSA IV.A.2.(b)&(c)) Approved Supervisor Limits: • *OHAN supervisors* – 6 investigators • *Foster Care* and *Adoption* supervisors – 5 case managers	Foster Care Team Leaders: 42% within the required limit. (March 2018) 36% had more than 125% of the limit. (March 2018) Adoption Team Leaders: 38% within the required limit. (March 2018)	Foster Care Team Leaders: 86% within the required limit 4% had more than 125% of the limit. Adoption Team Leaders: 82% within the required limit	Foster Care Team Leaders: 90% within the required limit. Monthly range within the required limit: 86 – 91% 4% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 3 – 5% Adoption Team Leaders: 90% within the required limit	Foster Care Team Leaders:[132] 96% within the required limit. Monthly range within the required limit: 90 – 97% 1% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 0 – 4% Adoption Team Leaders:[133] 96% within the required limit

[132]Team Leaders' workloads may be higher than reported, as data initially produced by DSS show an increase in the number of Team Leaders carrying direct cases in addition to supervising staff during each month between October 2022 and March 2023 compared to prior monitoring periods. DSS is in the process of further validating and assessing these data, and is working with the Co-Monitors to ensure future data submissions in this area accurately reflect Team Leader workloads. DSS has identified situations in which it may be necessary for Team Leaders to be directly responsible for a case(s) for a short period of time. See, *supra* note 36.

[133] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
	19% had more than 125% of the limit. (March 2018) IFCCS Supervisors:[130] 57% within required limit. (March 2018) 29% had more than 125% of the limit. (March 2018)	9% had more than 125% of the limit.	Monthly range within the required limit: 88 – 96% 0% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 0 – 9%	Monthly range within the required limit: 90 – 100% 0% had more than 125% of the limit. Monthly range supervising more than 125% of the limit: 0%
Visits Between Case Managers and Children: 3. At least 90% of the total minimum number of face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place. (FSA IV.B.2.)	24% of cases reviewed had all agreed-upon elements of a visit. (September 2019)	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been substantial increase in performance.	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been substantial increase in performance.	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been substantial increase in performance.
Visits Between Case Managers and Children: 4. At least 50% of the total	22% of documented face-to-face contacts with children had all agreed upon elements of a visit and took place in the	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of

[130] The IFCCS case manager and supervisor positions were eliminated as of January 2020, with staff positions and cases transferred to county foster care case manager and supervisor positions and caseloads in December 2019.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place in the residence of the child. (FSA IV.B.3.)	child's residence. (September 2019) 92% of face-to-face contacts took place in the child's residence. (September 2019)	records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been substantial increase in performance.	records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been substantial increase in performance.	records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been substantial increase in performance.
Investigations - Intake: 5. At least 95% of decisions not to investigate a Referral of Institutional Abuse or Neglect about a Class Member must be made in accordance with South Carolina law and DSS policy. (FSA IV.C.2.)	44% of screening decisions to not investigate were determined to be appropriate. (March 2017)	Between October 2021 and March 2022, 97% of screening decisions not to investigate were determined to be appropriate.	Between April and September 2022, 96% of screening decisions not to investigate were determined to be appropriate.	Between October 2022l and March 2023, 100% of screening decisions not to investigate were determined to be appropriate.
Investigations - Case Decisions: 6. At least 95% of decisions to "unfound" investigations of a	47% of applicable investigation decisions to unfound were determined to be appropriate. (March 2017)	72% (36) of 50 applicable investigation decisions to unfound were determined to be appropriate.	86% (38) of 44 applicable investigation decisions to unfound were determined to be appropriate.	92% (35) of 38 applicable investigation decisions to unfound were determined to be appropriate.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was abused or neglected. (FSA IV.C.3.)				
Investigations - Timely Initiation: 7. The investigation of a Referral of Institutional Abuse or Neglect must be initiated within twenty-four (24) hours in accordance with South Carolina law in at least 95% of the investigations. *Investigations - Contact with Alleged Child Victim:* 8. The investigation of a Referral of Institutional Abuse or Neglect must include face-to-face contact with the alleged victim	78% of applicable investigations were timely initiated. (March 2017)	80% (41) of 51 applicable investigations were timely initiated.	90% (46) of 51 applicable investigations were timely initiated.	100% (43) of 43 applicable investigations were timely initiated.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
within twenty-four (24) hours in at least 95% of investigations, with exceptions for good faith efforts approved by the Co-Monitors.[134] (FSA IV.C.4.((a)&(b))				
Investigations - Contact with Core Witnesses: 9. Contact with core witnesses must be made in at least 90% of the investigations of a Referral of Institutional Abuse or Neglect, with exceptions approved by the Co-Monitors. (FSA IV.C.4.(c)	27% of applicable investigations included contact with all necessary core witnesses. (March 2017)	51% (26) of 51 applicable investigations included contact with all necessary core witnesses.	67% (34) of 51 applicable investigations included contact with all necessary core witnesses.	81% (35) of 43 applicable investigations included contact with all necessary core witnesses.
Investigations - Timely Completion: 10.a. At least 60% of	95% of applicable investigations reviewed were appropriately closed within 45 days. (March 2017)	93% of investigations reviewed were appropriately closed within 45 days.	95% of investigations reviewed were appropriately closed within 45 days.	84% of investigations reviewed were appropriately closed within 45 days.

[134] The Co-Monitors' interpretation of the FSA requires that investigations be initiated within 24 hours of receipt of the referral by DSS, not within 24 hours of the decision to accept the referral, and that initiation is completed by making face-to-face contact with the alleged victim child(ren). As a result, the performance for both FSA measures IV.C.4.(a) and (b) are measured using the same methodology and timeframes – the time between receipt of referral and face-to-face contact with alleged child(ren) victim must be within 24 hours.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
investigations of a Referral of Institutional Abuse or Neglect shall be completed within forty-five (45) days of initiation of an investigation, unless the DSS Director or DSS Director's designee authorizes an extension of no more than fifteen (15) days upon a showing of good cause.[135] (FSA IV.C.4.(d)) ***Final target by March 2021: 95% closure in 45 days***				
Investigations - Timely Completion: 10.b. At least 80% of investigations of a Referral of Institutional Abuse or Neglect shall be completed within sixty (60) days of initiation of the investigation, and all investigations not completed within sixty (60) days shall have	96% of investigations reviewed were closed within 60 days. (March 2017)	100% of investigations reviewed were closed within 60 days.	100% of investigations reviewed were closed within 60 days.	100% of investigations reviewed were closed within 60 days.

[135] For the purposes of this measure, an investigation is not completed if DSS determines the report is unfounded because the deadline to complete the investigation has passed.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
authorization of the DSS Director or DSS Director's designee of an extension of no more than thirty (30) days upon a showing of good cause.[136] (FSA IV.C.4.(e)) ***Final target by March 2021: 95% closure in 60 days***				
Investigations - Timely Completion: 10.c. At least 95% of all investigations of a Referral of Institutional Abuse or Neglect not completed within sixty (60) days shall be completed within ninety (90) days.[137] (FSA IV.C.4.(f))	93% of investigations reviewed were closed within 90 days. (September 2017)	100% of investigations reviewed were closed within 60 days.	100% of investigations reviewed were closed within 90 days.	100% of investigations reviewed were closed within 90 days.

[136] Ibid.
[137] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
Family Placements for Children Ages Six and Under: 11. No child age six and under shall be placed in a congregate care setting except with approved exceptions. (FSA IV.D.2.)	Baseline data for this measure are not available.	The circumstances of all but 4 children met an agreed upon exception. A total of 16 Class Members ages six and under were placed in congregate care.	The circumstances of all children met an agreed upon exception. A total of 16 Class Members ages six and under were placed in congregate care.	The circumstances of all children met an agreed upon exception. A total of 26 Class Members ages six and under were placed in congregate care.
Phasing-Out Use of DSS Offices and Hotels: 12. No child shall be placed or housed in a DSS office, hotel, motel, or other commercial non-foster care establishment.	Baseline data for this measure are not available.	DSS reports there were 273 overnight placements in a DSS office (for 107 unique children).	DSS reports there were 53 overnight placements in a DSS office (for 28 unique children).	DSS reports there were 86 overnight placements in a DSS office (for 53 unique children).
Congregate Care Placements: 13. At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period.	78% of children in foster care were placed outside of a congregate care setting. (March 2018)	86% of children in foster care were placed outside of a congregate care setting.	87% of children in foster care were placed outside of a congregate care setting.	88% of children in foster care were placed outside of a congregate care setting.[138]

[138] This does not include 33 children who were hospitalized (12), in a correctional/juvenile justice facility (20), or in a DDSN Residential Facility (1).

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
(FSA IV.E.2.)				
Congregate Care Placements - Children Ages 12 and Under: 14. At least 98% of the Class Members 12 years old and under shall be placed outside of Congregate Care Placements on the last day of the Reporting period unless an exception pre-approved or approved afterwards by the Co-Monitors is documented in the Class Member's case file. (FSA IV.E.3.)	92% of children ages 12 and under in foster care were placed outside of a congregate care setting. (March 2018)	98% of children ages 12 and under in foster care were placed outside of a congregate care setting.	99% of children ages 12 and under in foster care were placed outside of a congregate care setting.	99%[139] of children ages 12 and under in foster care were placed outside of a congregate care setting.[140]
Emergency or Temporary Placements for More than 30 Days: 15. Class Members shall not remain in any Emergency or	Baseline data for this measure are not available.	Data are not available for this period.	6 children remained in an initial Emergency or Temporary Placement for more than thirty (30) days.	19 children remained in an initial Emergency or Temporary Placement for more than thirty (30) days.

[139] This includes 10 children ages 6 and under who resided in congregate care placements on the last day of the monitoring period pursuant to a valid exception.
[140] This does not include nine children who were hospitalized on the last day of the monitoring period.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
Temporary Placement for more than thirty (30) days. (FSA IV.E.4.) ***Dates to reach final target and interim benchmarks to be added once approved.***				
<u>*Emergency or Temporary Placements for More than Seven Days:*</u> 16. Class Members experiencing more than one Emergency or Temporary Placement within twelve (12) months shall not remain in the Emergency or Temporary Placement for more than seven (7) days. (FSA IV.E.5.) ***Dates to reach final target and interim benchmarks to be added once approved***.	Baseline data for this measure are not available.	Data are not available for this period.	Of the 67 children who experienced an Emergency or Temporary Placement in the month of September and had experienced an additional Emergency or Temporary Placement in the prior 12 months, 20 children experienced a subsequent Emergency or Temporary Placement for more than seven (7) days.	Of the 286 children who experienced more than one Emergency or Temporary Placement in a 12-month period, 153 (53%) children experienced at least one subsequent Emergency or Temporary Placement for more than seven (7) days.
<u>*Placement Instability:*</u> 17. For all Class Members in	3.55 moves per 1,000 days. (October 1, 2016 to September 30, 2017).	Data for this measure are produced on an annual basis.	5.70 moves per 1,000 days. (October 1, 2021 to September 30, 2022).	Data for this measure are produced on an annual basis.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
foster care for eight (8) days or more during the 12-month period, Placement Instability shall be less than or equal to 3.37. (FSA IV.F.1.)				
Sibling Placements: 18. At least 85% of Class Members entering foster care during the Reporting Period with their siblings or within thirty (30) days of their siblings shall be placed with at least one of their siblings unless an exception applies (FSA IV.G.2.&3.)	63% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry. (March 2018)	74% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.	76% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.	75% of children entering foster care with siblings were placed with at least one of their siblings on the 45th day after entry.[141]
Sibling Placements: 19. At least 80% of Class Members entering foster care during the Reporting Period with	38% of children entering foster care with siblings were placed with all their sibling on the 45th day after entry. (March 2018)	53% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	48% of children entering foster care with siblings were placed with all their siblings on the 45th day after entry.	52% of children entering foster care with siblings were placed with all their siblings on the 45th day

[141] Exceptions have been approved, though not applied during this monitoring period; therefore, actual performance may be higher than reported. DSS will develop a process for review and approval of exceptions in a future monitoring period.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
their siblings or within thirty (30) days of their siblings shall be placed with all their siblings, unless an exception applies.				after entry.[142]
Youth Exiting the Juvenile Justice System: 20. When Class Members are placed in juvenile justice detention or another Juvenile Justice Placement, DSS shall not recommend to the family court or DJJ that a youth remain in a Juvenile Justice Placement without a juvenile justice charge pending or beyond the term of their plea or adjudicated sentence for the reason that DSS does not have a foster care	Baseline data for this measure are not available.	See Section VIII. *Placements*.	See Section VIII. *Placements*.	See Section VIII. *Placements*.[143]

[142] Ibid.

[143] As discussed in Section VIII. *Placements,* the limited quantitative data available in this area has made tracking performance in this area a challenge, and the Co-Monitors have historically had to rely significantly on anecdotal reports by stakeholders to assess performance. In November 2022, the Co-Monitors and DSS, with DJJ's permission and collaboration, published a report of findings from their joint comprehensive review of the experiences of children dually involved with both DSS and DJJ, accessible here: https://cssp.org/wp-content/uploads/2022/10/FINAL-Children-Concurrently-Involved-with-SC-DJJ-and-DSS-Joint-Review-Findings-002.pdf). This review and report have been an important collaboration, and a key step in identifying some of the barriers to meeting the needs of many of the children in DSS's care who present with high levels of need.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
placement for the Class Member. DSS shall take immediate legal and physical custody of any Class Member upon the completion of their sentence or plea. DSS shall provide for their appropriate placement. (FSA IV.H.1.)				
Therapeutic Foster Care Placements - Referral for Staffing and/or Assessment: 21. All Class Members that are identified by a Caseworker as in need of interagency staffing and/or in need of diagnostic assessments shall be referred for such staffing and/or assessment to determine eligibility for	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[144]

[144] At the time of finalization of the Placement Implementation Plan, the Co-Monitors and Parties determined that, because the process of assessing and identifying the need for more intensive supports and placements would likely be modified as DSS began to implement its Placement Implementation Plan, DSS would wait to propose benchmarks and timelines until implementation began. These modifications have not yet occurred. As discussed in Section VIII. *Placements*, the Co-Monitors have made recommendations that DSS consider alternatives to the current leveling approach, which is frequently based only on placement availability and a child's current behavior, rather than the child's underlying needs.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
therapeutic foster care placement and/or services within thirty (30) days of the need being identified. (FSA IV.I.2.) ***Dates to reach final target and interim benchmarks to be added once approved*.**				
Therapeutic Foster Care Placements - Receipt of Recommendations for Services or Placement: 22. All Class Members that are referred for interagency staffing and/or needed diagnostic assessments shall receive recommendations for specific therapeutic foster care placement and/or services within forty-five (45) days of receipt of the completed referral. (FSA IV.I.3.)	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[145]

[145] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
Dates to reach final target and interim benchmarks to be added once approved.				
Therapeutic Foster Care Placements - Level of Care Placement: 23.a. Within 60 Days: At least 90% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within sixty (60) days following the date of the first Level of Care Placement recommendation. (FSA IV.I.4.) ***Dates to reach final target and interim benchmarks to be added once approved.***	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[146]

[146] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
<u>Therapeutic Foster Care Placements - Level of Care Placement:</u> 23.b. At least 95% of children assessed as in need of therapeutic foster care placement shall be in the Therapeutic Level of Care and specific placement type that matches the Level of Care for which the child was assessed within ninety (90) days following the date of the first Level of Care Placement recommendation. (FSA IV.I.5.) ***Dates to reach final target and interim benchmarks to be added once approved.***	Baseline data for this measure are not available.	Data are not available for this period.	Data are not available for this period.	Data are not available for this period.[147]
<u>Family Visitation - Siblings</u> 24. At least 85% of the total minimum number of monthly sibling visits for all siblings not	66% of all required visits between siblings occurred for those who were not placed together. (March 2018)	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on

[147] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
living together shall be completed, unless an exception applies. (FSA IV.J.2.)		this measure for at least four monitoring periods, or until DSS reports there has been a substantial increase in performance.	this measure for at least four monitoring periods, or until DSS reports there has been a substantial increase in performance.	this measure for at least four monitoring periods, or until DSS reports there has been a substantial increase in performance.[148]
Family Visitation - Parents: 25. At least 85% of Class Members with the goal of reunification will have in-person visitation twice each month with the parent(s) with whom reunification is sought, unless an exception applies. (FSA IV.J.3.)	12% of children with a permanency goal of reunification visited twice with the parent(s) with whom reunification was sought. (March 2018)	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been a substantial increase in performance.	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been a substantial increase in performance.	Upon agreement of all Parties, the Co-Monitors suspended a review of a statistically valid sample of records and reporting on this measure for at least four monitoring periods, or until DSS reports there has been a substantial increase in performance.[149]
Health Care - Immediate Treatment Needs: 26. Within forty-five (45) days of	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are

[148] DSS is working with staff on multiple levels to improve performance in this area and does not yet believe there has been significant improvement. With implementation of SafeMeasures®, DSS expects to produce reliable data reports on children's visits with their siblings and parents and eliminate the need for a review of case records, though the timeline for completion has not yet been established.
[149] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
the identification period, DSS shall schedule the necessary treatment for at least 90% of the identified Class Members with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue. (FSA IV.K.4.(b))				not available.[150]
Health Care - Initial Medical Screens 27. At least 90% of Class Members will receive an initial medical screen prior to initial placement or within 48 hours of entering care. ***Dates to reach final target and***	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[152]

[150] FSA IV.K.4.(b)). required that by August 31, 2016, DSS "identify Class Members with Immediate Treatment Needs (physical/medical, dental, or mental health) for which treatment is overdue." Though initially intended to apply to children in DSS custody at the time of entry into the agreement in October 2016, DSS has lacked a mechanism for measuring performance with respect to this requirement. On October 28, 2019, DSS and Plaintiffs entered into the Joint Agreement on the Immediate Treatment Needs of Class Members (Dkt. 162) which set out a timeline for specific action steps DSS would take to comply with, and ultimately measure performance with respect to, a new set of standards that would replace the initial FSA IV.K.4(b) requirements.

[152] DSS ADR is currently teaming with CAPSS IT to extract data collected from the completion of the FAST medical module to potentially utilize for this purpose.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
interim benchmarks to be added once approved.[151]				
Health Care - Initial Comprehensive Assessments 28. At least 85% of Class Members will receive a comprehensive medical assessment within 30 days of entering care.	36% of children received a comprehensive medical assessment within 30 days. (March 2019)	36% of children received a comprehensive medical assessment within 30 days.	35% of children received a comprehensive medical assessment within 30 days.	40% of children received a comprehensive medical assessment within 30 days.[153]
Health Care - Initial Comprehensive Assessments 29. At least 95% of Class Members will receive a comprehensive medical assessment within 60 days of entering care.	52% of children received a comprehensive medical assessment within 60 days. (March 2019)	56% of children received a comprehensive medical assessment within 60 days.	52% of children received a comprehensive medical assessment within 60 days.	53% of children received a comprehensive medical assessment within 60 days.[154]

[151] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS was to present approvable interim benchmarks for Initial Medical Screens and Initial Mental Health Assessments to the Co-Monitors by May 31, 2020. Given the delay in production of baseline data, benchmarks have not yet been proposed.
[153] As discussed in Section IX. *Health Care*, these data are based on Medicaid claims and have not been independently validated by the Co-Monitors.
[154] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
Health Care - Initial Mental Health Assessments 30. At least 85% of Class Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 30 days of the comprehensive medical assessment. ***Dates to reach final target and interim benchmarks to be added once approved.***	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[155]
Health Care - Initial Mental Health Assessments 31. At least 95% of Class	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[156]

[155] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, these data were to be reported for all children entering DSS custody between October 2019 and March 2020. DSS has provided data on the *total* number of children who receive mental health assessments, but those assessments are not tied to an identified need for a mental health assessment from a comprehensive medical assessment. DSS is not yet able to report data on the number of children receiving mental health assessments after the *need* for such an assessment has been identified. As a result, the Co-Monitors have not reported these data.
[156] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
Members ages three and above for whom a mental health need is identified during the comprehensive medical assessment will receive a comprehensive mental health assessment within 60 days of the comprehensive medical assessment. ***Dates to reach final target and interim benchmarks to be added once approved.***				
<u>*Health Care –Referral to Developmental Assessments*</u> 32. At least 90% of Class Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 30 days of entering care.	19% of children under 36 months of age were referred within 30 days. (July-December 2017)	89% of children under 36 months of age were referred within 30 days.	82% of children under 36 months of age were referred within 30 days.	88% of children under 36 months of age were referred within 30 days.
<u>*Health Care –Referral to Developmental Assessments*</u> 33. At least 95% of Class	20% of children under 36 months of age were referred within 45 days. (July to December 2017)	93% of children under 36 months of age were referred within 45 days.	89% of children under 36 months of age were referred within 45 days.	93% of children under 36 months of age were referred within 45 days.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
Members under 36 months of age will be referred to the state entity responsible for developmental assessments within 45 days of entering care.				
Health Care – Initial Dental Examinations 34. At least 60% of Class Members ages two and above for whom there is no documented evidence of receiving a dental examination in the six months prior to entering care will receive a dental examination within 60 days of entering care.	35% of children ages one and above received a dental exam within 60 days. (March 2018)	46% of children ages two and above received a dental exam within 60 days.	45% of children ages two and above received a dental exam within 60 days.	44% of children ages two and above received a dental exam within 60 days.[157]
Health Care – Initial Dental Examinations 35. At least 90% of Class Members ages two and above for whom there is no documented evidence of receiving a dental	48% of applicable children ages one and above received a dental exam within 90 days. (March 2018)	60% of applicable children ages two and above received a dental exam within 90 days.	64% of applicable children ages two and above received a dental exam within 90 days.	57% of applicable children ages two and above received a dental exam within 90 days.[158]

[157] As discussed in Section IX. *Health Care*, these data are based on Medicaid claims and have not been independently validated by the Co-Monitors.
[158] Ibid.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
examination in the six months prior to entering care will receive a dental examination within 90 days of entering care.				
Health Care – Periodic Preventative Care (Well visits) 36. At least 90% of Class Members under the age of six months in care for one month or more will receive a periodic preventative visit monthly.	49% (40) of 82 children under the age of six months received a periodic preventative visit monthly. (March 2019) 30% (42) of 137 children under the age of six months who entered care between October 1, 2018 and March 31, 2019 received a periodic preventative visit monthly.	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
Health Care - Periodic Preventative Care (Well visits) 37. At least 90% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit in accordance with current American Academy of Pediatrics (AAP) periodicity	38% of children between the ages of six and 36 months received periodic preventative visits in accordance with the periodicity schedule. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance**[124]
guidelines.				
<u>*Health Care – Periodic Preventative Care (Well visits)*</u> 38. At least 98% of Class Members between the ages of six months and 36 months in care for one month or more will receive a periodic preventative visit semi-annually.	62% of children between the ages of six and 36 months received a periodic preventative visit semi-annually. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
<u>*Health Care – Periodic Preventative Care (Well visits)*</u> 39. At least 90% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit semi-annually.	12% of children ages three years and older received a periodic preventative visit semi-annually. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
<u>*Health Care – Periodic Preventative Care (Well visits)*</u> 40. At least 98% of Class Members ages three and older in care for six months or more will receive a periodic preventative visit annually.	58% of children ages three years and older received an annual preventative visit. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
Health Care – Periodic Dental Care 41. At least 75% of Class Members ages two and older in care for six months or longer will receive a dental examination semi-annually.	54% of children ages two years or older received a dental exam semi-annually. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
Health Care – Periodic Dental Care 42. At least 90% of Class Members ages two and older in care for six months or longer will receive a dental examination annually.	81% of children ages two years or older received an annual dental examination. (March 2019)	See Section X. *Health Care*	See Section X. *Health Care*	See Section X. *Health Care*
Health Care - Follow-Up Care 43. At least 90% of Class Members will receive timely accessible and appropriate follow-up care and treatment to meet their health needs.	Baseline data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.	Data for this measure are not available.[160]

[160] DSS has proposed collecting additional qualitative information using a case review process to measure follow-up care, based on the instrument used for the CFSR, and is discussing potential approaches and review design with the Co-Monitors.

Summary Performance on Settlement Agreement Requirements				
Final Settlement Agreement (FSA) Requirements	**Baseline Performance**	**October 2021 – March 2022 Performance**	**April – September 2022 Performance**	**October 2022 – March 2023 Performance[124]**
Dates to reach final target and interim benchmarks to be added once approved.[159]				

[159] Pursuant to the DSS Addendum to the Health Care Improvement Plan, approved February 25, 2019, DSS was to present approvable interim benchmarks to the Co-Monitors by November 30, 2019.

Michelle H., et al. v. McMaster

SUPPLEMENTAL REPORT: SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES

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Michelle H. Co-Monitors' Supplemental Report Regarding South Carolina's Placement Crisis

July 27, 2023

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INTRODUCTION

The Co-Monitors submit this report in response to Plaintiffs' June 23, 2023 letter expressing concern about the escalating DSS placement crisis and requesting that the Co-Monitors provide a summary and analysis of recent information collected, along with recommendations for the Parties to discuss and implement. Data reported herein includes: 1) Child and Adult Protective Services System (CAPSS) data on placements produced by DSS for the period October 1, 2022 – March 31, 2023; 2) DSS documentation and copies of Universal Applications (UAs) for children who experienced overnight stays in DSS offices from April 1 through June 30, 2023; 3) information compiled through interviews with DSS staff during site visits to county and regional offices in the Upstate (Spartanburg, Anderson, and Greenville) during the week of June 5, 2023; and 4) information gathered through discussions with DSS, private providers, and other stakeholders from January – June 2023.

The DSS placement crisis has reached new extremes in recent months, with children sleeping overnight in DSS offices daily, or being moved through numerous "emergency placements" while waiting for stable placement to be found. Though perceived by some early in the lawsuit as an issue that impacted a small number of "high needs" children, data now clearly demonstrate that the problem is widespread. Between October 1, 2022 and March 31, 2023, 489 unique children experienced at least one emergency placement and 53 unique children slept overnight in a DSS office, which together comprise 10 percent of the approximately 5,000 children who spent time in DSS custody during the same period.[1] Many of these children were not assessed by DSS to need intensive or restrictive levels of foster or group home placement.

Emergency placements and overnight stays in DSS offices are reflective of instability experienced more broadly for children in DSS's custody, whether they are directly served by DSS or through provider agencies.[2] Though the majority of children in DSS custody are not necessarily being moved through placements *specifically* identified as "emergency" in nature, many are being cycled through series of placements.[3] For the six-month period ending March 31, 2023, of the 5,177 children who spent any time in foster care during the period, 872 (17%) were moved through three or more placements for whatever period of time they remained in DSS custody during those six months.

As discussed below, the placement crisis is fundamentally a symptom of the severe shortage of services and supports for children and families throughout South Carolina. There are other contributing factors: the lingering impact of the COVID-19 pandemic on family stress and

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[1] Though DSS's capacity to reliably track emergency and overnight placements has increased significantly, it is possible that data reported herein do not fully account for all instances. DSS reports that it expects the validity of these data to continue to improve.

[2] As in many systems across the country, some private organizations are licensed as Child Placing Agencies (CPAs). These agencies receive funding to provide foster care placement and monitoring through group facilities or by recruiting, training, and licensing foster parents. Over the course of the monitoring period, approximately one-fourth of children in DSS custody were placed through CPAs.

[3] This is in line with findings from the last monitoring period (April 1 to September 31, 2022) that children had experienced the highest degree of placement instability since the inception of the lawsuit. For more information see: Michelle H., et al. v. McMaster and Leach Progress Report for the Period April – September 2022, p.77 - 79.

foster parent recruitment; efforts by the state to appropriately reduce the number of non-therapeutic group care placements; slow implementation of Qualified Residential Treatment Providers (QRTPs);[4] limited access to intensive residential treatment for a small number of youth who need that level of care; and the compounding failures of other child- and family-serving systems that have resulted in children entering foster care.

DSS has put significant effort into meeting *Michelle H*. Settlement Agreement requirements, attempting to improve the experiences and outcomes of the children in its care. Since receiving an influx of funding from the General Assembly in July 2022, DSS leadership has hired extensively to fill newly allocated positions, worked to retain current staff, and engaged with county and regional directors throughout the state to maximize the impact of new funding. This has helped to decrease caseloads and improve performance in some key areas.

However, the State defendants in this lawsuit cannot succeed in their mission of supporting children's safety, permanency, and well-being, and strengthening families, without more readily available supports and treatment services for families and their children from other public agencies who have the responsibility to fund and provide such services and supports. DSS must nest its services and responsibilities within a broader system of care that can intervene earlier and effectively when families experience crises and need help.

Under federal law, state Medicaid agencies are required to provide comprehensive preventative screening, diagnostic, and treatment services to all children under age 21 who are enrolled in Medicaid, necessary to meet their physical, mental, and behavioral health needs, pursuant to the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) benefit:[5] "This affirmative obligation to children with recommended treatment makes EPSDT different from Medicaid for adults."[6] Regardless of whether a child is in foster care, "services that are appropriately defined as 'medical assistance' under the Medicaid regulations and are 'medically necessary to correct or ameliorate a condition' must be provided to children under 21 who are covered by Medicaid."[7]

Without an improvement in the state's capacity to address children's behavioral health needs and to help parents and other caregivers who struggle to support children with disabilities,

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[4] In February 2018, the federal Family First Prevention Services Act (FFPSA) was passed to promote placement of children in family foster care settings as opposed to congregate care settings, and to allow states to use federal IV-E funding to provide evidence-based prevention services in the community to reduce the need for out-of- home placement. FFPSA prevents federal reimbursement of congregate care facilities that do not meet the new criteria for a Qualified Residential Treatment Program (QRTP), which include: a trauma-informed treatment model, on-site registered or licensed nursing and clinical staff, inclusivity of family members in treatment planning, offering aftercare support 6 months post-discharge, and accreditation by a select group of bodies. (Family First Prevention Services Act, Publ. L. No. 115-123, H.R.253. (2017)).

[5] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B); 1396d(r)

[6] U.S. Department of Health and Human Services, EPSDT: A Guide for States. (June 2014) p. 6 https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/epsdt_coverage_guide_140.pdf

[7] S.D. ex rel. Dickson v. Hood, 391 F.3d 581, 590 (5th Cir. 2004), as discussed in Jennifer Lav and Kim Lewis. *Children's Mental Health Services: The Right to Community-Based Care*. National Health Law Program.https://healthlaw.org/wp-content/uploads/2018/09/NHeLP-Issue-Brief_Children%E2%80%99s-Mental-Health-Services.pdf

health issues, and child and family trauma, the foster care placement system will continue to be overwhelmed, and DSS will be hamstrung in its ability to provide the children in its care – nearly all of whom are Medicaid eligible – with stable placement (or, in many cases, any placement at all). DSS and its state agency partners – including the SC Department of Health and Human Services (DHHS), the SC Department of Mental Health (DMH), the SC Department of Juvenile Justice (DJJ), the SC Department of Disabilities and Special Needs (DDSN), the SC Department of Education (DE), and the Department of Children's Advocacy (DCA) – must collaborate, share responsibility, and share accountability for ensuring that services for children and families in need are accessible. These state agencies must also reach out to and make it possible for the many willing and able private providers throughout the state to join with them in addressing this urgent crisis.

Included below is a summary of the current placement crisis; factors that may be contributing to it; steps DSS is currently undertaking to address it; and the Co-Monitors' recommendations for additional strategies for consideration.

SUMMARY OF PLACEMENT CRISIS

The *Michelle H.* Final Settlement Agreement (FSA) stipulates that children cannot sleep overnight in state offices and requires that DSS inform the Co-Monitors in the rare instances that this occurs. For the first several years of the lawsuit, the Co-Monitors were notified of a child sleeping overnight in an office about 10 times per year. In April 2021, DSS reported that across the state, an increasing number of children in its custody were sleeping in offices overnight because placements could not be found, even though the total number of children in foster care had declined from prior years. Between April 1 and September 30, 2021, 34 unique children were reported to be subjected to this practice over 68 nights. During the following period, from October 1, 2021 – March 31, 2022, the number climbed to an unprecedented 107 children experiencing 273 nights sleeping in DSS offices. This increase triggered the Parties to jointly enter into an Overnights Plan on March 23, 2022.[8]

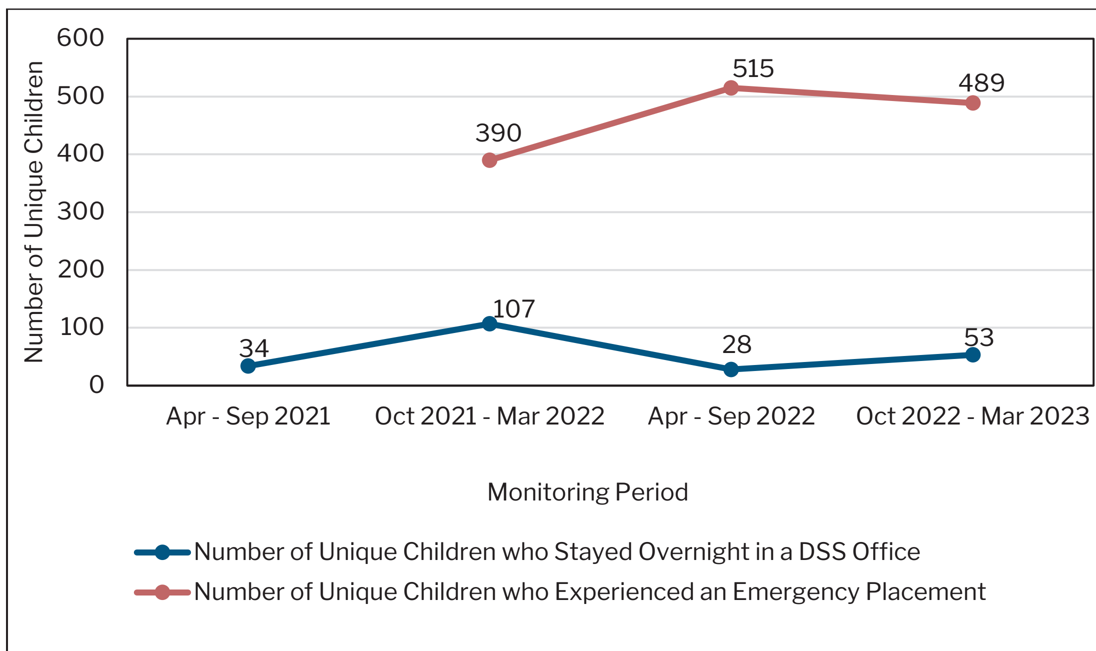
The Overnights Plan required DSS to accelerate several strategies already in place, such as updating policies and practice expectations for when approval of a Regional Director is required for placement decisions; increasing opportunities for training for kinship care coordinators; collecting more detailed information about the histories and needs of children awaiting placement, and requiring DSS to enact new initiatives such as piloting specialized foster homes and peer mentors for children with high clinical needs.

DSS also adopted twice daily, "all-hands-on-deck" calls to coordinate emergency arrangements for children waiting in DSS offices for placement. Staff at all levels began spending hours on calls, and driving children across the state in an effort to ensure every child had a bed, if only for a few hours. Due to the extraordinary efforts of DSS staff and provider agencies, the number of children sleeping overnight in DSS offices declined. However, the placement crisis raged on as the efforts to ensure every child had a bed each night meant that children were increasingly moving between short-term emergency placements. As shown in Figures 1 and 2, between October 1, 2022 and March 31, 2023, DSS reported that almost 500 unique children spent 7,400 total nights in emergency placements. Many of

[8] Overnight Stay Plan (March 23, 2022, Dkt. 236)

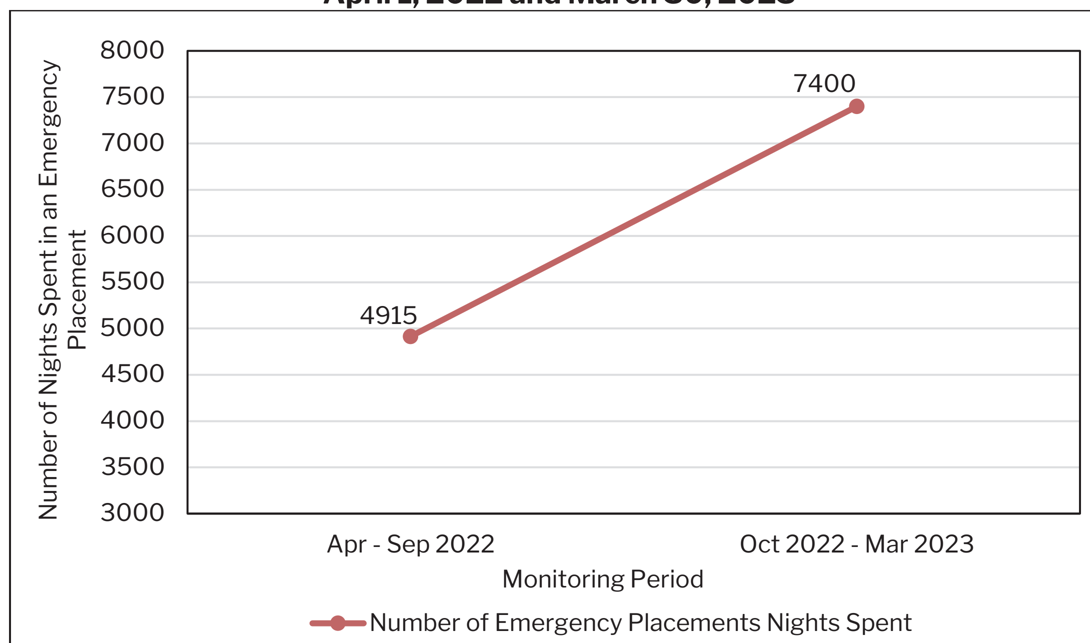
these children continued to spend their daytime hours in DSS offices, after being picked up early in the morning from their emergency placements, still waiting for a stable, welcoming placement to be found.

Figure 1: Children who Stayed Overnight in a DSS Office or Experienced an Emergency Placement between April 1, 2021 and March 30, 2023



Source: DSS Data

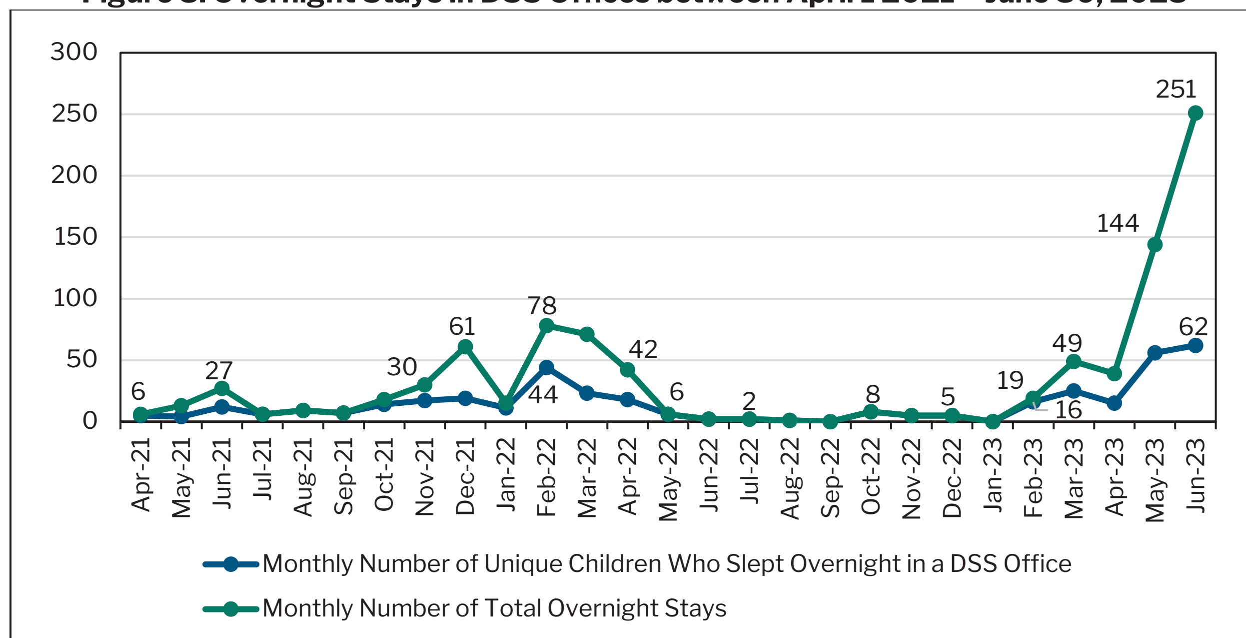
Figure 2: Number of Nights Spent in an Emergency Placement between April 1, 2022 and March 30, 2023



Source: DSS Data

In February 2023, reports of children sleeping overnight in offices began to climb once again, as shown in Figure 3, even as emergency placements remained rampant. Now, three months into the current monitoring period (April 1, 2023 – September 30, 2023), the number of children sleeping overnight in DSS offices has reached alarming levels, even higher than in the *six-month* period that led to the development of the Overnights Plan. **Between April 1, 2023 and June 30, 2023 alone, 109 unique children spent 434 nights sleeping in DSS offices.** The Co-Monitors now receive multiple notifications of children spending the night in DSS offices every day.

Figure 3: Overnight Stays in DSS Offices between April 1 2021 – June 30, 2023



Source: DSS Data

The Co-Monitors conducted an analysis of the Universal Applications (UAs), which are sent to providers to request that a child be accepted for placement, for the 109 children who stayed overnight in DSS offices between April 1 and June 30, 2023. These UAs reflected that, of the 109 children, 41 (38%) had newly entered foster care at the time of sleeping overnight in the DSS office, whereas 68 (62%) had prior DSS placements immediately preceding the overnight stay in the DSS office. Table 1 indicates the type of placement preceding a child's period of instability and subsequent overnight stay. In many cases, children experienced a number of emergency placements for weeks or months before ending up having to sleep in a DSS office. Table 2 provides examples of experiences documented on UAs. The results of this analysis indicate a variety of needs that demonstrate why a comprehensive response from a number of state agencies is essential.

Table 1. Analysis of Previous Placement Type for Children Who Stayed Overnight in DSS Offices from April to June 2023 (N=109)

Previous Placement	Number (%) of Children
Family (kin or home of origin)	41 (38%)
Foster Home	14 (13%)
Group Care 1 (Level 1)	13 (12%)
Therapeutic Foster Care (TFC)	12 (11%)
Mental Health Hospitalization	11 (10%)
Group Care 3 (Level 3)	8 (7%)
DJJ or Correctional Facility	6 (6%)
Psychiatric Residential Treatment Facility (PRTF)	2 (2%)
Group Care 2 (Level 2)	2 (2%)

Source: UAs provided by DSS
*Totals may not equal 100% due to rounding

Table 2. Analysis of Universal Applications for Children Who Stayed Overnight in DSS Offices from April to June 2023 (N=109)

Documented Experience	Number (%) of Children
Mental Health Diagnosis	86 (79%)
Suicidal Thoughts	34 (31%)
DJJ History	29 (27%)
Individualized Education Plan (IEP)	25 (23%)
Disability	20 (18%)
Substance Use	16 (15%)

Source: UAs provided by DSS

Though the Co-Monitors have not yet received updated data on emergency placements for the period April through June 2023,[9] the increase in children sleeping overnight in DSS offices is likely matched by an increase in children being shuffled from placement to placement, night-to-night. During site visits held by the Co-Monitors in June 2023, the frequency of this disturbing occurrence was reported by DSS staff.

Impact of Placement Crisis on Children and DSS Staff

Regardless of whether they are sleeping overnight in a DSS office, or spending a few hours in a stranger's home, a significant number of children in DSS's custody at any time are effectively homeless. These children live out of DSS office buildings, spending their days waiting on the possibility that a bed will be identified for use a few hours that night – before being driven up to three or four hours across the state, only to repeat this the next day. One case manager in a county office expressed, "It's hard for us, but the overnight placements are so unhealthy [for the kids], and the distance makes it even worse. I just had a child that

[9] DSS will be providing updated data to the Court on July 28, 2023.

had to go three hours for an overnight placement and then pick them up and drive them three hours back, for three days in a row. [The child's] frustration level was so high."

While at emergency placements, children are sometimes barred from bathing, eating meals, accessing their phones, and taking their medication. The constant pattern of waiting in offices, bathing in public community centers, and moving through different placements – all the while being sent the message "you are not wanted" – can last days, weeks or even months.

This situation has compounded the day-to-day responsibilities of an already overburdened workforce at a time when DSS has been focused on recruiting and retaining staff. In many county offices, case managers have had to carry out their ongoing responsibilities and act as direct care providers for the children in the office around the clock. This has meant grocery shopping, dispensing medications, serving meals, and transporting children to and from school, therapy, visits with their family members, and emergency placements. One case manager described the experience, saying, "When I had a kid in the office for a year, I had to make sure [they] got to appointments, to school, make sure [they] ate; and it was humiliating for [them] because we don't have any accommodations for hygiene, nutrition … we don't have a stove. [They] just had to sit in the office and do nothing. [They] used the lobby bathroom to brush [their] teeth, wash [their] face, and change [their] clothes. I had to bring [them] to [a community facility] to shower."

Staff in one county reported to the Co-Monitors that they frequently work 12-hour days and could not recall a month when there was not a child living out of the office. One case manager expressed the dual emotional strain of feeling like she had failed the children on her caseload as well as her own family because she could not be present at home. A team leader[10] agreed, "I am a single mom. My workers have small children of their own. I have workers saying, 'My husband told me to quit.' Some are separated [from their spouses] because [they say], 'My family can't handle me in this mindset,' or 'I can't address my own children's issues because I have to work.'" Workers who the Co-Monitors interviewed said that hiring additional workers to lower caseloads and increasing their salaries had helped them remain with DSS in these challenging times, but worried that these improvements would feel "meaningless" when children are living out of the office and there is no relief in sight.

The drain of this crisis has also been felt by many private providers who have been essential partners in DSS's mission of serving children and families. Provider staff have spent considerable time and effort trying to assist DSS in finding and supporting appropriate homes for children. Despite these efforts, and the important work DSS has done in recent years to engage the private provider community as partners, private providers are still hindered by breakdowns of communication, lack of involvement in CFTMs, lack of accurate clinical assessment of child and family needs, and the dearth of needed supportive services.

This crisis is not only harmful to children and draining for staff, but also costly to the state. Foster parents typically receive a nightly incentive payment ranging from $75 to $150 per

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[10] The FSA utilizes the term "supervisor" to refer to DSS staff who oversee case-carrying staff. As part of its Guiding Principles and Standards (GPS) case practice model development and work to define enhanced job expectations, DSS now utilizes the term "team leader," effective May 2023.

night to "house" children. Case managers caring for and transporting children living out of DSS offices are compensated through overtime pay.[11] As pressures and exhaustion mount, it will be increasingly difficult to keep staff from leaving the DSS workforce in high numbers, amplifying costs in recruitment and training of new staff. The time and focus on children in the offices or without placement also hinders worker's ability to serve other children and families on the road to reunification, extending their time in foster care, thus increasing costs.[12]

FACTORS CONTRIBUTING TO PLACEMENT CRISIS

A Severe Shortage of Supports and Services in Face of Increasing Need

Parenting is an inherently stressful task that demands a sense of connectedness, trust, and community support. Many states have a shortage of community services, programs, and funding for families; South Carolina is no exception. The services and supports that the Co-Monitors have long recommended DSS develop by partnering with other state agencies and their private Managed Care Organization (MCO) partners have yet to materialize at a sufficient scale, while the needs of children and families in the state have continued to escalate.

The COVID-19 pandemic placed additional stress on families, and much evidence suggests that it exacerbated the mental and behavioral health needs of children across the country.[13] In South Carolina, which ranks 41 out of 50 states in availability of mental health professionals, this need is even starker (nationally, the average ratio is one mental health professional per 350 people; in South Carolina, the ratio is one mental health professional per 520 people).[14] South Carolina is the lowest ranked state in terms of having the highest percentage of youth with major depression who do not receive mental health treatment.[15] According to the Rural Health Information Hub, all but five counties in South Carolina are considered "mental health services shortage areas."[16] One case manager expressed to the Co-Monitors, "finding a child psychiatrist is like finding a leprechaun."

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[11] On March 24, 2023, in response to the placement crisis, DSS approved eligible staff to receive overtime pay for additional hours worked through the end of 2023. This was a significant shift in policy – prior to that, staff received only compensatory ("comp") time.

[12] Ringel, Jeanne S., et al., *Improving Child Welfare Outcomes: Balancing Investments in Prevention and Treatment,* RAND Corporation, RR-1775-1-APFF, 2017. Retrieved July 15, 2023: https://www.rand.org/pubs/research_reports/RR1775-1.html

[13] Grace Whaley and Betty Pfefferbaum, *Parental Challenges During the COVID-19 Pandemic: Psychological Outcomes and Risk and Protective Factors*. Current Psychiatry Reports vol. 25,4 (2023): 165-174. (*See also*: Centers for Disease Control and Prevention, Youth Risk Behavior Survey 2011-2021. Retrieved from: https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf and *Opinion: America's Teens Are in Crisis. States Are Racing to Respond*. The Washington Post (April 2023). Retrieved from: https://www.washingtonpost.com/opinions/2023/04/01/teen-mental-health-state-programs/)

[14] Access to Care Ranking 2023. Mental Health America. Retrieved from: https://mhanational.org/issues/2023/mental-health-america-access-care-data

[15] Youth Ranking 2023. Mental Health America. Retrieved from: https://mhanational.org/issues/2023/mental-health-america-youth-data

[16] Rural Health Information Hub. (2023). Rural Data Explorer. Retrieved from https://www.ruralhealthinfo.org/data-explorer?id=209&state=SC

While the Co-Monitors do not have quantitative data on waitlists for mental health services in South Carolina, case managers and team leaders in the counties visited suggested that children are not getting the health care to which they are legally entitled under federal EPSDT provisions of the Medicaid Act.[17] Under EPSDT provisions, nearly all of the 109 children who slept in DSS offices overnight between April 1 and June 30, 2023, as indicated in Table 2 above, would have likely be eligible for Medicaid-funded appropriate and timely mental health services. The lack of these services undoubtedly contributed to their status as children without placement.

As reported in South Carolina's Joint Citizens and Legislative Committee on Children's 2023 Annual Report, a hospital emergency department is often the first stop for children who can benefit from psychiatric care, but is largely unequipped to handle behavioral health emergencies.[18] Children may remain at hospitals waiting for care for hours, days, or weeks, and the environment causes additional stress for pediatric patients experiencing a crisis.[19] Children often leave these acute settings without community-based supports or long-term treatment in place, suggesting a likely return. Recent data show that all too often, families and health care providers who feel they are out of options for the care of a child in mental health crisis, seek support from DSS. As shown in Table 1 above, 11 of the children who slept overnight in DSS offices between April 1 and June 30, 2023 came to the office *directly* from an acute mental health hospitalization. As shown in Table 2 above, 86 (79%) had at least one mental health diagnosis.

This is consistent with reports from case managers who describe the increasing degree to which parents who are not suspected of abuse or neglect "refuse" to take their child home from either hospitals or juvenile detention because they do not see any other options for support, and they hope DSS or the Department of Juvenile Justice (DJJ) can provide it. Some of these parents are willing to submit to allegations of child neglect because they are desperate for help for their child. Many of the 41 children who slept in an office in the most recent three-month period after newly entering DSS's care were brought into DSS custody because the child's caregiver expressed an inability to care for the child.

South Carolina currently has one-24-hour Crisis Stabilization Unit (CSU), which only serves persons 18 and older. Although the state is working to develop more CSUs, these units will not be accessible to the majority of youth in foster care due to the age limit.[20] DSS staff reported that the SC Department of Disabilities and Special Needs (DDSN) generally turns away children in foster care. The state has been slow to expand Mobile Response Stabilization Services (MRSS), which is currently the responsibility of the Department of Mental Health (DMH), an all-hours crisis resource utilized across the country. Due to evidence

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[17] See *supra* FN 5

[18] *2023 Annual Report*. Joint Citizens and Legislative Committee on Children. (p.4) Retrieved from: https://www.sccommitteeonchildren.org/_files/ugd/587cb7_d7971d16c4f14322810407008cb01fbb.pdf

[19] Ibid.

[20] S.C. Code § 44-7-130 (26), "'Crisis stabilization unit facility' means a facility, other than a health care facility, operated by the Department of Mental Health or operated in partnership with the Department of Mental Health that provides short-term residential program, offering psychiatric stabilization services and brief, intensive crisis services to individuals 18 and older, 24 hours a day, seven days a week."

of its success in keeping families safely together,[21] the federal government offered financial incentives that began during the COVID-19 pandemic and are still ongoing.[22] Current MRSS practice in South Carolina, as distinguished from other states,[23] requires a child to be actively suicidal, homicidal or experiencing psychosis in order to activate a response. A case manager in one county office reported calling MRSS about a child in crisis after exhausting all other options and being told, "we'll call you back." She received a return call two days later.

A key barrier to the development of adequate community-based and in-home therapeutic services has been that there are no clear lines of responsibility or authority among the various state agencies in South Carolina for creating an expanded mental health network for its citizens. For example, if a child is dually diagnosed with autism and a behavioral health disorder, the responsibility for providing services to address those issues is split among agencies and frequently not addressed by any. As shown in Table 2 above, of the 109 children who slept overnight in a DSS office in the last three months, 20 (18%) had a documented disability.

In South Carolina, there has been a moratorium on the development of new Rehabilitative Behavioral Health Services (RBHS) since 2015,[24] and little to no development by Medicaid in making financing available for evidence-based intensive in-home and community-based services that are needed by children and families,[25] such as Homebuilders, Family Functional Therapy (FFT), Family Centered Treatment (FCT), Multisystemic Therapy (MST), and

[21] A 2018 report by the National Association of State Mental Health Program Directors cited findings that MRSS is instrumental in averting unnecessary emergency department visits, hospitalizations, out-of-home placements, and placement disruptions. In addition to improved outcomes for youth, MRSS services have been shown to reduce overall costs. (Manley, E., et al. (2018). *Making the case for a comprehensive children's crisis continuum of care*. National Association of State Mental Health Program Directors.
https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf)

[22] The federal government issued guidance in December 2021 that increased the reimbursement rate for state expenditures on qualifying community-based mobile crisis intervention, so that states can receive an 85 percent federal match for these services for the first three years. South Carolina did not utilize this approach. To see the December 28, 2021 Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services, go to: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf

[23] For example, New Jersey's MRSS effort, which provides 24/7 access to behavioral health workers to all families in the state, works with families to deescalate behaviors, provide intervention services for 72-hours, and develop a plan that may include stabilization management for up to 8 weeks, with referral to intensive in-community and/or behavioral health treatment when needed. In addition, MRSS pro-actively visits with all children in new kin or foster families placements in the first week of placement. For more information on New Jersey's implementation of MRSS, go to: https://www.nj.gov/njfosteradopt/services/mrss.html. More information on MRSS is in the Recommendations section below.

[24] DHHS created an enrollment exception process to the moratorium for current DSS-licensed CPAs to enroll in Medicaid.

[25] See Recommendations section below for discussion of Palmetto System of Care Waiver, granted in 2021 for children enrolled in the South Carolina Continuum of Care (COC).

Intercept®.[26] Medicaid supported RHBS services can allow providers to offer a range of important services for children in foster care, including Behavior Modification (B-Mod), Family Support (FS), Therapeutic Foster Care (TFC), and Therapeutic Child Care (TCC).[27] In July 2022, the moratorium was lifted but only for school-based mental health services, and the ratio of students to counselors has improved, from approximately one counselor to 1,300 children, to one counselor to 800 children, based on recent DHHS accounts. As shown in Table 2 above, of the 109 children who slept overnight in DSS offices in the most recent three months, 25 (23%) had an Individualized Education Plan (IEP) in school.[28] DHHS now reports that the moratorium for new RHBS providers will be lifted in January 2024.

The lack of available services, supports, and creative problem solving to meet children's underlying needs can also result in behaviors such as running away, physical altercations, absence from school, verbal aggression, and substance use. These behaviors are often criminalized and result in involvement with law enforcement and DJJ. Unlike juvenile justice agencies in some jurisdictions, the options for diversion, pre-adjudication supervision, or alternatives to detention or commitment in the form of community-based interventions in South Carolina are limited. As shown in Table 1 above, six of the 109 children who slept overnight in a DSS office came directly from DJJ detention; as shown in Table 2, 29 (26%) had a recent history of DJJ involvement.

As reported by DSS case managers, it increasingly seems as if an untenable reality has taken hold – in the absence of sufficient voluntary, community-based services – there are only two realistic options for children in need: legal separation from family and placement in DSS custody, or detainment through DJJ. Neither option provides access to resources or infrastructure to keep families together and to address children's escalating needs. For the most part, DSS staff do not have specialized clinical training or the ability to access different services (or the same services more rapidly) than those available to children not in their custody. One DSS case manager said, "We have medically fragile children with special needs and we're held responsible for assessing safety, but we're not trained…We can't do medication management. We don't have the ability to recognize and prevent escalation. We work well together but we're human – we don't have the ability to continue to serve the children."

Though DSS leadership has been rallying staff in a collective effort to stem the crisis for months, a severe insufficiency of services and supports for families is fundamentally

[26] Intercept®, developed by Youth Villages, is an evidence-based intensive in-home parenting skills program used to safely prevent children from entering out-of-home care or to reunify them with family as quickly as possible if a period of out-of-home care is necessary. Services range from four to nine months (typically, four to six months for prevention or six to nine months for reunification). For more information, go to: https://youthvillages.org/wp-content/uploads/2022/05/Overview-of-Intercept.pdf

[27] "Rehabilitative Behavioral Health Services (RBHS) Provider Manual." (2023). South Carolina Department of Health and Human Services. Retrieved from: https://provider.scdhhs.gov/internet/pdf/manuals/RBHS/Manual.pdf

[28] Case managers in one county reported that for children with IEPs, many of whom need the most support in and out of school, schools sometimes require an abbreviation of the school day as an accommodation of a child's IEP. This can make it more difficult to ensure their educational needs are met, and to identify caregivers who are available to support them.

preventing progress and contributing to a pattern of exacerbating harm for children in foster care. As shown in Table 2 above, between April 1 and June 30, 2023, 34 (31%) of the 109 unique children who slept overnight in a DSS office were noted to be actively suicidal or had a documented recent experience of suicidality in DSS records. Some of these children entered foster care for different reasons but have developed heightened needs due to the impact of instability and experiences while in DSS custody.

It is important to note that, though data reflect a high level of need amongst many of the children currently in DSS's custody without placement, many, if not most, of these children could thrive with their families or in family settings with the right services and supports. In addition, and just as importantly, the availability of sorely needed community-based supports to South Carolina families could prevent the need for family separation and placement in DSS custody in the first place.

Placement Outside of Congregate Settings, In Accordance with Best Practice and National Trend

In accordance with best practice that children be placed in family-based settings whenever possible, federal law, and the FSA, DSS, like jurisdictions throughout the country, has transitioned away from its historical reliance on congregate care placements for the children in its care. This shift is strongly supported by research on the importance of family settings for children's growth, development, and success. Commendably, DSS leadership has promoted that children first and foremost should be placed with kin, and that the vast majority of children can live in a family setting with the right services and supports, and do not require institutional care. At the outset of the *Michelle H.* lawsuit, in March 2017, 22 percent of children in DSS's custody were placed in a congregate care setting. As of March 2023, this number had dropped to 13 percent.

DSS's progress in moving children out of congregate care, and the closing of facilities that resulted, was not, however, accompanied by an equally strong effort to recruit foster parents to serve children with complex needs and to develop the supports necessary to ensure children can thrive in family-like settings. One team leader expressed frustration about not being able to place children safely with kin initially, noting "[l]ater, we're trying to revisit them [as placement options], but trying to figure out how to get services to maintain it, after kids have already been moved a million times. It feels like a lose-lose."

In addition, DSS was slow to engage with DHHS and its private providers about transitioning to programs that could successfully support children in both family and treatment-oriented group settings. DSS's efforts to transition some of its remaining congregate care facilities to Qualified Residential Treatment Programs (QRTPs), in accordance with Family First Prevention Services Act (FFPSA), have been far slower than initially imagined, reducing access to institutional settings that provide specific, tailored, evidence-based services to meet the complex behavioral and mental health needs of children when it is determined that a congregate care setting is needed.[29] As of June 30, 2023, DSS did not have any approved

[29] Zhou, X., McClanahan, J., Huhr, S., & Wulczyn, F. (2021) *Using Congregate Care: What the Evidence Tells Us*. Chicago, IL: Center for State Child Welfare Data, Chapin Hall at the University of Chicago. https://assets.aecf.org/m/resourcedoc/chapinhall-usingcongregatecare-2021.pdf

and funded QRTPs to treat children (making their remaining congregate care facilities ineligible for federal IV-E funding). DHHS and DSS struggled to determine how to develop QRTPs in the state that conform to the federal requirements limiting Institutions for Mental Disease (IMDs),[30] while some other states have been able to anticipate this obstacle and move forward with creative solutions.[31] DSS, DHHS, and Select Health are still planning to implement a limited number of QRTP contracts in Fall 2023.

Improved Data Capacity to Capture Depth of a Placement Crisis

In order to comply with the FSA, DSS introduced an automated system for collecting data on emergency placements in August 2021, though DSS reports inconsistent entry of these data into CAPSS until March 2022. DSS continued to make refinements to technological processes during the April to September 2022 monitoring period. As a result, recent reports on emergency placements are likely more accurate than those of prior periods, meaning that the precipitous rise in emergency placements may be, in part, a reflection of improvements in DSS's capacity to track these children's experience and produce data.

As discussed below, DSS's increased data capacity, and the newly enhanced functionality of its data system to produce management reports across a range of metrics, will be extremely helpful to DSS leadership in identifying children who are at risk of placement instability and intervening earlier.

A Crisis that Feeds on Itself

The cyclical nature of the placement crisis has left all involved – children, families, kin, foster parents, group home staff, private providers, DSS frontline staff and leaders – strained, tired, and operating with less patience than they were prior to April 2021, when reports of children staying overnight in DSS offices began to escalate. Constant placement instability places stress on all parties, which can shorten tempers of both children and potential foster parents or kin caregivers, who have the power to ask DSS for children to be removed from their homes at any time. One DSS staff in a regional office said, "We have a therapeutic kid who has a foster home, but it takes two or three months to get them into therapy. In that time, the foster parent says, 'This is taking too long, I can't handle this,' and then the kid moves again."

Foster parents have expressed burnout after being asked to take children on an emergency basis so frequently, particularly when they have full-time jobs, and – now that it is summer – when children are not in school. As a result, there are fewer foster parents available and willing to take children even on an emergency basis, thus tightening the crisis even further. This has been particularly concerning in light of the pre-existing shortage of foster parents

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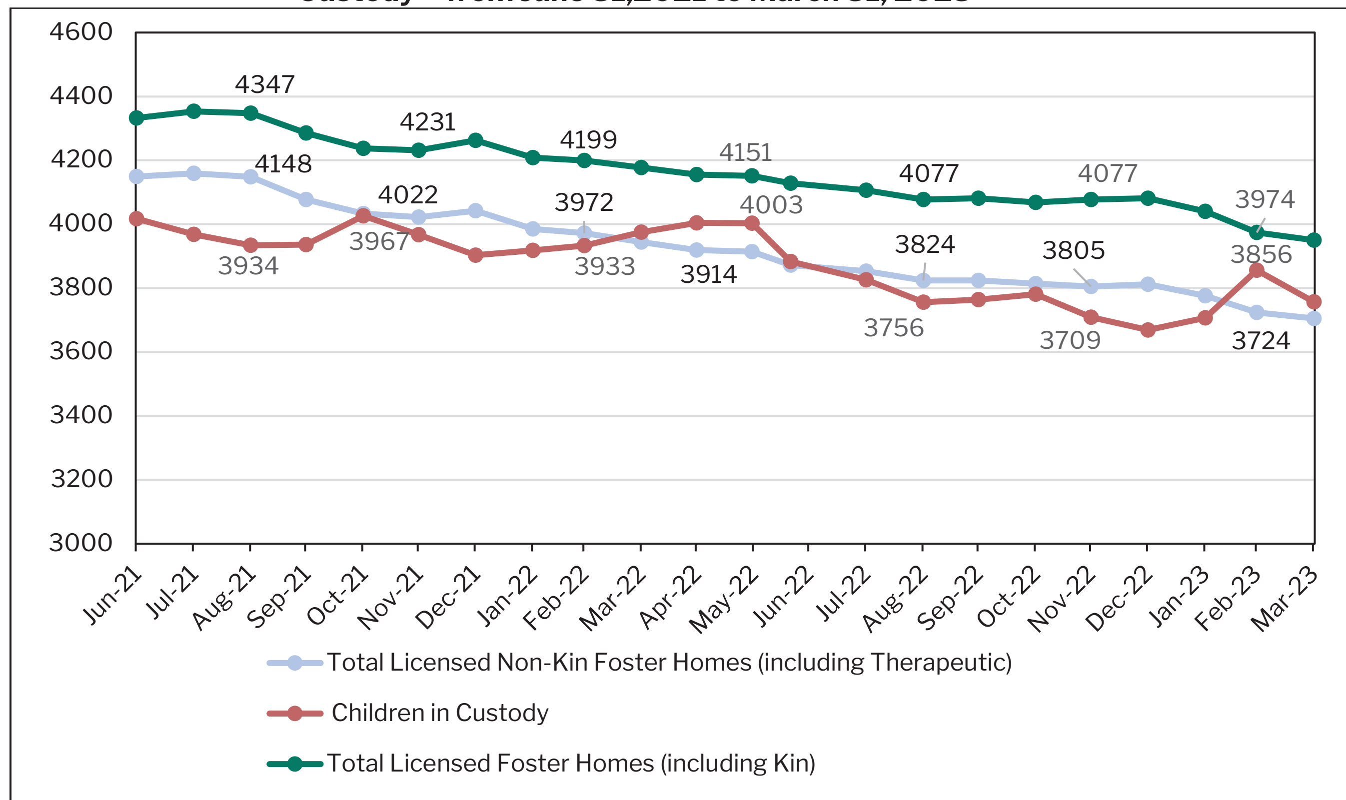
[30] Section 1905(i) of the Social Security Act defines an IMD as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." Under the FFPSA, IMDs are not currently eligible for QRTP designation.

[31] For example, eight providers were initially interested in transitioning to the higher level of clinical services required by the QRTP model, but some had more than 16 beds and were told they would not be eligible. As of this report, there remain only two providers interested in becoming QRTPs.

statewide, particularly those willing to accept teenagers, children with disabilities, and children who identify as LGBTQ+.

Figures 4 and 5 show licensed foster homes opened, closed, and available, relative to the number of children in DSS custody.[32,33]

Figure 4: Total Licensed Foster Homes[34] as Compared to Number of Children in Custody[35] from June 31,2021 to March 31, 2023

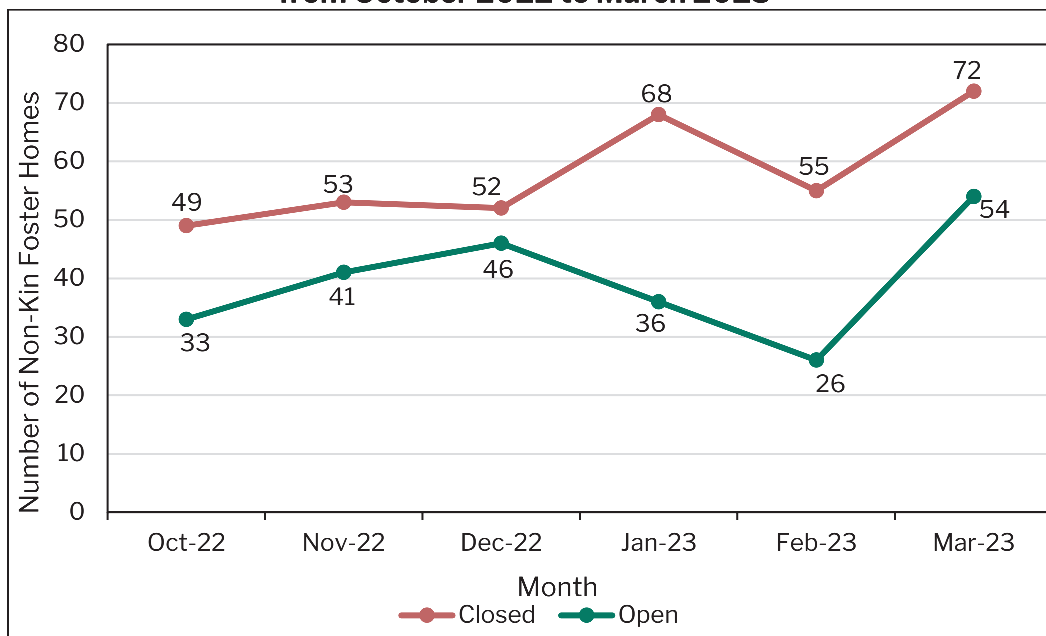


Source: DSS Data

[32] Though DSS requires foster families to have a child reside in their home during the prior 12 months to maintain their license, not all licensed homes accept children for placement at any given time.
[33] The Co-Monitors have found that states that have worked to build up an adequate array of foster placements so that staff can match individual children with homes that can meet their needs and honor children's preferences have found that they need a buffer of at least twice the bed capacity as children in custody at any point in time. For example, as of June 2022, New Jersey had total bed capacity for 6,398 children in 2,834 licensed resource family homes (including kin homes), with 3,154 children in out-of-home placement. In 2019, Oregon calculated the additional capacity needed (with a buffer) for foster homes depending on level of care and average length of stay, and found that it needed 10,146 beds for the 7,500 children in custody.
[34] Approximately 10 percent of children are placed with kin in unlicensed placements. Data do not reflect these unlicensed kin placements.
[35] These data may include children in foster care who do not fall within the definition of Class Members ("all children who are involuntarily placed in DSS foster care in the physical or legal custody of DSS now or in the future" [FSA II.A.]) as per the FSA.

In the most recent monitoring period, between October 1, 2022 and March 31, 2023, more foster homes (both licensed through DSS and through Child Placing Agencies (CPAs)) closed than opened in each month. As shown in Figure 5, 349 homes closed, and 236 homes opened.

Figure 5: Total Non-Kin Foster Homes Opened and Closed Monthly from October 2022 to March 2023[36]



Source: DSS Data

For children who come to DSS after forced separation from everything they know – family, friends, communities – instability and uncertainty can be devastating. Being moved day after day through offices and strangers' homes, having to bathe in public places, losing access to one's phone (and only lifeline) would be dysregulating to any adult, no less children looking for a sense of control and stability. As the days mount, behavior can understandably escalate.[37] Children are frequently described as "refusing" placement, although such decisions likely reflect the lack of any agency children feel they have, and the logical preference to remain in one place rather than move again, for just a few hours.

One DSS case manager emphasized, "[The children are] having behaviors here because they're frustrated being in the office all day, but we have to work." Another in a different office noted: "I would not want to stay in a room all day and then go to a home just to go to sleep. That's not a life for a teenager. They go to school and hear about other people going to the mall, but they have nothing to do. We have no windows. I would misbehave in the same situation." As children's behavior escalates, and they cycle through an increasing number of placements, it also becomes more and more difficult to find placements for them.

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[36] These data exclude kin foster homes.
[37] For more information on how the experience of instability while in DSS custody can impact involvement with DJJ, go to: https://cssp.org/wp-content/uploads/2022/10/FINAL-Children-Concurrently-Involved-with-SC-DJJ-and-DSS-Joint-Review-Findings-002.pdf

As the placement crisis deepens, it also becomes more difficult for case managers to focus on the day-to-day responsibilities that are core to their role and essential to helping families move towards reunification. One case manager said, "We're raising children in this office, but we have other children on our caseload. I was in the office for an entire month with a kid so I had to do virtual visits with the other children on my caseload, which is not acceptable." In the Upstate Adoption Office, which serves the entire region, workers expressed having an increasing number of children with high therapeutic needs experiencing instability on their caseloads, which has reduced their capacity to process adoptions. This has the effect not only of increasing the time that families are separated, but of feeding the placement crisis by keeping children in DSS's custody unnecessarily.

The placement crisis has also siphoned energy from DSS leadership's focus on implementing its Guiding Principles and Standards (GPS) case practice model with fidelity.[38] Individualized and strength-based engagement, functional assessment, and trauma-informed and family-centered planning are vital for DSS to achieve safety, permanency, and well-being for children in their custody. Though basic training occurred to orient staff to the GPS model when it was initially introduced, there has long been a need for deeper integration of these principles at all levels. To alleviate this placement crisis, DSS staff need these skills more than ever, yet leadership has had diminished capacity to devote to these efforts. Barriers to addressing underlying needs and individualized service planning for children and families must be understood and addressed for *any* changes to take hold in a meaningful way.

CURRENT DSS STRATEGIES TO ADDRESS PLACEMENT CRISIS

DSS has been actively engaged in efforts to address this crisis. In addition to the strategies already discussed, in recent months DSS has reported implementing the following:

Prior to July 1:

- Targeted Foster Family Recruitment: DSS has been delivering training to private providers responsible for recruitment and licensing of foster homes on targeted practices for recruiting homes to support adolescents, youth who identify as LGBTQ+, and large sibling groups. After shifting its focus exclusively to the licensing of kin homes in July 2020, DSS re-initiated direct licensing of foster homes for these same populations in May 2023. DSS leadership is in the process of assessing the need for additional licensing staff to support these efforts.

- Access to Legal Representation for Parents: When parents have access to legal representation, their children are less likely to enter foster care and may be reunified in a timelier manner.[39] In January 2019, the Children's Bureau revised its policies to allow child welfare agencies to claim administrative costs of legal representation for children who are candidates for title IV-E foster care and their parents in all stages of

[38] DSS's GPS case practice model was designed in recognition of the need for a culture that 'engage[s], encourage[s], honor[s], and support[s] families.' To see the GPS case practice model, go to: https://dss.sc.gov/media/2746/gps-practice-model-final.pdf

[39] "How can pre-petition legal representation help strengthen families and keep them together?" (2020). Casey Family Programs. Retrieved from: https://www.casey.org/preventive-legal-support/

foster care legal proceedings.[40] DSS has expressed a commitment to utilizing this option and has an agreement in place with the Office of Indigent Defense (OID) to fund parent representation.

- Small Test of Change (STOC) Strategic Co-Design: In Greenville, Anderson, and Spartanburg Counties, a national philanthropic consultant is supporting DSS and cross-sector stakeholders to design and test approaches to serve teens who may otherwise enter DSS custody related to status offenses, parent-child conflict, and/or allegations of behavioral issues. The STOC Design Team met at a two-day retreat in June 2023 to brainstorm priorities and solutions, and each county will begin implementing strategies discussed over the coming months.

- Implementation of Limited In-Home Supports to Prevent Foster Care Entry: DSS currently contracts with Homebuilders, Family Centered Treatment, and Brief Strategic Family Therapy (among others), and is planning to implement Intercept®[41] – all evidence-based and well-supported trauma treatment models of home-based family therapy. These services are being used in accordance with FFPSA to help prevent entry into foster care, as well as to support children in custody through one-time Family First Transition Act (FFTA) funding. The number of contracted providers and availability for these services remains limited. In many states, these services are supported by Medicaid and such funding will be necessary to expand and sustain these contracts.

Beginning July 1, 2023:

- Increased Day Treatment Program Capacity: Though DSS recognizes that children are fundamentally in need of stable placements and normalized school experiences, DSS has launched a new day treatment program through a contractual arrangement with private providers, which began July 5, 2023. Contracts for the program include educational and treatment services to keep youth out of DSS offices during the day, or for youth in regular foster homes who cannot attend school. There will be capacity for 25 slots located in Columbia and 10 slots located in York County (beginning August) when at full capacity. The Columbia program currently has 15 slots.

- Case-level Support: A consultant has been engaged to review UAs and treatment information for youth with high placement instability to develop creative solutions to stabilize placement. In an effort to begin generating internal expertise, the consultant will work with a "Core Team" comprised of staff from Child Placement, Child Welfare Operations, and Child Health and Well-Being. This will begin with a review of five youth, with the possibility that the scope can be broadened.

- Sitter Support, Behavior Modification Specialist Support, and Licensed Therapist Support in selected DSS offices: A licensed therapist will be located in both Greenville and Richland counties to provide therapy services to youth in these and surrounding

[40] U.S. Department of Health and Human Services (2021). Log No: ACYF-CD-IM-21-06. Retrieved from: https://www.acf.hhs.gov/sites/default/files/documents/cb/im2106.pdf

[41] See *supra* FN 26.

counties who are experiencing placement instability and are unable to be served by community mental health offices (costs will be shared with DMH). The contract with DMH has been finalized and hiring for these therapists is in progress. In addition, DSS has expanded an existing contract with a private provider to co-locate seven Behavior Modification Specialists in the Upstate (2), Midlands (2), Pee Dee and Lowcountry (1), as well as one additional Specialist to cover a second shift at night in the Upstate and Midlands each (2).

Beginning August 15, 2023:

- Increased Transportation Support: DSS added a change order to an existing transportation contract to provide additional assistance to counties in transporting youth to and from placements 24 hours per day/7 days per week to alleviate burdens on case managers.[42]

Beginning Fall 2023:

- Additional In-Home Supports for Kin Placements and Services to Prevent Foster Care Entry: DSS is planning to launch Family Resource Connection and Preservation Services (FRCPS) in the fall. FRCPS is a new fixed-price bid service which includes services like parent education and skill building, behavior management, and substance use disorder support for kinship placements (both licensed and unlicensed), and families engaged with DSS through an open Family Preservation or Investigation case. Families will be contacted to participate in in-person meetings, assessment and planning, home- and community-based services (which may also include concrete supports like clothing and food), and transition planning. DSS is in the process of estimating the number of families who may be served by FRCPS.

RECOMMENDATIONS FOR ADDITIONAL STRATEGIES TO ADDRESS PLACEMENT CRISIS

Although the Co-Monitors commend the work that DSS is already undertaking, these efforts will only help at the margins as they remain too small or isolated to address the root causes of the crisis. Only through an acceleration of the multi-agency work to develop a true range of supports and services for children and families, along with efforts to improve child welfare practice in accordance with DSS's practice model, will South Carolina begin to tackle the placement crisis.

The recommendations below are categorized as stop gaps, other immediate actions, and short-, medium-, and long-term strategies. Work on all strategies, no matter the category, should begin immediately and with urgency, although some will take time to fully implement across the state and at a sufficient scale. While many of these initiatives do require planning time, it is essential that the work move with expediency beyond planning and to implementation – in partnership with stakeholders, consultants, and private and state agency partners – to reduce the harm currently being caused to children and families. Without the long-term strategies, most of which require partnership with and action by other state

[42] According to DSS, this change will allow the four existing providers to transport any youth going to or coming from an emergency placement statewide. Referrals will be accepted from 5:00 a.m. to 11:00 p.m., though transport will be available 24/7. DSS reports that the providers are willing to add additional staff if the need outpaces current staffing availability.

agencies, the short-term strategies will not be able to sustainably produce the intended outcomes. For many of the recommendations, the Co-Monitors suggest starting in counties experiencing the most significant placement challenges, which provides the opportunity for DSS leadership, performance coaches, trainers, and staff to learn from the work underway and prepare to mentor additional counties as the reforms expand.

Stop Gaps

The Co-Monitors recommend that DSS immediately implement the following recommendations in an attempt to decrease harm and risk of harm to children (while other more sustainable strategies are underway). DSS has expressed concern that these strategies could result in increased numbers of children staying overnight in DSS offices in the short term. For that reason, we recommend the Department take the next 30 days to engage with local leadership and community providers to develop additional safe options for children's immediate placement on a temporary basis in their counties of origin.[43] These are intended as stop gap measures that should be discontinued as soon as is feasible and appropriate.

1. Allow Local Flexibility in Placement Decision-Making for Best Interests of Child: Counties should be permitted flexibility in making local decisions to accept emergency placements if they are not in the child's best interest. Children should not be driven (nor should case managers be expected to drive children) significant distances at night for an emergency placement for the sole purpose of avoiding an overnight stay in an office. Additional staffing may also be temporarily needed in offices with high numbers of unplaced children.

2. Modify Expectations for Emergency Incentive Payment: DSS should adjust requirements for receipt of emergency incentive payments to foster parents, to include basic standards of care, including requirements around minimum stays, meals, and access to medications and showers. Consideration should be given to developmental needs of adolescents, including maintaining reasonable access to phones, and maximum times/month a single foster caregiver can be granted emergency incentive payment.

Other Immediate Actions

1. Make Available Results from Family Advocacy and Support Tool (FAST) and Child and Adolescent Needs and Strengths (CANS) to Private Providers: The purpose of FAST is to identify existing needs and behaviors to inform placement matching when a child first enters care, and the CANS is used to guide discussion around treatment needs and make decisions about what care and services will be helpful to children and their caregivers.[44] These assessment tools can help placement staff and private providers

[43] The Co-Monitors acknowledge that this recommendation could reduce compliance with the *Michelle H.* settlement agreement for a short period of time, but believe it could reduce harm to children currently shuffled through emergency placements, and reduce driving time for staff.
[44] For more information on FAST and CANS see: https://praedfoundation.org/tcom/tcom-tools/the-child-and-adolescent-needs-and-strengths-cans/ (retrieved Feb. 7, 2023)

make decisions about their capacity to meet a child's needs and must be completed in all cases and made available along with the Universal Assessment.

2. Arrange an In-Person Planning Session between the Co-Monitors, Private Providers, DSS, DHHS, DMH, DE, and DDSN: Related Department leaders and key members of the private provider community should come together in September to review the recommendations included herein and develop action plans for coordinated implementation, facilitated by an outside philanthropic consultant.

Short-Term (3-6 months)

1. Recruit Leadership Support: The Deputy Director of Child Welfare should create a new senior position and begin recruitment for someone to oversee all efforts to deal with the placement crisis. This person would work closely with county and regional office leadership and have the authority to sign off on resources that can be used quickly to address individual children's needs.

2. Intensify Efforts to Identify, Utilize, and Support Kin Caregivers: Further extend successful efforts to prioritize kin placement by dedicating additional resource staff as a SWAT "kin expeditor" team with a collective commitment to finding, approving, placing with, supporting, and maintaining placement with kin. Rollout can begin in Richland, Spartanburg, or Greenville with statewide rollout to follow. This work includes:
   a. Re-examining standards that can be waived if placement could be safe and stable;
   b. Providing immediate supports with flexible funding to make potential kin homes safe and acceptable, wherever possible (e.g. fire extinguishers, smoke detectors, additional mattresses, etc.);
   c. Developing streamlined guidelines for kin approval to promote consistency and clarity around the process for staff statewide;
   d. Ensuring provision of all supports needed for placement with both licensed and non-licensed kin to be successfully maintained, immediately upon placement (e.g. daytime child care, a bigger refrigerator, a tutor, a wheelchair ramp, etc. to meet needs identified by families);
   e. Providing emergency enhanced payments to help kin prepare for a placement before the point of removal;
   f. Implementing a process for Regional Director approval of all initial non-kin placements;
   g. Escalating all denials of applications for kin resources to Deputy Director of Child Welfare to determine if the family could be supported to be a safe placement; and
   h. Moving forward with planned pilot around Kinship Therapeutic Foster Care and implementation of Kinship Guardianship Assistance Program (kinGAP).[45]

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[45] South Carolina enacted legislation to support a kinGAP program on May 26, 2023, which would allow for permanent placement of children with approved or licensed kin, with financial assistance in the same manner as adoption assistance payments are provided for children adopted from foster care. For more information, see: https://www.scstatehouse.gov/sess125_2023-2024/bills/380.htm.

3. Develop and Implement Creative Approaches to Recruitment of Additional Foster Parents: Consideration should be given to the use of professional foster parents,[46] who could be paid full-time (whether beds in their homes are filled or not) to care for children without placement and those with higher needs. DSS should explore and adopt innovative ideas for targeted recruitment efforts,[47] quickly determine if additional staff are needed for foster home recruitment and, if so, create positions to increase internal staffing. DSS should add internal licensing staff as determined necessary to increase foster parent licensing, particularly in light of the additional tasks taken on by licensing unit in response to the placement crisis.[48]

4. Expand and Improve use of Pre-Removal Child and Family Team Meetings (CFTMs) and Risk of Placement Disruption CFTMs: DSS leadership and staff report that convening a CFTM prior to a child's removal into foster care has been effective throughout the state at keeping families together and identifying kin and other family resources. These CFTMs should be mandated before or upon placement, with regularity and in accordance with the GPS case practice model. We recommend DSS engage technical assistance (TA) support in the form of external expert consultation around the assessment of underlying needs and innovative problem-solving strategies with families, including use of flexible funds that could meet the needs of families to avoid family separation. This work can begin in Richland, Spartanburg, and Greenville, and extend to counties that reach a designated level of overnight and emergency placements. Consideration should be given to the initial CFTM being in-person rather than virtual, unless it impedes the participation of the parent or child. Intensive TA support should be made available to these counties to craft individualized services and solutions.

5. Increase the Availability and Accessibility of Flexible Funds: Simple guidelines for use and access of flexible funds should be immediately available to staff, along with brief training to fiscal staff (which can be integrated into TA work described above). Successful implementation will require funds to be available to children experiencing instability in placement, to support families to prevent placement into foster care, and to speed up reunification. Funds should be used for things that are not currently funded through other state and federal funded programs and available for concrete supports and non-traditional services and supports to meet needs identified by children and their families. As described above, flexible funds should be available to

[46]A professional foster parent receives a salary from a child welfare agency and agrees not to work outside of the home. Professional foster parents receive additional specialized training and are typically responsible for caring for only one child at a time, often a child who needs a therapeutic level of care. For more information on how Washington State plans to utilize professional foster parents to reduce the number of children sleeping in offices or hotels see: https://imprintnews.org/top-stories/washington-state-plans-to-move-foster-youth-out-of-hotels-and-offices/240969

[47] For example, new ideas for recruitment could include adding a checkbox indicating interest in serving as a placement resource to forms for social workers seeking to renew their licenses, teachers getting certified, and other professionals who already require background checks and have an interest in caring for children and families.

[48] As referenced above, DSS re-initiated direct licensing of foster homes for adolescents, LGBTQ+ youth, and large sibling groups in May 2023.

the child and family team without unnecessary layers of approval. This need for flexible funds was identified as a high priority in the planning work underway in the STOC counties (Greenville, Anderson, and Spartanburg).

6. Track and Integrate Data on Placement Moves into Real-Time Management Reporting: DSS has made significant progress over recent months to further develop its data capacity, and state leadership now relies on a "data dashboard" to track important indicators for management purposes. The addition of a placement moves report, already in development, would allow for the identification and flagging of children at risk of placement instability. Better understanding the settings from which children most often disrupt and the impact of CFTMs on their stability could help DSS identify children at risk of placement issues and inform paths forward. The regional Well-Being Teams should be engaged to lead special reviews for children who move placements twice within a six-month period, with consideration for the number of children within that population who experienced and did not experience regular CFTMs.

7. Fully Implement planned Exceptional Needs Pilot: The Overnights Plan required DSS to pilot a comprehensive treatment approach with 20 specialized foster homes with 24/7 crisis management, intensive counseling, short-term respite, and full mental health evaluations. Foster parents are expected not to reject or eject children placed through this pilot and are paid an enhanced rate. Implementation of this pilot has begun, but has been very limited. Only one CPA has served any children at this time, with two children currently placed.[49] DSS should work with private providers to identify and address barriers to full implementation.

8. Work with Law Enforcement to Reduce Unnecessary Removals: In South Carolina, law enforcement has the unilateral authority to place children in Emergency Protective Custody (EPC). As indicated in Table 1 above, between April 1 and June 30, 2023, 21 (19%) of 109 children who slept overnight in a DSS office had been brought into DSS custody by a law enforcement officer. Work in some counties to bolster the relationship between local DSS leadership, community service providers, and law enforcement has helped significantly in reducing the number of children brought into DSS's custody by EPC. Efforts to build off these models and formalize structures for community support throughout the state could serve to reduce family separations and improve local partnerships.[50]

9. Engage TA Support for Regional Placement Teams: Several years ago, DSS shifted to a placement process that requires regional placement teams to search for and approve all placements, rather than placements being managed by case managers in county offices. A reassessment of how this decision-making process works in

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[49] As reported in the most recent Overnight Stay Plan Status Update on July 17, 2023 (Dkt. 282), the CPA who has begun the pilot work has an additional family currently in the matching process, and two families in the licensing process. Another CPA has two families in the licensing process and anticipates they will be trained and able to accept placements by October 2023.

[50] For more information on how interaction with law enforcement can contribute to a child's placement instability, go to: https://cssp.org/wp-content/uploads/2022/10/FINAL-Children-Concurrently-Involved-with-SC-DJJ-and-DSS-Joint-Review-Findings-002.pdf

practice is warranted. Consideration should be given to practices around UAs, including need for clinical review of information and more targeted approaches to placement match identification (in place of "UA blasts"). External TA providers can work in identified regions (beginning in the Upstate) to shadow the placement team, assess practice, engage with private providers and foster parents, and make recommendations.

Medium-Term (6-12 months)

1. DHHS should fully remove the RBHS Moratorium to Allow for Expanded Therapeutic Supports: As discussed above, DHHS put a moratorium on the enrollment of new providers of RBHS in 2015, in response to concerns about a lack of quality and accountability controls after policy changes had been introduced in July 2014. DHHS subsequently extended the moratorium and, as the Co-Monitors understand it, it remains formally in effect. The moratorium has contributed to the inability of DHHS to assure that the services to which children are entitled under federal EPSDT provisions are available. Until the moratorium is lifted, DSS's ability to expand its service array will be severely limited, as providers have long advocated. In addition to lifting the moratorium, DSS and DHHS must make active efforts to engage potential RBHS providers through capacity building grants. Select Health will also be an important partner in enrolling new providers on its panel as needed, since RBHS became part of the MCO's responsibility in July 2016.

2. Begin Expanding Provision of Therapeutic In-Home Services, Funded Through Medicaid: Once the RBHS Moratorium is lifted in January 2024, capacity building to expand needed in-home services can begin with selected providers to ensure the development of adequate skills and capacity to stabilize placements. Therapeutic supports, including access to evidence-based services like Homebuilders, FFT, FCT, MST, and Intercept should be made available to children who do not have placements and/or who are at risk of instability in their placement setting. This work should be done collaboratively with DSS, DHHS, and private providers, with initial start-up costs covered through provider grants. All consideration should be given to how services developed could be funded through Medicaid (see long-term recommendation #1). Rollout can begin in Richland, Spartanburg, or Greenville, with statewide rollout to follow.

3. DHHS and DSS should Assess Use of Existing Waiver and Explore Potential Enhanced Partnership with Continuum of Care: In June 2021, the SC Continuum of Care (COC), through DCA, was granted a Medicaid Section 1915 (c) Palmetto Coordinated System of Care (PCSC) Home and Community Based Waiver for children. This allowed children and youth who would otherwise be served in inpatient psychiatric settings to receive a range of intensive behavioral health services and supports in their homes and communities. The waiver is intended to serve individuals up to age 21 with serious emotional disturbances who meet a hospital level of care, but it is unclear which and

how many services have been provided through the waiver to this population.[51] The Co-Monitors recommend that DSS work with DHHS and COC to determine what outcomes have been achieved by this waiver thus far for the foster care population, and whether potential child welfare involvement could be avoided by maximizing use of the waiver. Though COC has decision-making authority over enrollment, DHHS and DSS should work closely with COC on potential ways to expedite and streamline enrollment for families in acute need.

4. Reassess Current Placement and Leveling System: DSS should work with the Co-Monitors and their internal CQI team on a process for assessing its system for placing children and assigning their levels of care. The assessment should include consideration of alternatives to the current leveling approach, frequently based on placement availability and a child's current behavior, rather than the underlying needs of children. The assessment should also include an analysis of the Interagency System for Caring for Emotionally Disturbed Children (ISCEDEC) clinical assessment and eligibility process, with input from private providers who utilize these assessments. Work to evaluate and improve this system can help inform a determination about a useful mechanism for measuring compliance with FSA therapeutic supports and placement measures[52] and requirements from the Health Care Plan Addendum which assesses DSS's performance in meeting children's therapeutic and well-being needs.

Long-Term (12-24 months)

Nearly all children in foster care in South Carolina are eligible for Medicaid, and it is a shared responsibility of DSS and DHHS, the agency that oversees Medicaid, to ensure these children's health needs are met.[53] Not only is this legally required as part of the Medicaid EPSDT mandate, it also fiscally prudent. When states pay for services included in federally approved Medicaid State Plans and waiver programs, they receive federal matching funds for these expenditures at a state's Federal Medical Assistance Percentage (FMAP) rate. In South Carolina, this rate is currently 70.58 percent. This means that for every dollar of Medicaid-reimbursable mental health services provided to these children, South Carolina pays only 31 cents and the federal government pays almost 71 cents. This is both a considerably higher rate than the reimbursement rate for most expenditures under Title IV-E (the other major source of federal child welfare funding) and one that can be applied broadly to almost all children in foster care as opposed to the more limited number that meet Title IV-E eligibility requirements.[54]

Jurisdictions throughout the country have been successful in leveraging Medicaid funding to support children and families involved with the child welfare system. Often, the impact has

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[51] Application for a §1915(c) Home and Community- Based Service Wavier: SC.1688.R00.02. (2021). To see the application, go to: https://www.scdhhs.gov/sites/default/files/documents/PCSC%20Waiver.PDF

[52] FSA IV.B.I(2-5)

[53] Although the Medicaid State Plan the responsibility of the single state entity – in SC, DHHS – the administration of specific services and financing is sometimes delegated by DHHS to other state agency partners (e.g. DSS, DMH, DDSN).

[54] Approximately 45 percent of children in foster care in SC meet Title IV-E eligibility requirements (referred to as the state's Title IV-E penetration rate).

been profound, and has enabled the creation of vital systems of care.[55] This can be achieved through Medicaid State Plan amendments and/or Waivers to provide or increase the provision of key home- and community-based- services. The work of developing these services across the state is longer term in nature, but essential in addressing the root causes that underlie the current placement crisis, and building a system of supports for families that can enable DSS to meet their obligations under *Michelle H.* and improve experiences and outcomes for families.[56]

1. DHHS should expand Home- and Community-Based Services through Medicaid: Medicaid is critically important and extensively used in jurisdictions throughout the country to provide intensive in-home and community-based services. While services must always be individualized, there are some services that are foundational to any family-serving system that can be financed through Medicaid, including: intensive care coordination (ICC) and high-fidelity wraparound,[57] intensive in-home mental health treatment services,[58] therapeutic foster care, and peer mentoring, among

[55] Early in the New Jersey lawsuit, the state developed the NJ Children's System of Care (CSOC), an integrated system for behavioral health across child-serving systems in NJ, serving children and youth 21 or younger with mental health issues, substance use, and/or intellectual/developmental disabilities and their families. CSOC is significantly financed through Medicaid, with the state match initially paid largely through funding recaptured by the child welfare system for services for which they were using state dollars, but determined were Medicaid-eligible. CSOC has had a significant and lasting impact in NJ and remains a single point of contact for families seeking support, regardless of whether they are system-involved. For more information about the development and financing of CSOC through Medicaid see https://www.chcs.org/media/Making_Medicaid_Work.pdf.

[56] For a detailed discussion of a range of strategies in four states (Arizona, New Jersey, Massachusetts, Michigan) that utilized Medicaid as a primary source of funding in the development of services and supports for children in foster care, go to: https://www.chcs.org/media/Making_Medicaid_Work.pdf

[57] ICC is "a robust, comprehensive form of case management services, designed specifically for children and youth with significant mental health needs," and should include: assessment and service planning; help with access to and coordination with services, including crisis services, support for meeting basic needs, family advocacy, and progress monitoring. (Lav, Jennifer and Lewis, Kim *Children's Mental Health Services: The Right to Community-Based Care* (April 1, 2018) (citing Joint Centers for Medicare and Medicaid Services (CMS) and SAMHSA Informational Bulletin, Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions (May 7, 2013), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf).)) ICC is often provided through a "wraparound" model, which is a structured approach to individualized family- and youth-driven care coordination. (Center for Health Care Strategies, *Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs: State and Community Profiles 5 (*July 2014*)*, https://www.chcs.org/media/ICC-Wraparound-State-and-Community-Profiles1.pdf; *see* Jennifer Schurer Coldiron et al., *A Comprehensive Review of Wraparound Care Coordination Research*, 1986-2014, 26(5) Journal for Child and Family Studies 1245 (2017)).

[58] Intensive in-home mental health treatment services are comprehensive, collaborative interventions provided to improve child, youth, and family functioning and to prevent the need for out-of-home placement, placement disruption, inpatient hospitalization, or residential treatment. Multisystemic Therapy, Intensive Family Preservation Services, Homebuilders, Functional Family Therapy are examples of such interventions, amongst many others. (Barbot, B., Bick, J., Bentley, M.J., Balestracci, K., Woolston, J., Adnopoz, J.A., & Grigorenko, E. (2016) *Changes in mental health outcomes with the Intensive In-Home Child and Adolescent Psychiatric Service: A multi-informant, latent consensus*

other things.[59] Medicaid allows states flexibility in tailoring services or coverage for a specific population, and, as such, have been an essential tool in the development of services and supports for children in foster care for decades. As the Co-Monitors have long-recommended, DSS and DHHS should work together, employing a consultant with Medicaid expertise if needed, to consider the many ways in which jurisdictions throughout the country have utilized Medicaid, including 1915(c) and (i) Home- and Community-Based Services (HBCS) Waivers and quickly begin building an array of services in South Carolina not already covered and/or provided in the state under or outside of the Medicaid State Plan.[60]

2. DHHS and DMH should Expand Availability and Access to Mobile Crisis Response Services (MRSS): MRSS is a child- and family- crisis intervention model that can provide rapid, de-escalation, support, and connection to ongoing resources to families in need. When used effectively, it can play an important role in preventing future crises, keeping families together, and reducing hospitalization and involvement with law enforcement. MRSS can be reimbursed substantially through Medicaid (financing should come from DHHS or DMH) and has been used broadly in other jurisdictions to reduce the need for foster care, as well as to maintain kinship and foster placements at risk of disruption. Enough capacity should be developed so that MRSS is available 24 hours per day, 7 days per week, for both short-term, ongoing, and one-time crisis interventions, and there is proactive outreach to all new placements (and re-placements) within one week of placement to notify families of the availability of this support.[61] In South Carolina, there is an opportunity for direct connection to other

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approach. International Journal of Methods in Psychiatric Research.*; see* Stroul, B, et al. *The Evolution of the System of Care Approach*. University of Maryland Institute for Innovation and Implementation.https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf)

[59] Center for Health Care Strategies. *Lessons From Other Fields: What are Promising Practices for Using Medicaid State Plan Amendments and Waivers to Address the Needs of Children and Youth in Foster Care?* Casey Family Programs. Retrieved from: https://www.casey.org/media/20.07-KM-LFOF-Medicaid-waiver-authorities.pdf

[60] For example: New York's Bridges to Health (B2H) 1915 (c) waiver allows for the provision of a broad range of services to children in foster care who have intellectual or developmental disabilities to help them live in a home- or community-based setting. Services include immediate crisis response, help with daily activities, intensive in-home supports, family and caregiver supports and services, healthcare coordination, respite care, skill building, and employment support. Wisconsin utilizes a 1915 (c) waiver to access Medicaid funding to reimburse foster care providers who care for children with higher level needs at an increased rate. Arizona has used a 1115 waiver since 1982 implement a Comprehensive Health Plan for children in foster care, based on a partnership with the Arizona Department of Health Services, Division of Behavioral Health Services, and a single MCO. Oregon was recently granted a 1115 waiver to, among other things, address social determinants of health using non-medical services, with children in foster care as one target population. North Carolina has used a 1115 waiver to implement evidence-based interventions to address social determinants of health through its "Healthy Opportunities Pilots" program, which focuses on housing instability, transportation insecurity, interpersonal violence, and toxic stress for a limited number of managed care enrollees who meet needs-based criteria.

[61] As mentioned above, MRSS is available 24 hours a day/7 days a week to all families in New Jersey who need help when a child is involved in an emotional or behavioral crisis that causes a disruption in

agency supports through MRSS, obviating the need for child welfare involvement for some families. Rollout can begin in Richland, Spartanburg, and Greenville county, with statewide rollout to follow.

3. Partner with Department of Education (DE) around School-Based Support: DSS should identify barriers to a more robust partnership with the school system to determine appropriate roles for intervention. For example, teachers are mandatory reporters to Child Welfare Services when they suspect child maltreatment, but do not necessarily receive effective training around the consequences of an investigation, or what services or supports could be made available to families to prevent maltreatment and entry into foster care. A more robust DSS – DE partnership could also improve coordination for supports to children in foster care with IEPs or 504 plans. This could build on the productive work on a case-level of the Regional DSS Well-Being teams.

4. DHHS should utilize "In Lieu of Services" Option (ILOS): On January 4, 2023, CMS issued guidance offering states the option of utilizing Medicaid managed care programs to reduce health disparities and address unmet health-related social needs (HRSNs), such as housing instability and nutrition insecurity, through the use of supports offered "in lieu" of a service or setting (ILOS) covered under the Medicaid State Plan. This makes ILOS an important tool for utilizing Medicaid funding to effectively support families through services for which reimbursement has not traditionally been available, including resources for permanent supportive housing, environmental modifications, medically-tailored meals, and lactation consultants, among other things.[62] When used effectively, such services can be used to prevent entry into foster care, speed up reunification, and ensure families, particularly kin providers, have the supports to safely maintain their families. Though DHHS had previously expressed an interest in utilizing the ILOS option as a means of developing services for children in foster care, this has not occurred. South Carolina should consider models that have already been implemented in jurisdictions across the country that are effectively helping to meet families' needs through the use of ILOS.[63]

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the home, with a one-hour response time (or as determined to be convenient to the family). New Jersey's MRSS effort "has kept 94 percent of children experiencing a crisis in their existing living situation, as opposed to hospitalization or institutionalization." (*Opinion: A governor's playbook for improving youth mental health should catch on*. The Washington Post (July 2023). Retrieved from: https://www.washingtonpost.com/opinions/2023/07/04/youth-mental-health-governor-playbook/). For more information on New Jersey's implementation of MRSS, go to: https://www.nj.gov/njfosteradopt/services/mrss.html. For information on New Hampshire's use of MRSS, implemented more recently, go to https://newhampshirebulletin.com/2022/01/12/a-real-turning-point-mobile-crisis-units-offer-new-tool-in-mental-health-treatment/.

[62] For an example of creative uses of ILOS to support families in California go to: https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf

[63] Diana Crumley and Amanda Bank. *Appendix: Financing Approaches to Address Social Determinants of Health via Medicaid Managed Care: A 12-State Review*. Center for Health Care Strategies and Association for Community Affiliated Plans. (February 2023). https://www.chcs.org/media/ACAP-Financing-Approaches-to-SDOH-via-Medicaid-Managed-Care-Appendix.pdf

5. Expand Network of Behavioral Health Providers for Children in Foster Care: The expansion of a network of quality behavioral health providers available to children in foster care as well as in the community will require the sustained partnership of DMH, DDSN, DHHS, community healthcare providers, Select Health, hospitals, and other stakeholders. An important step will be a needs assessment to determine the extent to which Medicaid rates paid by Select Health are sufficient and/or impeding the availability of high-quality providers. It will also be important that providers understand the unique needs of children involved with a child welfare agency. DSS should consider models in other jurisdictions that leverage Medicaid's ability to establish standards for providers, in collaboration with contracted MCOs.[64]

6. DHHS should ensure Select Health Performance with Respect to Obligations in *Michelle H.* Health Care Plan and Care Coordination Addendum: As the sole MCO serving the majority of children in foster care in South Carolina, Select Health took on significant obligations pursuant to Court-entered plans for ensuring the physical health and behavioral needs of these children are met.[65] These responsibilities include, among other things, accountability for building out an appropriate service array and serving as health care coordinators, ensuring that children and families have timely access to services without long waitlists, and working in partnership with DHHS and DSS. DSS should have access to detailed information about what services children in their custody are receiving under the MCO contract. An evaluation of whether Select Health is adequately performing the functions to which they committed is long overdue, and work should be done to ensure obligations are met.

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[64] For example, Tennessee developed a Specialty Provider Network for children in foster care within its Medicaid managed care system. Arizona developed "practice protocols that outline procedures for coordinated service planning and delivery to guide behavioral health service delivery to children in child welfare." For more information, go to: https://www.casey.org/medicaid-funded-services/

[65] To see the Health Care Improvement Plan, go to: https://dss.sc.gov/media/1980/8-23-2018-final-approved-dss-health-care-implementation-plan.pdf. To see the Health Care Addendum, go to: https://dss.sc.gov/media/1962/2-25-2019-approved-health-plan-addendum.pdf.