Michelle H., et al. v. McMaster and Alford

Monitoring Period I

(October 1, 2016 – March 31, 2017)

Progress of the South Carolina Department of Social Services

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I. INTRODUCTION

This is the first report on the progress of the South Carolina Department of Social Services (DSS) in meeting the requirements of the Final Settlement Agreement (FSA), entered in *Michelle H., et al. v. McMaster and Alford*. Approved by the United States District Court on October 4, 2016, the FSA includes requirements governing the care and treatment of the more than 4,000 children in foster care in South Carolina[1] and incorporates provisions that had been ordered in the previous year in a Consent Immediate Interim Relief Order (the Interim Order)[2]. The report has been prepared by court-appointed independent Co-Monitors Paul Vincent and Judith Meltzer, with assistance from monitoring staff Rachel Paletta, Elissa Gelber and Gayle Samuels, and 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 result of a long negotiating process, the FSA outlines DSS's obligations to significantly improve experiences and outcomes for the children in its care. Conceived to guide a multi-year reform effort, the FSA reflects DSS's commitment to remediating long-standing problems in the operation of South Carolina's child welfare system and includes a broad range of provisions governing: caseworker caseloads; visits between children and their caseworkers and family members; investigations of allegations of abuse and neglect of children in foster care; appropriate and timely foster care and therapeutic placements; and access to physical and mental health care. What follows is a discussion of the Co-Monitors' general findings and themes, as well as detailed discussion of each FSA requirement and progress made during this monitoring period. As required by the FSA, the Co-Monitors will release reports addressing ongoing progress reports on the FSA requirements on a twice-annual basis.[3]

II. SUMMARY OF PERFORMANCE

DSS and its staff have demonstrated a commitment to reforming its foster care system in the two years since entry of the Interim Order. They have worked closely with the Co-Monitors, as well as others within and outside of DSS, to understand the infrastructure, operational and practice issues that underlie the problems identified in the FSA, and have made deliberate efforts to comply with the FSA requirements. DSS quickly appointed a new internal monitoring team and has been

[1] 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.).
[2] Consent Immediate Interim Relief Order, (September 28, 2015).
[3] FSA III.D. Pursuant to FSA III.K., "The Co-Monitors shall not express any conclusion as to whether the Defendants have reached legal compliance on any provision(s)."

consistently responsive to all Co-Monitor feedback and requests. DSS took early action to reduce the number of children ages six and under placed in congregate care facilities and to prohibit overnight stays in offices and hotels as part of initial work to implement a significant shift in practice. In addition, according to data reviewed to date on the frequency and location of caseworker visits with children in the class, DSS also appears to be meeting the FSA requirements for caseworker visitation, highlighting the commitment of its caseworkers to make efforts to maintain monthly contact with children even in the face of unmanageable caseloads.

In the vast majority of areas covered by the FSA, however, a lot of work needs to be done. Current assessments and performance data indicate that there is not a sufficient array of appropriate placement resources in most areas of the state to allow children to be placed close to their families and communities; lapses exist in the provision of diagnostic, preventative and ongoing health care to children; quality issues are present in the screening and investigation of reports of abuse or neglect of foster children; and there are a lack of reliable child welfare data. In addition, though data integrity and methodology issues have made it impossible for DSS and the Co-Monitors to calculate worker caseloads this reporting period, DSS acknowledges that caseworker caseloads throughout the state far exceed agreed upon standards.

All Parties recognize that achieving compliance with the FSA will require a major shift in DSS's operations, a significant investment of resources and a deepening of system capacity in multiple areas. It is for this reason that the FSA incorporates staged implementation over several years. Much of the early work required in this first monitoring period is in the form of baseline assessments, establishment of benchmarks, strategy planning and capacity development. Parties understand that these are foundational steps that will structure progressive improvements towards court-ordered final outcomes.

The Co-Monitors have identified some themes in its initial work with DSS and have discussed with DSS the importance of addressing them expediently for progress to take hold. Included below is a summary of these themes, along with Co-Monitor recommendations for actions DSS can take to address them.

Additional internal capacity and resources are needed to meet the requirements of the FSA

DSS has formed a team to implement the FSA through the addition of an Internal Monitoring Team, compromised of an Internal Class Action Lawsuit Monitor and a Data Coordinator. They will move forward this fall with hiring a third member of the team with child welfare practice experience. In addition, DSS is currently reorganizing the child welfare division so that responsibilities for core areas of child welfare reform can be spread across a broader leadership base. In the Co-Monitors view, however, DSS has not mustered the resources and the internal capacity needed to intensively drive reform. With very few exceptions, the individuals responsible for the significant planning and capacity-building aspects of the reform are also responsible for day-to-day child welfare operations and have roles that are already complex, demanding and time consuming. Reforming a foster care system with more than 4,000 children in care at any given

moment is not an easy task, especially if that system has been under-resourced for many years, as is true in South Carolina.

This challenge has been evidenced in the process that DSS has gone through during the first and second monitoring period to develop the many Implementation Plans required by the FSA. Although DSS has tried valiantly to comply with applicable timeframes by submitting initial proposed drafts on time, it was unable to produce plans in any content area with benchmarks and outcomes that could be approved by the Co-Monitors and are acceptable to Plaintiffs.[4] The Co-Monitors continue to be concerned about a lack of baseline data and enforceable benchmarks, as well as some of the proposed timelines for implementation, many of which reflect DSS's legitimate concerns about the limited human and financial resources they have available to do this work.

Co-Monitor Recommendations:

- **There must be an infusion of resources to drive reform**. As the FSA states, "The Defendants shall make all reasonable efforts to provide funding and other resources necessary to implementation and achievement of the obligations under the Settlement Agreement. Defendants' failure to provide or Defendants' efforts to provide such adequate funding and resources shall not excuse and shall not limit remedies to address the failure to implement or achieve any of the obligations set forth in the Settlement Agreement" (FSA I.I.). DSS has estimated in its May 31 and August 9, 2017 draft Implementation Plans that it will need to hire an additional 670 caseworkers to meet caseload standards. This cannot be done without significant additional resources both to recruit and hire quality staff, but also—and just as importantly—to house, equip, properly train, supervise and support caseworkers so that they remain over the long term. Further, education and experience requirements and salaries for caseworkers need to be recalibrated to compete with those in neighboring states to ensure an adequate pool of candidates willing and able to do this very difficult job. DSS recognizes these as necessary and has included some action related to them in its draft Implementation Plans, but has proposed delayed timelines based on its expectations for funding availability.

- **DSS needs to augment the internal leadership team charged with developing, managing and coordinating the reform work required by the FSA.** While the Co-Monitors recognize and support DSS's interest in involving mid-managers and line staff in the reform planning process, this work cannot be successfully driven by those also charged with the complex and challenging task of managing the day-to-day operations.

[4] After multiple re-drafts in response to Co-Monitor comments and discussions, on September 11, 2017, the Co-Monitors approved the Implementation Plan for Out-of-Home Abuse and Neglect (OHAN) investigative practice. The remaining step for a fully approved plan is to request and receive consent from Plaintiffs.

- **DSS should invest in developing and supporting new partnerships with private providers to create and implement a strategic plan to redeploy resources.** Funding currently devoted to more restrictive congregate care placements can be directed to a full array of community-based, family placement resources. Private providers have indicated a willingness to work closely with DSS to find new ways to provide safe and stable placements for children close to their families and communities but they need to be engaged as partners and supported by DSS in planning for and managing this important transition.

The FSA requirements must be nested within a broader vision for reform

At the FSA Fairness Hearing, Director Alford testified about the importance of understanding the FSA commitments within the context of DSS's broader effort to make South Carolina's child welfare system more effective for children, youth, families and communities. While the FSA contains specific requirements that can be identified, quantified and measured, successful reform requires a broader vision that is driven by the values, goals and principles of DSS. These need to be consistently understood, enunciated and recognized by DSS staff at all levels, as well as by external partners, including parents, private providers, community-based resource providers, judges, attorneys and guardian ad litems (GALs), all of whom will together drive the reform.

Co-Monitor Recommendations:

- **DSS needs to thoroughly and rapidly develop and begin implementation of a consistent model of case practice.** This model should rely heavily on a set of practice principles which relate to the goals and principles of DSS, and, for example, set expectations for meaningful engagement with children and families, including involvement in assessment of underlying needs, case planning and decision-making. The model should also inform the design of staff training, agency policies and an array of development and performance management processes.

- **DSS should ensure that its training curricula and practices and its management, supervision and quality assurance processes are aligned with and designed to measure fidelity of practice to its case practice model.**

DSS needs to focus on fundamentals

The need for focus on fundamentals is consistently apparent in the Co-Monitors' work with DSS this monitoring period. As DSS understands, this means not only the development of a case practice model as described above, but shoring up and, in some cases, creating a functional infrastructure for the work. This includes systems for collecting and utilizing reliable data; human resources and administrative capacity to recruit, hire, train and retain new caseworkers and supervisors; and a Continuous Quality Improvement (CQI) process that is closely tied to agency management and that can provide quantitative and qualitative information for managers, supervisors and direct practice caseworkers on the effectiveness of their work.

In its work with DSS to extract baseline data needed to move forward with the FSA requirements, the Co-Monitors have had a close look at DSS data systems and capacity. DSS's automated data system, Child and Adult Protective Services System (CAPSS), is the repository for information on case details, status and progress and is used for internal management reports, as well as reports to the Co-Monitors and the federal government. Despite consistent efforts by a small, dedicated staff, issues with the quality of documentation and the integrity of CAPSS data are pervasive, and the Co-Monitors have significant concerns with the way in which some data are entered by caseworkers or, in some cases, not entered at all. Additionally, DSS lacks mechanisms for ongoing oversight and accountability for data entry and consistency in definitions utilized in CAPSS. As discussed throughout this report, these issues have presented significant challenges in attempting to collect baseline data for the FSA requirements, including in such areas as supervisor workloads, visitation standards, placement type and stability and healthcare. Most recently, DSS and the Co-Monitors discovered that data regarding children's permanency goals—essential for any child welfare system and required for reporting to the federal government—were not accurate in a significant percentage of cases. Problems such as these need to be corrected immediately. Data integrity issues are not uncommon for child welfare systems, but fixing them can be difficult and requires that management, program and data staff work together in a focused way.

In terms of workforce capacity, DSS leaders have committed to hiring, training and supporting a sufficient number of caseworkers to meet FSA caseload standards over a four-year period. This is a significant undertaking, even if DSS had the necessary resources. It also requires a coordinated strategy that includes training, policy and practice changes needed to support caseworkers and supervisors in carrying out their work consistent with DSS's reform vision.

Co-Monitor Recommendations

- **There needs to be a comprehensive external audit of DSS's CAPSS system, including an assessment of its architecture and the processes in place to ensure accurate and reliable data.** The Co-Monitors believe this will require the engagement of an outside consultant who will work with DSS to assess for and implement recommended changes so that DSS has a system on which it can rely on to easily and routinely provide accurate data for both management and operations. The Co-Monitors spent significant time during the first monitoring period validating data necessary for reporting and are still not fully confident that what is being produced is reliable.

- **DSS needs to build a robust CQI process that utilizes both quantitative and qualitative data for measuring performance and quality of service provision, providing accountability and promoting learning and improvement.** The CQI processes should specifically seek information about DSS fidelity to key practice principles and include face-to-face interviews with children, families, DSS staff and external stakeholders about their experiences with DSS. Further, increasing the reliability and use of CAPSS data as part of CQI processes will also be critical.

- **DSS needs to more fully develop an operational plan for the recruiting, onboarding, training and provision of ongoing support for the caseworkers and supervisors it anticipates hiring between now and 2020**. This will require close coordination with human resources and facility staff, the University of South Carolina Center for Children and Family Studies (USC CCFS) and county and regional leadership, among others.

III. MONITORING ACTIVITIES

Pursuant to the FSA, the Co-Monitors are responsible for factual investigation and verification 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 used multiple methodologies to conduct their work, including verification and analysis of information available through CAPSS; independent review of individual case records; review and validation of data aggregated by DSS; and conversations with DSS leaders and staff. The Co-Monitors conducted site visits to three local DSS offices, where they met with managers, frontline staff, GALs and providers; and to four congregate care facilities. The Co- Monitors also met and spoke with a range of other child welfare stakeholders in an effort to fully understand issues relevant to DSS reform. Attached as Appendix B is the preliminary monitoring plan developed by the Co-Monitors and submitted to Parties and the Court on February 1, 2017.

The FSA gives the Co-Monitors the responsibility to review and approve plans and to approve or set performance benchmarks and outcomes in multiple areas. As a result, the Co-Monitors have worked with DSS and USC CCFS[5] to establish review protocols to assess current practice and performance and to gather baseline data. In so doing, the Co-Monitors and their staff have assumed a technical assistance role in addition to a strict monitoring function, helping to build capacity in DSS and USC CCFS staff and connect its leaders and managers with people and resources from across the country. The Co-Monitors strongly believe that this type of collaboration and use of external technical assistance is critical to DSS's ability to successfully reform its child welfare system.

Finally, the Co-Monitors have been engaged with Plaintiffs' counsel to both understand their views of the problems the FSA is designed to address and to keep them informed of DSS's progress in meeting deliverables. Where required by the FSA, the Co-Monitors have elicited feedback from Plaintiffs – most recently with respect to DSS's draft Implementation Plans – and have worked with them to build consensus, particularly with respect to commitments that require consent by all Parties. In general, the Co-Monitors believe that open communication with Plaintiffs and between

[5] DSS contracts with USC CCFS to complete all required and necessary case reviews and quality assurance activities.

Plaintiffs, DSS and the Co-Monitors will be an important element of constructive planning and implementation under the FSA.

IV. SUMMARY TABLES OF MICHELLE H., et al. v. MCMASTER and ALFORD FINAL SETTLEMENT AGREEMENT REQUIREMENTS

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Workload Limits for Foster Care: A foster care Workload Limit must apply to every Caseworker and to every Caseworker's supervisor. DSS may identify categories of Caseworker or Supervisor or both and set a different Workload Limit for each category. (FSA IV.A.2.(b)&(c)) Approved Caseworker Limits:[7] • OHAN investigator: 1 caseworker: 8 investigations • Foster Care caseworker: 1 caseworker: 15 children • IFCCS caseworker: 1 caseworker: 9 children • Adoptions caseworker: 1 caseworker: 17 children • New worker: ½ of the applicable standard for his/her first 6 months after completion of Child Welfare Basic Approved Supervisor Limits: • For Foster Care, IFCCS and Adoptions supervisors: 1 supervisor: 5 caseworkers • OHAN supervisors: 1 supervisor: 6 investigators	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. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available for this period.[8] DSS caseworkers may have more than one type of case on their caseloads, including Class Members and non-Class Members[9]. The methodology for assessing caseloads has not been approved by the Co-Monitors. DSS has proposed Interim Benchmarks and timelines to meet final target but they have not been approved by the Co-Monitors.
	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 Workload Limit. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved***	Data are not available for this period.[10]

[6] The obligations for the workload study (FSA IV.A.1.), placement needs assessment (FSA IV.D.1.) and select placement limitations (FSA IV.D.2., 3. & H.1.) became operative as of September 28, 2015, when the Consent Immediate Interim Relief Order was entered. Therefore, the Interim Relief Order requirements are incorporated into the FSA.
[7] These limits were approved by the Co-Monitors on December 6, 2016 after completion of the Workload Study.
[8] See discussion in Section V of this report.
[9] Non-Class Members include children receiving family preservation services while remaining in the home with their parent or caregiver and Adult Protective Services cases.
[10] DSS has informed the Co-Monitors that data for this measure are not currently available. Data clean-up in CAPSS is necessary to accurately reflect all supervisors who are managing caseworkers with Class Members on their caseload. DSS has represented to the Co-Monitors that the clean-up process will be completed by September 30, 2017.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Caseworker-Child Visitation: (FSA IV.B.2.&3.)	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.	Based on CAPSS data, monthly performance for caseworker visits to Class Members are below.[11] October 2016: 98% November 2016: 97% December 2016: 97% January 2017: 98% February 2017: 97% March 2017: 98%
	4. At least 50% of the total 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.	Based on a CAPSS data, monthly performance for caseworker visits to Class Members in their placement are below.[12] October 2016: 71% November 2016: 68% December 2016: 69% January 2017: 69% February 2017: 67% March 2017: 70%

[11] Co-Monitor staff completed a limited validation of these data, assessing only for frequency and location of visits, as described in Section VI of this Report. DSS appears to be meeting the caseworker visitation measures with respect to the frequency and location of worker-child visits. Plaintiffs have requested that the Co-Monitors perform a more in-depth review of visitation data and documentation in the future to assess the content of caseworker visits with children, based on their reading of the applicable FSA provisions.
[12] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Investigations – Intake: (FSA IV.C.2.)	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. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Between August 1, 2016 and January 31, 2017, there were 128 referrals with decisions not to investigate involving a Class Member; 44% (56) of the screening decisions were determined to be appropriate.[13] DSS has proposed Interim Benchmarks and timelines to meet final target but they have not been approved by the Co-Monitors.
Investigations – Case Decisions: (FSA IV.C.3.)	6. At 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. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Between June and November 2016, there were 94 investigations with decisions to unfound; 47% (44) of these decisions were determined to be appropriate.[14] DSS has proposed Interim Benchmarks and timelines to meet final target but they have not been approved by the Co-Monitors.

[13] Data were collected during a review conducted by USC CCFS and Co-Monitor staff in March 2017 of all applicable referrals made to OHAN for which there was a decision not to investigate. The total number of referrals that were not accepted for investigation during the period under review was larger than 128, however, some referrals were determined not to be applicable for review because the alleged victim child was not a Class Member (i.e., the child was voluntarily placed by the legal guardian or through ICPC from another state or was the biological child of the caregiver). DSS has represented to the Co-Monitors that all referrals of abuse and neglect in licensed foster homes, residential facilities and group homes across the state involving Class Members are received by or forwarded to OHAN for screening and investigation, as appropriate, and that screening decisions are not made by local office or Intake HUB staff.

[14] Data were collected during a review conducted by USC CCFS and Co-Monitor staff between March and June 2017 of all applicable investigations completed by OHAN with decisions to unfound the allegations.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Investigations – Timely Initiation: (FSA IV.C.4.(a))	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. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Between June and November 2016, of 107 applicable investigations, 78% (83) were timely initiated or had documentation supporting completion of all applicable good faith efforts.[15] DSS has proposed Interim Benchmarks and timelines to meet final target but they have not been approved by the Co-Monitors.
Investigations – Contact with Alleged Child Victim (FSA IV.C.4.(b))	8. The 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. ***Dates to reach final target and benchmarks to be added once Implementation Plan is approved.***	Between June and November 2016, of 107 applicable investigations, 78% (83) were timely initiated or had documentation supporting completion of all applicable good faith efforts.[16, 17] DSS has proposed Interim Benchmarks and timelines to meet final target but they have not been approved by the Co-Monitors.

[15] Data were collected during a review conducted by USC CCFS and Co-Monitor staff between March and June 2017 of all applicable investigations completed by OHAN during the period under review. Contact was made with the alleged victim child(ren) within 24 hours in 81 investigations and in an additional two investigations, documentation supported completion of all applicable good faith efforts.

[16] Ibid.

[17] 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.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Investigations – Contact with Core Witnesses (FSA IV.C.4.(c))	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. Core witnesses will vary from case to case and may or may not include the victim(s), Class Members, alleged perpetrators, reporter (if identified), identified eyewitness(es), other children in the placement, facility staff, treating professionals, and foster parents or caregivers as deemed to be relevant to the investigation. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Between June and November 2016, of 107 applicable investigations, contact was made with all necessary core witnesses for whom there was no approved exception in 27% (29) of cases.[18] DSS has proposed Interim Benchmarks and timelines to meet final target but they have not been approved by the Co-Monitors.
Investigations – Timely Completion: (FSA IV.C.4.(d-f))	10.a. At least 60% of 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. For the purposes of this section, an investigation is not completed if DSS determines the Report is unfounded because the deadline to complete the investigation has passed.	95% of applicable investigations received between June and November 2016 were appropriately closed within 45 days.[19]

[18] Data were collected during a review conducted by USC CCFS and Co-Monitor staff between March and June 2017 of all applicable investigations completed by OHAN during the period under review.

[19] Of the 107 investigations received between June and November 2016, two investigations are excluded from the 45 day compliance measure as extension requests for 15 days were submitted and approved by the OHAN Director. Of the remaining 105 investigations, 104 investigations were completed within 45 days, however, reviewers determined that four of the investigations closed within 45 days were closed as unfounded prematurely in an effort to meet the 45 day requirement. Therefore, the review determined that 100 of the 105 applicable investigations met the FSA standard.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
	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 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. For the purposes of this section, an investigation is not completed if DSS determines the Report is unfounded because the deadline to complete the investigation has passed.	96% of applicable investigations received between June and November 2016 were appropriately closed within 60 days.[20]
	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. For the purposes of this section, an investigation is not completed if DSS determines the Report is unfounded because the deadline to complete the investigation has passed. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	All investigations received between June and November 2016 were completed within 60 days; therefore, this measure was not applicable this period.

[20] Although all 107 investigations were closed within 60 days of initiation, four investigations were determined to be closed prematurely in an effort to meet the deadline and are not considered as compliant.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Family Placements for Children Ages 6 and Under: Within sixty (60) days, DSS shall create a plan, subject to the approval of the Co-Monitors, for preventing, with exceptions approved by the Co-Monitors, the placement of any Class Member age six (6) and under in any non-family group placement (including but not limited to group homes, shelters or residential treatment centers). The plan shall include full implementation within sixty (60) days following approval of the Co-Monitors. (FSA IV.D.2.)	11. No child age 6 and under shall be placed in a congregate care setting except with approved exceptions.	There were 142 children ages six and under in congregate care in November 2015. Since that time, this number has continuously declined. By October 2016, there were 17 children ages six and under in congregate care and in March 2017, only six children. The circumstances of five of those six children met an agreed upon exception for placement in congregate care.[21]

[21] Data about the number of children ages six and under age in a congregate setting and their circumstances was submitted by DSS but have not been validated by the Co-Monitors.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Phasing-Out Use of DSS Offices and Hotels: Within sixty (60) days, 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.)	12. No child shall be placed or housed in a DSS office, hotel, motel, or other commercial non-foster care establishment.	As of November 28, 2015, DSS was prohibited by the Interim Order from placing or housing children in DSS offices or hotels. Between November 28, 2015 and March 31, 2017, three children were reportedly[22] housed overnight in a DSS office.[23]
Congregate Care Placements: (FSA IV.E.2.)	13. At least 86% of the Class Members shall be placed outside of Congregate Care Placements on the last day of the Reporting Period. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	In March 2017, 78% (3,223 of 4,124) of all children in foster care were placed outside of a congregate care setting.[24] Interim Benchmarks and timelines to meet final target are not yet set.

[22] Data are based on self-report by DSS local offices and have not been validated by the Co-Monitors.
[23] As reported by DSS, the first two of these placements took place on January 6, 2016, and involved two children, ages 12 and 13. Both children presented with challenging behaviors, one child had specific placement requirements, and despite efforts, placements were not obtained for them on that day. The third placement occurred on October 20, 2016. The child, who was 14-years old, was ordered into DSS custody at his Department of Juvenile Justice (DJJ) court proceeding earlier that day. Numerous efforts were made throughout the day by DSS staff at all levels to find an appropriate placement for this child, however, placement was not secured and the child stayed overnight at the office.
[24] Data about the number of children in a congregate setting was provided by DSS but have not been validated by the Co-Monitors.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Congregate Care Placements – Children Ages 12 and Under: (FSA IV.E.3.)	14. At 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. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	In March 2017, 91% (2,630 of 2,905) of children age 12 and under in foster care were placed outside of a congregate care setting. [25, 26] Interim Benchmarks and timelines to meet final target are not yet set.
Emergency or Temporary Placements for More than 30 Days: (FSA IV.E.4.)	15. Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days. Under exceptions subject to the Co-Monitors' approval, if a child is initially placed in an Emergency or Temporary Placement that is not a Congregate Care Placement, and that placement is re-designated within thirty (30) days as a long-term foster home or therapeutic foster home, then the child's stay shall not be considered a violation of this provision and the re-designation shall not be considered a placement move under Section IV.F.1 below. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved***	Data are not available for this period. [27] Interim Benchmarks and timelines to meet final target are not yet set.

[25] Ibid.
[26] Exceptions to this standard have not yet been approved by the Co-Monitors; therefore, performance analysis does not consider any exceptions.
[27] The Co-Monitors have not been provided with data for this measure. The Co-Monitors anticipate that more information regarding methods to develop and implement data collection for analysis and monitoring will be included in the Placement Implementation Plan due to be complete by October 31, 2017 (60 days from delivery of the Placement Needs Assessment on August 31, 2017).

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Emergency or Temporary Placements for More than 7 Days: (FSA IV.E.5.)	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. Under exceptions subject to the Co-Monitors' approval, if a child's subsequent placement within twelve (12) months in an Emergency or Temporary Placement is not a Congregate Care Placement, and that placement is re-designated within thirty (30) days as a long-term foster home or therapeutic foster home, then the child's stay shall not be considered a violation of this provision and the re-designation shall not be considered a placement move under Section IV.F.1 below. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available for this period. [28] Interim Benchmarks and timelines to meet final target are not yet set.
Placement Instability: (FSA IV.F.1.)	17. For all Class Members in foster care for eight (8) days or more during the 12-month period, Placement Instability shall be less than or equal to 3.37.	Data are not available for this period.

[28] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Sibling Placements: (FSA IV.G.2.&3.)	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 one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) additional exceptions as approved by the Co-Monitors. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	As of January 1, 2017, 70% of children in care 30 days or longer were placed with at least one of their siblings. [29, 30] Interim Benchmarks and timelines to meet final target are not yet set.
	19. At least 80% 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 all their siblings, unless one or more of the following exceptions apply: (1) there is a court order prohibiting placing all siblings together; (2) placement is not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3**)** additional exceptions as approved by the Co-Monitors. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	As of January 1, 2017, 37% of children in care 30 days or longer were placed with all of their siblings. [31, 32] Interim Benchmarks and timelines to meet final target are not yet set.

[29] Sibling groups were identified utilizing data in CAPSS which defines a sibling group as a set of children with the same CAPSS case identifier.
[30] Exceptions to this standard have not yet been approved by the Co-Monitors and data were not provided to indicate instances in which a court order prohibited placement or in which the placement was determined not to be in the best interest of one or more siblings. Therefore, performance analysis does not consider any exceptions.
[31] Ibid.
[32] Sibling groups were identified utilizing data in CAPSS which defines a sibling group as a set of children with the same CAPSS case identifier.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Youth Exiting the Juvenile Justice System: (FSA IV.H.1.)	20. When 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 plea 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.	The Interim Order requirement that prohibited the maintenance of youth in Juvenile Justice Placements took effect on September 28, 2015. Between September 28, 2015 and March 31, 2017, DSS has reported that it is aware of two youth who were held in detention awaiting an available DSS placement.[33] DSS has acknowledged, however, that it does not yet have a reliable system in place for tracking compliance with this provision so this may be an underrepresentation of actual incidences.
Therapeutic Foster Care Placements –Referral for Staffing and/or Assessment: (FSA IV.I.2.)	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 therapeutic foster care placement and/or services within thirty (30) days of the need being identified. This requirement shall not apply if the Caseworker withdraws the identified need in good faith and in the best interests of the Class Member within thirty (30) days. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available for this period.[34] Interim Benchmarks and timelines to meet final target are not yet set.

[33] In December 2015, a youth remained in detention, at the order of a judge, because DSS was unable to find a placement for him. After more than a month, he was placed in an out-of-state facility. In September 2016, a youth remained at a detention center for seven days awaiting placement in a group home, upon judicial order.

[34] DSS has informed the Co-Monitors that data for this measure are not currently available as fields need to be added to CAPSS to capture and collect necessary information. The Co-Monitors anticipate that more information regarding methods to develop and implement data collection for analysis and monitoring will be included in the Placement Implementation Plan.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Therapeutic Foster Care Placements –Receipt of Recommendations for Services or Placement: (FSA IV.I.3.)	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. The recommendation(s) may include diagnostic assessment, community support services, rehabilitative behavioral health services, therapeutic foster care, group care, and psychiatric residential treatment facility. Level of Care Placement recommendations shall utilize the least restrictive care philosophy suitable to the child's needs and seek to place a Class Member in a family setting with a community support system. DSS shall update the assessment at least annually thereafter, upon a placement disruption or upon a material change in the Class Member's needs. In making that determination, DSS may consider the full array of appropriate placement alternatives to meet the needs of the Class Members. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available for this period.[35] Interim Benchmarks and timelines to meet final target are not yet set.

[35] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Therapeutic Foster Care Placements – Level of Care Placement: (FSA IV.I.4.&5.)	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. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available to for this period.[36] Interim Benchmarks and timelines to meet final target are not yet set.
	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. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available for this period.[37] Interim Benchmarks and timelines to meet final target are not yet set.

[36] Ibid.
[37] Ibid.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Family Visitation – Siblings and Parents : (FSA IV.J.2.&3.)	24. At least 85% of the total minimum number of monthly sibling visits for all siblings not living together shall be completed, with exceptions when (1) there is a court order prohibiting visitation or limiting visitation to less frequently than once every month; (2) visits are not in the best interest of one or more of the siblings and the facts supporting that determination are documented in the case file; or (3) with exceptions approved by the Co-Monitors. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	As of March 31, 2017, 47% of children in foster care as of March 31, 2017 visited with all siblings with whom they were not placed in the month of March.[38] DSS has proposed Interim Benchmarks and timelines to meet final target but they have not been approved by the Co-Monitors.
	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 (1) there is a court order prohibiting visitation or limiting visitation to less frequently than twice every month; or (2) based on exceptions approved by the Co-Monitors. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available for this period.[39] Interim Benchmarks and timelines to meet final target are not yet set.

[38] Data were collected during a review conducted by USC CCFS and Co-Monitor staff of a statistically significant random sample based on a 95% confidence level and +/- 5% margin of error. Sibling groups were identified utilizing data in CAPSS which defines a sibling group as a set of children with the same CAPSS case identifier.

[39] DSS and the Co-Monitors have determined that data for this measure are not currently available as fields need to be updated in CAPSS to capture and collect necessary information. The Co-Monitors anticipate that more information regarding efforts to update CAPSS and to develop and implement more reliable data collection practices will be available in the next monitoring period.

Table 1: Summary Performance on Settlement Agreement Requirements		
Final Settlement Agreement (FSA) Requirements[6]	**Final Target**	**MP1 or Baseline Performance**
Health Care Improvement Plan – Initial Health Assessment: By the end of sixty (60) days following final court approval of the Final Settlement Agreement (identification period), DSS shall identify Class Members who have been in DSS custody for more than sixty (60) days as of the date of final court approval of the Final Settlement Agreement, and who have not had initial health assessments (physical/medical, dental or mental health). (FSA IV.K.4.(a))	26. Within thirty (30) days after the identification period, Defendants shall schedule the initial health assessment for at least 85% of the identified Class Members. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Physical/medical assessment: Of the 168 children identified as needing an assessment, 10% (16 children) received the necessary assessment by January 5, 2017. Dental assessment: Of the 690 children identified as needing an assessment, 15% (102 children) received the necessary assessment by January 5, 2017. Mental Health assessment: Of the 740 children identified as needing an assessment, 6% (42 children) received the necessary assessment by January 5, 2017.[40]
Health Care Improvement Plan – Immediate Treatment Needs: By the end of ninety (90) days following final court approval of the Final Settlement Agreement (identification period), DSS shall identify Class Members with Immediate Treatment Needs (physical/medical, dental or mental health) for which treatment is overdue. (Immediate Treatment Needs means immediate non-elective physical/medical, dental or mental health treatment needs and documented assessment needs, excluding routine periodic assessments.) (FSA IV.K.4.(b))	27. Within forty-five (45) days of the identification period, DSS shall schedule the necessary treatment for at least 90% of the identified Class Members. ***Dates to reach final target and interim benchmarks to be added once Implementation Plan is approved.***	Data are not available for this period. [41] Interim Benchmarks and timelines to meet final target are not yet set.

[40] Calculation of performance data for this measure required numerous rounds of data clean-up and validation by DSS, USC CCFS and Co-Monitor staff. Reported performance reflects final analysis by DSS which was provided to the Co-Monitors on September 4, 2017.

[41] DSS has informed the Co-Monitors that data for this measure are not currently available. The Healthcare Workgroup has been assigned the task of defining "immediate treatment needs" and enhancements will then need to be made within CAPSS to capture and collect the necessary data.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of July 31, 2017)[42]**
Workload Study for Foster Care DSS shall design, conduct and complete a foster care Workload Study that applies to every Caseworker and to every Caseworker's supervisor and adopt one or more Workload Limits for foster care within 180 days (dates and obligations became operative as of September 28, 2015). The foster care Workload Study must be approved by the Co-Monitors before it is conducted. The results of the Workload Study must also be approved by the Co-Monitors before they are adopted by DSS. Each Workload Limit must be approved by the Co-Monitors before it is adopted. (FSA IV.A.1.)	Completion of Workload Study by March 28, 2016.	DSS began work in August 2015 to address concerns with caseloads. A Workload Estimation Workgroup was chartered to research best practice and develop recommendations for reducing caseloads. DSS collaborated with Casey Family Programs[43] to develop and conduct a workload estimation study which was approved by the Co-Monitors on February 22, 2016.[44] The study examined best practices and caseload limits in other states and conducted a time study. Based upon caseworker type, the study estimated time needed for specific activities and the amount of time caseworkers have available. An initial workload study report was submitted to the Co-Monitors on March 28, 2016 and a more complete copy of the study findings and recommendations on October 21, 2016.
	Adoption of Workload Limits for Foster Care by March 28, 2016.	On December 6, 2016, the Co-Monitors approved workload limits by establishing the following caseload standards for caseworkers and supervisors: Caseworker Limits: • OHAN investigator – 1 caseworker: 8 investigations • Foster Care caseworker – 1 caseworker: 15 children • IFCCS caseworker – 1 caseworker: 9 children

[42] In a few instances, information in this Table reflects the status of actions as of the date of this report.
[43] Casey Family Programs is an operating foundation, working nation-wide to influence long-lasting improvements to the safety and success of children, families and the communities where they live, focused on safely reducing the need for foster care with a mission to provide and improve — and ultimately prevent the need for — foster care. https://www.casey.org/about/
[44] See Appendix C.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of July 31, 2017)[42]**
		• Adoption caseworker – 1 caseworker: 17 children[45] • New caseworker – ½ of the applicable standard for first six months after completion of Child Welfare Basic training. The caseload standard for caseworkers carrying mixed caseloads has not yet been established. Supervisor Limits: • Foster Care, IFCCS and Adoption supervisors – 1 supervisor: 5 caseworkers • OHAN supervisors – 1 supervisor: 6 investigators[46] Although the caseload limits have been approved by the Co-Monitors, the methodologies to calculate performance for these limits have not. In addition to calculating performance for caseworkers servicing a single type of case, a standard and methodology is needed for caseworkers who have Class and Non-Class Members[47] on their caseload. To address these "mixed caseloads", DSS proposed a methodology to weight cases in accordance with the individual caseload limits and estimate of time available to caseworkers. The Co-Monitors have not approved the methodology or the mixed caseload standard. In an effort to bring additional data to the discussion, in February 2017, DSS proposed to pilot a methodology in one or more local offices. To date, DSS has not shared details of this pilot or any specific findings with the Co-Monitors.

[45] In approving these caseload limits, the Co-Monitors noted that although a caseload of 17 children for adoption caseworkers is not within the standard proffered by the Council on Accreditation, as DSS is currently structured, case management responsibilities remain with the foster care caseworker, even when an adoption caseworker is assigned, until parental rights have been terminated. Given that DSS adoption caseworkers may therefore have less direct casework responsibilities than in some other jurisdictions, the Co-Monitors accepted the proposed caseload limit for adoption caseworkers. If DSS's structure were to change so that adoption caseworkers have more case management responsibility for assigned children, the Co-Monitors would expect a proposed modification to the caseload standard.

[46] The Co-Monitors approved the higher caseload standard for OHAN supervisors in recognition that those caseworkers will have lower caseloads than other direct service caseworkers.

[47] Non-Class Members include children receiving family preservation services while remaining in the home with their parent or caregiver and Adult Protective Services cases.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of July 31, 2017)[42]**
Implementing the Workload Limits for Foster Care: Within sixty (60) days of the entry of the Order approving the Settlement Agreement, DSS shall develop an Implementation Plan to implement the achievement of the final targets in this subsection. The Implementation Plan shall have enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors, to measure progress in achieving the final targets in this subsection. Plaintiffs will not unreasonably withhold consent, and if the Co-Monitors approve and Plaintiffs do not consent, Plaintiffs will describe with sufficient detail, rationale, and recommendations that will lead to consent. (FSA IV.A.2.(a))	Completion of Workload Implementation Plan, which includes interim benchmarks with specific timelines by December 5, 2016.	DSS submitted a draft of the Workload Implementation Plan on November 30, 2016. Since that time, the Co-Monitors and Plaintiffs' counsel have provided feedback on several drafts and DSS has submitted revisions and modifications several times in response to comments. The Implementation Plan has not yet been finalized or approved by the Co-Monitors. DSS recognizes that much of the system reform and resulting improvements in outcomes depends upon ensuring caseworkers have manageable caseloads. The draft plans submitted to the Co-Monitors includes strategies for recruitment, hiring and training, among others. The Co-Monitors have discussed with DSS the importance of procuring resources needed to build the infrastructure and support necessary for the addition of caseworkers in the short and long-term, beginning this year.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of July 31, 2017)[42]**
Caseworker-Child Visitation Within sixty (60) days of the entry of the Order approving the Settlement Agreement, DSS shall develop an Implementation Plan to implement the achievement of the final targets in this subsection. The Implementation Plan shall have enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors, to measure the progress in achieving the final targets in this subsection. Plaintiffs will not unreasonably withhold consent, and if the Co-Monitors approve and Plaintiffs do not consent, Plaintiffs will describe with sufficient detail, rationale, and recommendations that will lead to consent. (FSA IV.B.1.)	Completion of Caseworker and Child Visitation Implementation Plan, which includes interim benchmarks with specific timelines by December 5, 2016.	DSS reported at the time of entry into the FSA that it was already achieving the final targets related to caseworker-child visitation, thus DSS did not develop an Implementation Plan for this measure.[48]

[48] As indicated above, DSS appears to be meeting the caseworker visitation measures with respect to the frequency and location of worker-child visits. Plaintiffs have requested that the Co-Monitors perform a more in-depth review of visitation data and documentation in the future to assess the content of caseworker visits with children, based on their reading of the applicable FSA provisions. Should Co-Monitors conclude at any point that practice in this area is not, in fact, sufficient to meet the FSA requirements, an Implementation Plan may be required in accordance with FSA IV.B.1.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of July 31, 2017)[42]**
Investigation Implementation Plan Within sixty (60) days of the entry of the Order approving the Settlement Agreement, DSS shall develop an Implementation Plan to implement the achievement of the final targets in this subsection. The Implementation Plan shall have enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors, to measure progress in achieving the final targets in this subsection. Plaintiffs will not unreasonably withhold consent, and if the Co-Monitors approve and Plaintiffs do not consent, Plaintiffs will describe with sufficient detail, rationale, and recommendations that will lead to consent. (FSA IV.C.1.)	Completion of Investigations Implementation Plan, which includes interim benchmarks with specific timelines by December 5, 2016.	DSS's OHAN Workgroup has been developing a plan for improving OHAN practice and DSS submitted a draft of the Investigation Implementation Plan on November 30, 2016. Since that time, there have been revisions and modifications based upon feedback from the Co-Monitors and Plaintiffs. On August 9, 2017, DSS submitted a version of the plan which the Co-Monitors approved on September 11, 2017. The remaining step for a fully approved plan is to request and receive consent from Plaintiffs. [49] Case record reviews conducted between March and June 2017 by USC CCFS and Co-Monitor staff have identified significant OHAN policy and practice issues. DSS has already begun to address some and these issues have been areas of focus in DSS's development of the Investigations Implementation Plan.

[49] FSA IV.C.1.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of July 31, 2017)[42]**
Placement Needs Assessment Within one hundred twenty (120) days, DSS, with prior input from and subject to approval by the Co-Monitors, shall perform a statewide and regional foster care Placement Needs Assessment in order to determine the minimally adequate capacity and array of placements for meeting the placement needs of all Class Members. The needs assessment shall include specific recommendations addressing all the assessment's findings, including but not limited to recommendations that address the capacity to place Class Members close to their home community, placing Class Members in the least restrictive, most family-like placement, the number and array of therapeutic foster care placements, a system of tracking availability of beds in family foster homes, and matching of Class Members to placements that can meet their needs . (FSA IV.D.1.)	Completion of Placement Needs Assessment, which includes findings and specific recommendations by June 30, 2017.[50]	The methodology for the Placement Needs Assessment was approved by the Co-Monitors on December 27, 2016. The Placement Needs Assessment was to be carried out by USC CCFS under its contract with DSS. The assessment began in February 2017 and involved an analysis of CAPSS quantitative data in addition to qualitative data collection. A core component was a strategic review of 90 cases selected for in-depth interviews using a protocol developed in consultation with the Co-Monitors. Focus group interviews and county surveys to assess the availability of home-based, mental health services were also conducted. The assessment findings and recommendations were forwarded to the Co-Monitors on August 31, 2017 and are being reviewed for discussion with DSS in a meeting in late September 2017.

[50] On December 27, 2016, the Co-Monitors granted an extension for completion of the Placement Needs Assessment to June 30, 2017 from the original expected completed date of January 28, 2017. On June 30, 2017, DSS notified the Co-Monitors that the assessment would be completed and a report would be submitted by August 31, 2017.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of July 31, 2017)[42]**
Placement Implementation Plan Within sixty (60) days of the completion of the needs assessment, DSS shall develop an Implementation Plan to implement the recommendations of the needs assessment within eighteen (18) months. The Implementation Plan shall have enforceable benchmarks with specific timelines, subject to approval by the Co-Monitors, to measure progress in executing the recommendations of the needs assessment. (FSA IV.D.1.(a)) Placement Implementation Plan shall include strategies to address the following areas, with accompanying interim benchmarks and specific timelines: • Congregate Care Placements (FSA IV.E.1.) • Sibling Placement (FSA IV.G.1.) • Therapeutic Foster Care Placements (FSA IV.I.1)	Completion of Placement Implementation Plan, which includes interim benchmarks with specific timelines. Originally, the Interim Order required the Placement Implementation Plan to be completed by March 28, 2016 (60 days from January 28, 2016). The IO then required implementation of the recommendations in the Plan by September 28, 2017.[51]	The Placement Implementation Plan is not due until 60 days after the Placement Needs Assessment has been completed. The needs assessment was completed on August 31, 2017, the Implementation Plan is due by October 31, 2017. The Co-Monitors' next report will provide updates on the plan.

[51] The Co-Monitors approved extensions to these deadlines as they worked with DSS and USC CCFS staff to design a more comprehensive Placement Needs Assessment.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of July 31, 2017)[42]**
Plan for Family Placements for Children Ages 6 and Under: Within sixty (60) days, DSS shall create a plan, subject to the approval of the Co-Monitors, for preventing, with exceptions approved by the Co-Monitors, the placement of any Class Member age six (6) and under in any non-family group placement (including but not limited to group homes, shelters or residential treatment centers). The plan shall include full implementation within sixty (60) days following approval of the Co-Monitors. (FSA IV.D.2.)	Completion of Plan to prevent placement of Class Members age six (6) and under in any non-family group placement by November 28, 2015.	On October 31, 2015, DSS provided the Co-Monitors with a draft plan to prevent the use of congregate care for children ages six and under. The plan included immediate actions to review and conduct staffings on cases of applicable children and DSS actions to amend contracts with existing therapeutic foster care providers who had or could develop family placements for these children via Change Orders. DSS had already been taking steps to improve recruitment, training and licensure of foster family placements through Regional Resource Teams. The draft plan also included proposed exceptions to the placement of young children in congregate care settings for review and approval by the Co-Monitors. The Co-Monitors provided feedback on these plans in January 2016, after conducting site visits to local county offices and speaking with caseworkers, service providers (including congregate care providers) and legal staff. In that feedback, the Co-Monitors suggested modifications to DSS's proposed exceptions. In March 2016, DSS and the Co-Monitors reached agreement on acceptable exceptions to this requirement and approved the Department's plan to prevent the placement of any Class Member age six and under in any non-family, group placement. DSS data demonstrate this plan has been largely successful, resulting in substantial reductions in the number of children ages six and under in congregate care.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of July 31, 2017)[42]**
Family Visitation – Siblings and Parent - Implementation Plan: Within sixty (60) days of the entry of the Order approving the Settlement Agreement, DSS shall develop an Implementation Plan to implement the achievement of the final targets in this subsection. The Implementation Plan shall have enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors, to measure progress in achieving the final targets in this subsection. Plaintiffs will not unreasonably withhold consent, and if the Co-Monitors approve and Plaintiffs do not consent, Plaintiffs will describe with sufficient detail, rationale, and recommendations that will lead to consent. (FSA IV.J.1.)	Completion of Family Visitation Implementation Plan, which includes interim benchmarks with specific timelines by December 5, 2016.	DSS convened a Visitation Workgroup in October 2016 to assess systemic barriers to family visitation and develop and assist with the implementation of the Visitation Implementation Plan. DSS submitted a draft of the Visitation Implementation Plan on November 30, 2016 and upon receipt of feedback from the Co-Monitors and Plaintiffs' counsel, has completed several rounds of revisions and modifications. Many of the draft strategies center around increasing supervisory skills, revising policy and procedures, educating caseworkers, increasing foster parent participation and developing plans to reduce logistical barriers. The plan has not yet been approved by the Co-Monitors.

Table 2: Status of Implementation Plans and Assessments		
Final Settlement Agreement (FSA) Requirements for Study and Plan Development	**Final Target**	**Status of Implementation Plans and Assessments (as of July 31, 2017)[42]**
Health Care Improvement Plan: Within one hundred eighty (180) days, Defendants, with prior input from and subject to approval by the Co-Monitors, shall develop a Health Care Improvement Plan with enforceable dates and targets for phased implementation and concerning initial screening services, periodic screening services, documentation, and health care treatment services for Class Members in the areas of physical health, immunizations and laboratory tests, mental health, developmental and behavioral health, vision and hearing, and dental health. The Plan shall address: (a) Developing the capacity to track screening and treatment services for individual children and aggregate tracking data, including but not limited to screens that are due and past due; (b) Assessing the accessibility of health care screening and treatment services throughout the State, including the capacity of the existing health care providers to meet the screening and treatment needs of Class Members; and (c) Identifying baselines and interim percentage targets for performance improvement in coordinating screens and treatment services. With approval of the Co-Monitors and based on evidence of progress toward the development of the Health Care Improvement Plan, Defendants may request an extension of an additional sixty (60) days to complete the Plan. (FSA IV.K.1.)	Completion of Health Care Improvement Plan by March 31, 2017. On April 19, 2017, the Co-Monitors approved a 60 day extension, with an expected completion date of June 2, 2017. On June 1, 2017, DSS filed a Motion for Extension of Time, which was approved and extended the deadline to September 30, 2017.	DSS has requested two extensions to the deadline for completion of the Health Care Improvement Plan and the Implementation Plan is now due on September 30, 2017. In developing this plan, DSS has created a Healthcare Work Group; made efforts to effectively track health assessments; conducted county surveys to identify providers being utilized for assessments and follow up care; held discussions with other states and two model assessment centers within SC; and planned discussions with the Department of Health and Human Services (DHHS), SC's Medicaid agency and representatives from Select Health, the Medicaid MCO. As of August 2017, DSS, with support from Casey Family Programs, engaged an external consultant to assist with plan development.

V. CASELOADS

A sufficient, qualified and well-trained workforce with manageable workloads is foundational to a well-functioning child welfare system. DSS recognizes that it is critically important that caseloads be lowered across the State and that meeting many other FSA requirements will not be possible until this happens. The FSA required DSS to take immediate action with respect to caseworker and supervisor caseloads. As discussed below, this is an issue DSS has been working to address in the months since the Interim Order went into effect — convening a workgroup, performing a workload study, requesting additional caseworkers in the FY2018 budget and proposing caseload limits. The Co-Monitors have encouraged and DSS has represented that they have vigorously advocated for the resources needed to hire, train and retain high quality caseworkers who will be able to do the challenging work required by the FSA over the coming years to improve outcomes for South Carolina's children and families. Although DSS acknowledges that caseloads throughout the State are in excess of agreed upon limits, there is currently no system in place for reliably measuring caseloads for the purpose of assessing FSA compliance. The lack of reliable caseload data is a significant barrier for DSS and it is critical that it be addressed immediately.

A. Workload Study

Pursuant to the FSA, DSS was ordered to design and complete a workload study and develop workload limits for DSS caseworkers by January 28, 2016 (FSA IV.A.1.(a)). The limits apply to caseworkers who provide direct service to children in foster care (foster care caseworkers); caseworkers who are responsible for adoption activities for children in foster care (adoption caseworkers); caseworkers who provide direct service to children categorized as in need of Intensive Foster Care and Clinical Services (IFCCS caseworkers); caseworkers who investigate reports of abuse or neglect against Class Members (Out-of-Home Abuse and Neglect (OHAN) caseworkers); and supervisors who provide direct supervision to caseworkers who service Class Members. The Co-Monitors were required to approve both the workload study methodology and DSS's proposed caseload limits.

Beginning in August 2015, DSS chartered a Workload Estimation Workgroup to research best practice recommendations for caseload standards and develop recommendations for equalizing caseloads throughout the State. Guided by a methodology developed by Casey Family Programs and approved by the Co-Monitors on February 22, 2016, the workgroup outlined essential caseworker tasks and estimated time required to complete each task. Co-Monitor staff observed workgroup meetings and reviewed the information supporting the recommended Caseloads.

B. Approved Workload Limits

On December 6, 2016, the Co-Monitors approved the following caseload limits for caseworkers and supervisors as shown in Table 3 below. These standards are in line with national practice standards adopted in other states.

Table 3: Caseworker Caseload Limits and Supervisor Limits

Caseworker Limits	Supervisor Limits
• OHAN investigator – 1 caseworker: 8 investigations • Foster Care caseworker – 1 caseworker: 15 children • IFCCS caseworker – 1 caseworker: 9 children • Adoptions caseworker – 1 caseworker: 17 children[52] • New caseworker – ½ of the applicable standard for first 6 months after completion of Child Welfare Basic training.	• Foster Care, IFCCS and Adoptions supervisors – 1 supervisor: 5 caseworkers • OHAN supervisors – 1 supervisor: 6 investigators[53]

DSS has agreed that it will apply these caseload limits to any caseworker or supervisor with at least one Class Member on their caseload. Recognizing that caseworkers in some counties, especially less populated ones, can, at times, have a mix of Class and Non-Class Members (mixed caseload)[54], DSS proposed a methodology to weight cases in accordance with the individual caseload limits. The Co-Monitors have not approved this methodology or the mixed caseload standard. In an effort to bring additional data to the discussion, in February 2017, DSS proposed a plan to pilot test the methodology in one or more local offices. The pilot was eventually limited to Lexington County. To date, DSS has not shared details of this pilot or any specific findings with the Co-Monitors.

Further, many of DSS's frontline supervisors currently are assigned cases with casework responsibility, in addition to their supervisory responsibilities. The Co-Monitors have communicated to DSS that, once fully implemented, the FSA and its new caseload limits will prohibit supervisors from being assigned cases except in temporary or emergency situations.

[52] In approving these caseload limits, the Co-Monitors noted that although a caseload of 17 children for adoption caseworkers is not within the standard proffered by the Council on Accreditation, as DSS is currently structured, case management responsibilities remain with the foster care caseworker, even when an adoption caseworker is assigned, until parental rights have been terminated. Given that DSS adoption caseworkers may therefore have less direct casework responsibilities than in some other jurisdictions, the Co-Monitors accepted the proposed caseload limit for adoption caseworkers. If DSS's structure were to change so that adoption caseworkers have more case management responsibility for assigned children, the Co-Monitors would expect a proposed modification to the caseload standard.

[53] The Co-Monitors approved the higher workload standard for OHAN supervisors in recognition of the fact that those caseworkers will have lower caseloads than other direct service caseworkers.

[54] Non-Class Members include children receiving family preservation services while remaining in the home with their parent or caregiver and Adult Protective Services cases.

C. Workload Implementation Plan

The FSA requires that by December 5, 2016, DSS develop an Implementation Plan to implement the final FSA workload requirements. The Implementation Plan must include "enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approved (sic) by the Co-Monitors, to measure progress in achieving the final targets…" (FSA IV.A.2 (a)).

In the months since Co-Monitor approval of the caseload limits, the Workload Estimation Workgroup has continued to meet with the goal of developing a plan for staged implementation of the caseload limits. DSS submitted an initial draft of the Workload Implementation Plan on November 30, 2016. Since that time, the Co-Monitors and Plaintiffs have provided feedback on several drafts of the plan and DSS has completed multiple rounds of revisions and modifications. The Implementation Plan has not yet been finalized or approved by the Co-Monitors. DSS has proposed interim benchmarks and targets but they have not yet been approved.

DSS recognizes that the achievement of many, if not all, of the FSA requirements depends upon meeting caseload limits for foster care, adoption, IFCCS and OHAN workers, and has expressed a commitment to onboarding new caseworkers to begin relieving high caseloads, with an initial focus on hiring new IFCCS caseworkers across the State and in counties in which caseworkers are particularly overburdened. DSS also recognizes that in order to hire, onboard and maintain these new caseworkers, it must address human resource and recruitment systems, develop and adopt improved initial and ongoing training to reflect changes in case practice and implement retention strategies.

The Co-Monitors have discussed with DSS the importance of procuring the resources to support the necessary addition of caseworkers in the short and long term, beginning this year. For FY2018, DSS requested and received 163 new caseworkers for assessment, family preservation and foster care, though it has not yet been determined how many of these positions will be dedicated to services for Class Members. DSS anticipates needing funding for and hiring an additional 507 new caseworkers over the next three years.

DSS's ability to finalize the Workload Implementation Plan has been limited by the fact that data are not yet available to allow for the reliable measurement of baseline performance or for tracking progress. DSS generates a number of caseload reports for managers on a regular basis through CAPSS, however due to current data limitations within the system, there are barriers to collecting and analyzing caseload data for the FSA at this time. For example, DSS has identified the need to develop a more precise method to identify children needing IFCCS services in CAPSS before

IFCCS caseworker caseloads can be accurately measured,[55] and has yet to develop a system for identifying supervisors who are managing caseworkers with Class Members on their caseloads[56], or for tracking the hiring and completion of basic training by new caseworkers[57]. In addition, the finalization of the mixed caseload standard and methodology for measuring performance is essential to DSS's ability to establish reliable baseline measures. DSS has represented that as of January 2017, there were 383 caseworkers carrying at least one Class Member on their caseload. Of those, 139 had caseloads with only Class Members (non-mixed) – 73 adoption caseworkers[58], 52 IFCCS caseworkers[59], eight OHAN investigators[60] and six foster care caseworkers. The majority of foster care caseworkers – 97 percent (198 of 204 caseworkers) – carried mixed caseloads. These issues will need to be addressed before interim benchmarks can be developed and the Workload Implementation Plan can be approved by the Co-Monitors.

VI. CASEWORKER-CHILD VISITATION

Visits between caseworkers and children in foster care, preferably where the children are residing, are an important way in which DSS supports the safety and well-being and progress of the children in its care. Caseworker visits with children in foster care are a core element of DSS practice and DSS has maintained that caseworkers throughout the State visit with children on a monthly basis in nearly all cases. An initial review of CAPSS documentation on caseworker visits by the Co-Monitors indicates that monthly visits are, in fact, occurring.

A. FSA Visitation Requirements

The FSA requires "[a]t least 90% of the total minimum number of monthly face-to-face visits with Class Members by caseworkers during a 12-month period shall have taken place" (FSA IV.B.2.) and that "[a]t least 50% of the total 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.). The FSA further required that by December 5, 2016, DSS was to develop an Implementation Plan with "enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors" (FSA IV.B.1.) to achieve the final targets related to caseworker visitation with children. Based on review of its data, DSS determined at the

[55]Currently, IFCCS children are identified by the office of the caseworker who manages them and possible siblings of children needing IFCCS services may be incorrectly assumed to be categorized as IFCCS. DSS has indicated that a plan to appropriately identify children needing IFCCS services in CAPSS will be complete by December 2017. As a result, data on caseloads of IFCCS caseworkers will not be available until that time.
[56]DSS has indicated that a plan to appropriately identify and track supervisors will be completed by September 2017. DSS has proposed in its Implementation Plan that the new system will be implemented by August 2018.
[57] DSS has indicated that a plan to appropriately identify completion of Child Welfare Basic training by new caseworkers in CAPSS will be complete by September 2017.
[58] There were a total of 75 adoption workers in January 2017; therefore, 97 percent had non-mixed caseloads.
[59] There were a total of 95 IFCCS workers in January 2017; therefore, 55 percent had non-mixed caseloads.
[60] There were a total of eight OHAN investigators in January 2017; all (100%) had non-mixed caseloads.

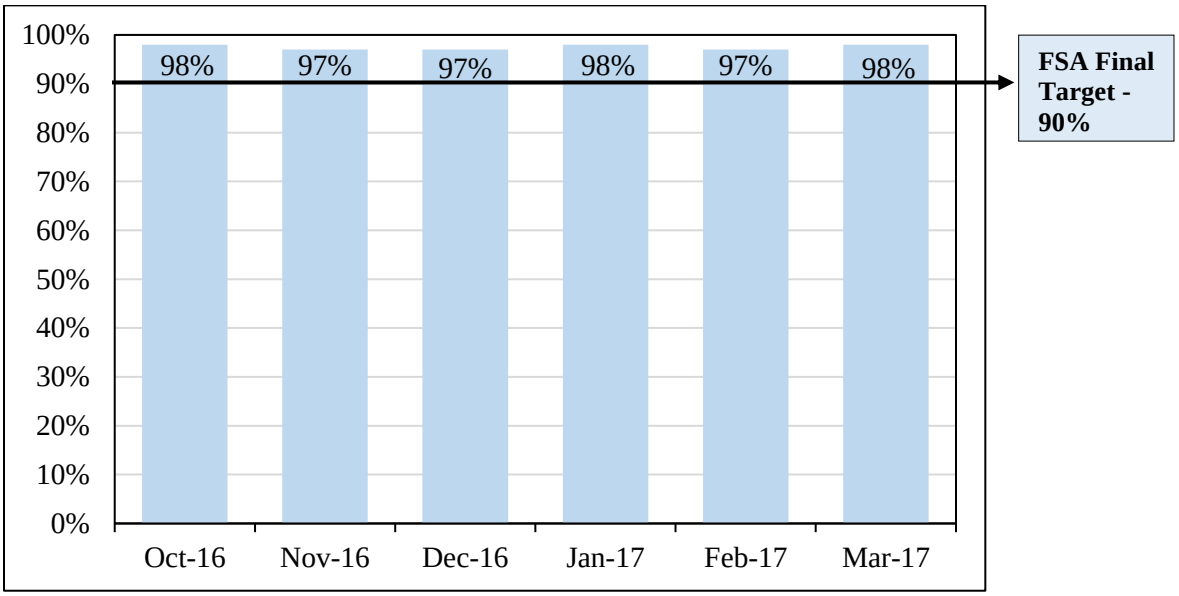
time of entry into the FSA that it was already achieving the final targets related to caseworker-child visitation, and thus DSS informed the Co-Monitors that it believed it did not need to develop an Implementation Plan for the worker-child visitation measures.[61]

B. Performance Data

Monthly Face-to-Face Caseworker Visits with Children

Caseworkers are required to record information in CAPSS about monthly visits with children. CAPSS data indicate for each of the six months in the monitoring period that DSS exceeded the requirement that at least 90 percent of Class Members have at minimum a monthly visit by a caseworker.[62] For example, in March 2017, there is documentation in CAPSS that caseworkers made 3,714 (98%) of the required 3,804 monthly visits with children. Figure 1 below shows the data from CAPSS for monthly visits during October 2016 and March 2017.

Figure 1: Monthly Face-to-Face Caseworker Visits With Children
October 2016 – March 2017



Source: CAPSS Data Provided by DSS

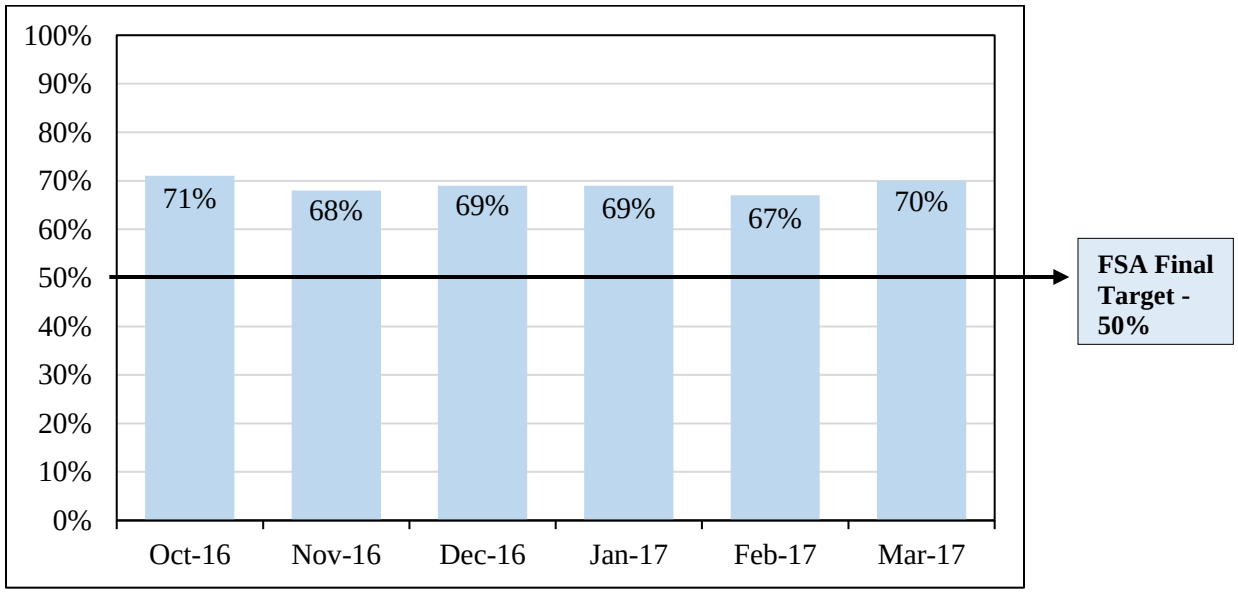
[61] As discussed below, the Co-Monitors conducted a limited validation of CAPSS visitation data and DSS appears to be meeting the caseworker visitation measures with respect to the frequency and location of worker-child visits. Plaintiffs have requested that the Co-Monitors perform a more in-depth review of visitation data and documentation in the future to assess the content of caseworker visits with children, based on their reading of the applicable FSA provisions. Should the Co-Monitors conclude at any point that practice in this area is not, in fact, sufficient to meet the FSA requirements, an Implementation Plan may be required in accordance with FSA IV.B.1.

[62] It is important to note that the FSA requires monthly visits to children by a caseworker and not necessarily the caseworker assigned to the child or family.

Face-to-Face Caseworker Visits with Children in Residence

CAPSS data indicate that DSS exceeded the requirement that at least 50 percent of the monthly caseworker visits take place in the child's residence for each of the six months in the monitoring period. For example, in March 2017, CAPSS documentation indicates that 2,672 (70%) of the required 3,804 monthly visits were made in the child's residence. Figure 2 provides the data for each of the six months in the monitoring period.

Figure 2: Monthly Face-to-Face Caseworker Visits With Children in Their Residence October 2016 – March 2017



Source: CAPSS Data Provided by DSS

DSS and Plaintiffs hold different views of the type of validation required to determine compliance with the FSA visitation requirements. DSS's interpretation of the requirements is that they are explicitly focused only on whether visits occurred and where they were held. Plaintiffs believe that that validation requires a review of visit content to ensure not only that caseworkers visited with children, but that they did so in a way that accords with the core purpose of visitation and includes necessary elements as defined by practice standards and DSS policy. In order to validate DSS's data with respect to caseworker visits with children, Co-Monitor staff reviewed documentation in the CAPSS case files of a statistically significant sample of children who were reported to have visited with a caseworker in the month of February 2017.[63] Because CAPSS documentation was not sufficient to allow for a fuller review of visit content, the review was limited and done solely

[63] In February 2017, there were 3,798 children reported by DSS to have visited with a caseworker. A statistically valid random sample of 349 cases was pulled based on a 95% confidence level and +/- 5% margin of error.

for the purpose of measuring the percentage of cases in which documentation indicated that a caseworker had visited the child in that month, and where the visit occurred.[64] The Co-Monitors did not assess the content of the visits nor the extent to which visits were done in accordance with DSS policy.

Based on its review, Co-Monitor staff found that there was documentation that a caseworker visit had occurred in 95 percent of cases reviewed. As a result, the Co-Monitors determined that CAPSS data could be used to calculate performance with respect to the FSA caseworker visitation requirements for this reporting period.

VII. INVESTIGATIONS

For children who have been removed from their homes due to concerns of abuse or neglect, it is imperative that allegations of abuse or neglect in their foster care placement be managed in a sensitive, appropriate manner. DSS is aware that this is an area in need of improvement, particularly in light of the historically high caseloads of investigation caseworkers and the Co-Monitors' baseline findings from record reviews. DSS has committed to addressing its OHAN practice expeditiously.

A. Investigation Implementation Plan

The FSA requires that by December 5, 2016, DSS develop an Implementation Plan for the provisions related to intake and investigations. The Implementation Plan must have "enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors, to measure progress in achieving the final targets…" (FSA IV.C.1.). DSS's OHAN Workgroup has been developing a plan for improving OHAN practice, adapted in response to the Co-Monitors' baseline review findings, discussed below. DSS submitted a draft of the Investigation Implementation Plan on November 30, 2016. Since that time, the Co-Monitors and Plaintiffs have provided feedback on several drafts of the plan and DSS has completed multiple rounds of revisions and modifications. A revised Implementation Plan with interim benchmarks and targets was submitted on August 9, 2017. On September 11, 2017, the Co-Monitors approved this plan. The remaining step for full approval is review and consent by Plaintiffs, as required in Section IV.C.1. of the FSA.

[64] In the course of their review, Co-Monitor staff found that documentation of caseworker visits was often either sparse or substantially duplicative of documentation entered in prior months. Though CAPSS documentation consistently included references to key domains based on a template, it was often not possible to reliably discern the extent to which those domains had been addressed during the visit or whether the visit supported ongoing assessment of the child's needs or planning.

B. Baseline Data

In February 2017, DSS, USC CCFS and Co-Monitor staff began to develop a methodology to collect baseline data for the FSA measures related to intake and investigations. Two review instruments were developed – the first (intake instrument) to assess appropriateness of decisions not to investigate a referral of institutional abuse or neglect about a Class Member and the second (investigation instrument) to assess specific components within an investigation of a referral of institutional abuse and neglect (specifically, timely initiation, timely completion, contact with core witnesses and decisions to "unfound"). These instruments were finalized in March 2017. Reviewers looked at hardcopy records, CAPSS data and videos, when applicable. SurveyMonkey, a web-based survey tool, was used for collecting and analyzing data.

USC CCFS and Co-Monitor staff conducted training prior to each review, which included a discussion of the instrument and purpose of each question and completion of a test case to promote interrater reliability. A Child Welfare Basic trainer from USC CCFS participated in the training for the investigation review and presented information on practice for appropriate assessments of safety and risk. Sixteen first level reviewers participated in the intake review and 22 first level reviewers participated in the investigation review. There were five second level reviewers who reviewed all (100%) instruments from both reviews to ensure completeness and consistency in decision-making; some instruments also received a third level review. Any disagreements between first and second level reviewers were discussed and edits were made accordingly.

All applicable abuse and neglect referrals[65] received and screened out by DSS's OHAN unit between August 1, 2016 and January 31, 2017, a total of 128, were reviewed during the intake review. The investigation review assessed 107 applicable investigations[66] received between June and November 2016.

Intake

Pursuant to SC state statute and DSS protocol, all allegations of abuse or neglect of a child in out-of-home settings, including licensed foster homes, residential facilities and group homes, that are received by local county offices or regional intake hubs must be forwarded to OHAN for screening and, if accepted, for investigation. [67, 68] OHAN staff make decisions to either accept a referral for

[65] Some referrals were found not to be applicable for review because the alleged victim child was not a Class Member (i.e. the child was voluntarily placed by the legal guardian or through ICPC from another state, or was the biological child of the caregiver). DSS has represented to the Co-Monitors that all referrals of abuse and neglect in licensed foster homes, residential facilities and group homes across the state involving Class Members are received by or forwarded to OHAN for screening and investigation, as appropriate, and screening decisions are not made by local office or Intake HUB staff.
[66] Some investigations were deemed not applicable for the same reasons as the intake review.
[67] SC Code § 63-7-1210; Human Services Policy and Procedural Manual, Chapter 7-721. p.3 (effective date 11/29/2012); SC DSS Directive Memo, April 26, 2016.
[68] Allegations of abuse or neglect by a foster parent against their biological or adopted child are investigated by local county offices.

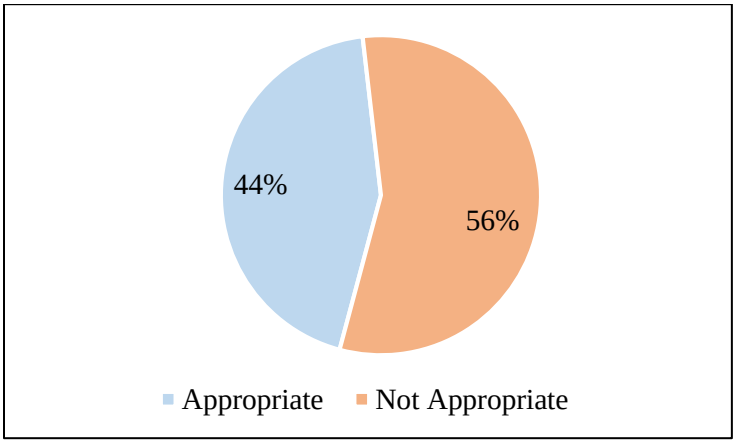
investigation or take no further action on the referral based upon information collected from reporters to determine if the allegations meet the state's statutory definition of abuse or neglect[69]. DSS policy establishes three main screening criteria for investigations of abuse or neglect of children in out-of-home care: (1) the alleged victim child is younger than 18 years of age; (2) there is an allegation of actual harm that has occurred or is occurring to a child or the caregiver's acts or omissions present a significant risk of harm; and (3) the alleged perpetrator is a person responsible for the child's welfare.[70] OHAN staff are also directed to accept for investigation referrals which identify safety and risk factors to the child in care. All screening decisions are reviewed and approved by a supervisor prior to being finalized.

The FSA requires, "[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.). When assessing performance for this measure, reviewers considered three main criteria: (1) the allegation, if true, meets the legal definition of maltreatment; (2) the OHAN caseworker did not collect all information necessary to make an appropriate screening decision; and (3) safety or risk factors were identified within the information shared. If any of these questions were answered in the affirmative, the decision not to investigate was determined to be inappropriate.

Of the 128 referrals that were not accepted for investigation by OHAN between August 1, 2016 and January 31, 2017, reviewers determined 56 (44%) of the screening decisions were appropriate (see Figure 3). These baseline data will be utilized to establish interim benchmarks and timelines to move toward the final target of 95 percent.

[69] SC Code § 63-7-20.
[70] This includes a foster parent; an employee or caregiver in a public or private residential home, institution or agency; or an adult who has assumed the role and responsibility of a parent or guardian for the child, but who does not necessarily have legal custody of the child. Human Services Policy and Procedural Manual, Chapter 7-721. p.3 (effective date 11/29/2012).

Figure 3: Appropriateness of Decision Not to Investigate Referral (Alleging) Institutional Abuse (and/)or Neglect
August 1, 2016 – January 31, 2017
N=128

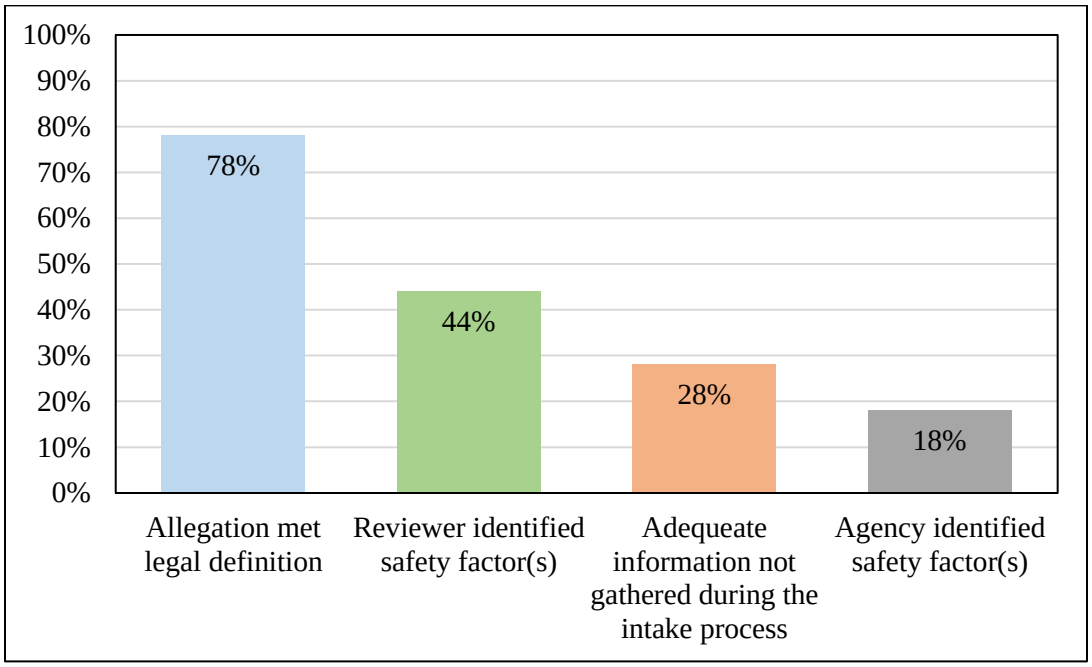


Source: March 2017 Case Record Review, USC CCFS and Co-Monitor staff

The reason for reviewer determinations that the decision not to investigate a referral was incorrect varied, and in some cases, more than one reason was given[71]. The most common reason, cited in 78 percent (56 of 72) of referrals, was that the allegation met the legal definition of maltreatment as defined by state statute and should have been accepted for investigation. This finding supports the need for additional guidance, training and supervisory support to staff who are making intake decisions. In 44 percent (32) of the 72 referrals, the reviewer identified safety factors which made the decision not to accept the referral inappropriate and in 28 percent (20) of the referrals, the reviewer determined that the OHAN caseworker did not collect all information necessary to make an appropriate screening decision.

[71] Of the 72 screen out decisions that were not appropriate, reviewers in 47% (34) cited one reason for determining the screen out was not appropriate, reviewers in 38% (27) cited two reasons and reviewers in 15% (11) cited three reasons.

Figure 4: Reason for Reviewer Disagreement with Decision Not to Investigate Referral
August 1, 2016 – January 31, 2017
N=72



Source: April 2017 Case Record Review, USC CCFS and Co-Monitor
Totals do not equal 100 percent as reviewers could select all that apply.

Investigations

If a referral is accepted for investigation, the FSA and OHAN policy require face-to-face contact with the alleged victim child(ren) within 24 hours to assess safety and risk and the investigation is to be completed within 45 days.[72] OHAN policy also requires that throughout the course of the investigation, the investigator must conduct a safety assessment of the alleged victim child, including a private interview with that child; work with the child's caseworker 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.[73] All of these activities are critical components of a quality investigation which results in accurate assessments and findings.

There are seven FSA measures pertaining to investigations – timely initiation (two measures), contact with core witnesses (one measure), investigation determination decisions (one measure) and timely completion (three measures). Baseline data collected during the recent case record review are discussed below. The data demonstrate that current practice in most instances accords

[72] Human Service Policy and Procedural Manual, Chapter 7-721. p. 6, 12 (effective date 11/29/2012).
[73] Human Services Policy and Procedural Manual, Chapter 7-721. p. 7 (effective date 11/29/2012).

with the timelines established for investigations, however, the quality of practice is in need of improvement.

Timely Initiation

The FSA requires, "[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)). Additionally, FSA Section IV.C.4.(b) requires, "[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." The Co-Monitors interpretation of the FSA treats both of these requirements in the same manner – investigations must 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. With these considerations, the performance for both FSA 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 the alleged child victim must be within 24 hours.

The Co-Monitors approved the following as "good faith efforts" for timely initiation which must be completed and documented, as applicable, for exceptions to contact with an alleged victim child(ren) within 24 hours:

Table 4: Good Faith Efforts to Contact Alleged Victim Children

• Investigator attempted to see child(ren) at school • 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/CAC interview	• Investigator attempted to see child(ren) at therapist's office • Investigator contacted the assigned foster care caseworker(s) and/or supervisor(s) • Investigator attempted to contact the parent/guardian of the victim child(ren) if the child(ren) has gone home • Investigator attempted to see child(ren) at child care facility • Investigator attempted to contact the child at all foster care placements where the child may temporarily be placed in the first 24 hours

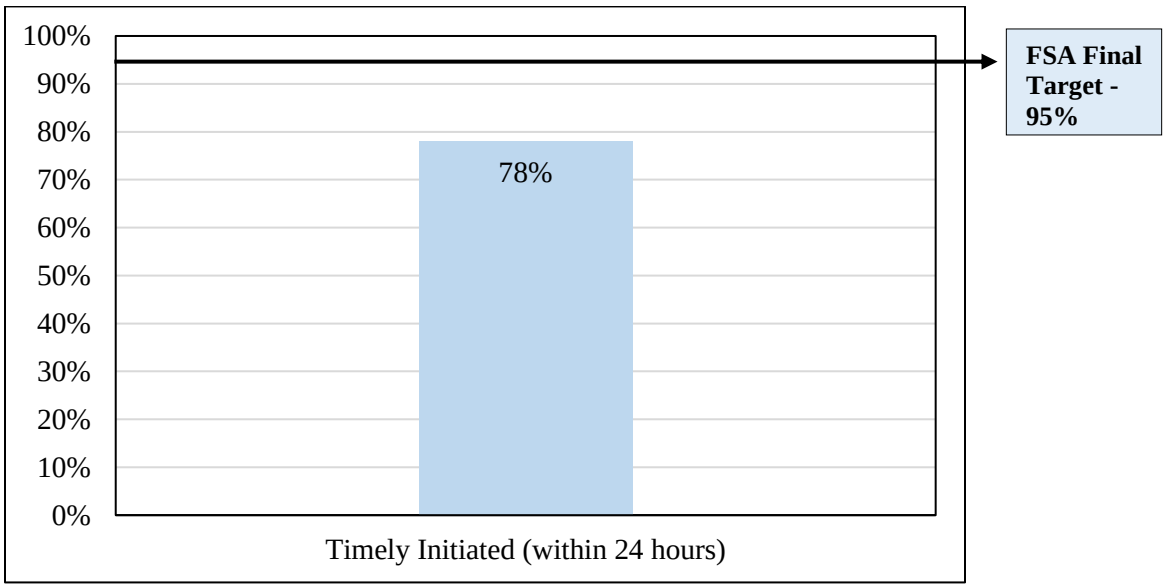
Additionally, the following extraordinary circumstances were also approved by the Co-Monitors as exceptions to timely initiation:

Table 5: Extraordinary Circumstance Exceptions to Contact with Alleged Victim Children

• Child was returned to biological family prior to report and family refuses contact • Child is deceased • Law enforcement prohibited contact with child	• Facility restrictions due to child's medical requirements • Natural disaster • Child missing despite efforts to locate (efforts should include all applicable good faith efforts listed above)

Of the 107 applicable investigations[74] conducted between June and November 2016, contact was made with the alleged victim child(ren) within 24 hours in 81 (76%) investigations and in an additional two (2%) investigations, documentation supported completion of all applicable good faith efforts. Therefore, baseline performance for FSA IV.C.4.(a) and (b) is 78 percent (see Figure 5).

Figure 5: Timely Initiation of Investigations
June – November 2016
N=107



Source: March – June 2017 Case Record Review, USC CCFS and Co-Monitor staff

[74] Some investigations were found not to be applicable for review because the alleged victim child was not a Class Member (i.e. the child was voluntarily placed by the legal guardian or through ICPC from another state, or was the biological child of the caregiver).

Contact with Core Witnesses

The FSA requires, "[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. Core witnesses will vary from case to case and may or may not include the victim(s), Class Members, alleged perpetrators, reporter (if identified), identified eyewitness(es), other children in the placement, facility staff, treating professionals, and foster parents or caregivers as deemed to be relevant to the investigation" (FSA IV.C.4.(c)).

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 in any individual investigation to investigation, but in all cases include: reporter(s), alleged perpetrator(s), alleged child victim(s), child's DSS caseworker, 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.

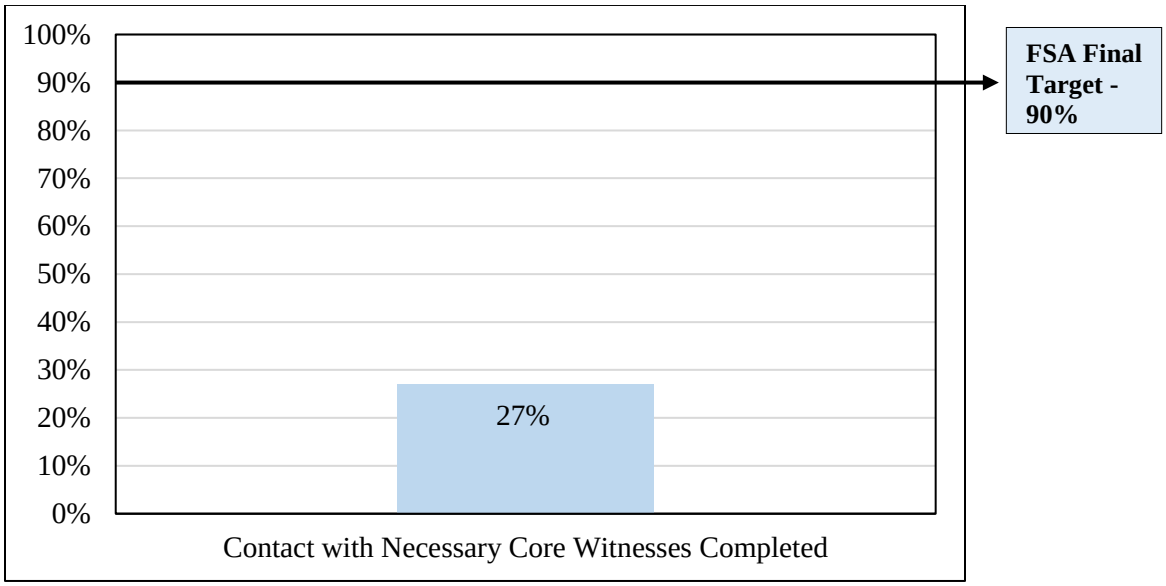
The following are exceptions to the requirement that the investigator make contact with a core witness during an investigation, approved by the Co-Monitors. In all instances, the exception must be supported by documentation of the exception reason and best efforts to engage:

Table 6: Exceptions to Contact with Core Witnesses

• Witness refused to cooperate • Witness advised by counsel or law enforcement that interview could not occur (e.g. pending charges, lawsuit) • Witness is deceased	• Unable to locate or identify witness • Medical conditions prevented witness from cooperating

Of the 107 applicable investigations received between June and November 2016, reviewers determined that the investigator made contact with all necessary core witnesses for whom there was no approved exception in 29 (27%) investigations (see Figure 6).

Figure 6: Contact with All Necessary Core Witnesses during the Investigation
June – November 2016
N=107



Source: March – June 2017 Case Record Review, USC CCFS and Co-Monitor staff

In the 78 investigations in which contact was not made with all necessary core witnesses, the reporter was the most frequent missing core witness and was only interviewed in 45 percent (35) of the investigations. Of these 78 investigations, the alleged child victim was interviewed in all (78) and the alleged perpetrator(s) was interviewed in 86 percent (67) of investigations.[75]

Case Decisions

At the conclusion of the investigation, a case decision is made based upon the totality of the information collected, with the preponderance of the evidence as standard of proof of the facts.[76] The allegations are either founded (indicated) or unfounded.

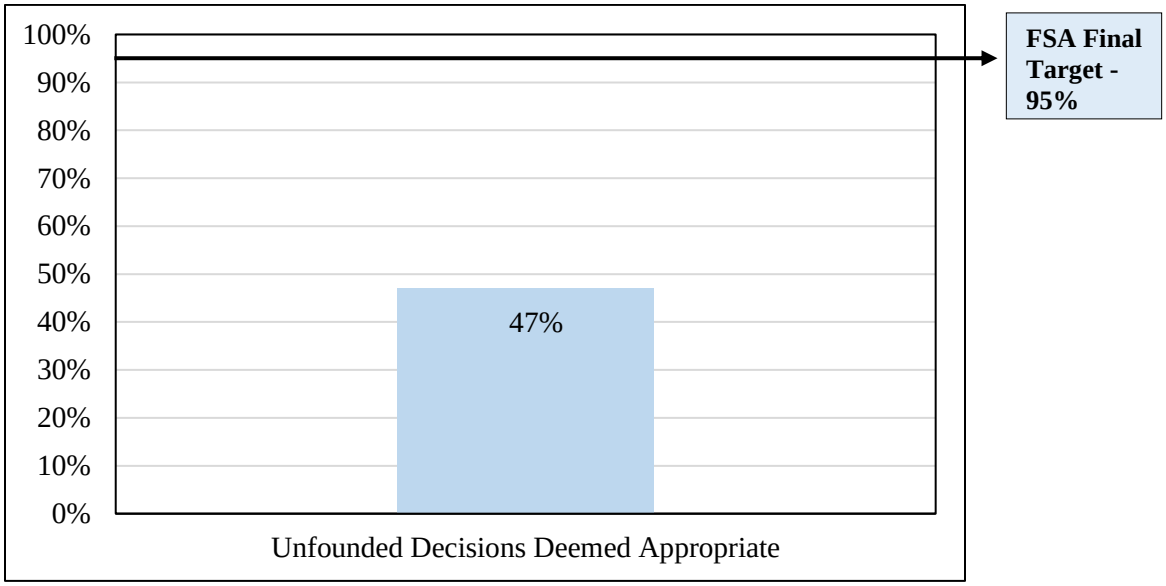
Section IV.C.3. of the FSA requires, "[a]t least 95% of decisions to 'unfound' investigations of a Referral of Institutional Abuse or Neglect must be based upon DSS ruling out abuse or neglect or DSS determining that an investigation did not produce a preponderance of evidence that a Class Member was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

The investigations received between June and November 2016 included 94 investigations with a case decision to *unfound* the allegations. Reviewers agreed that the case decision to *unfound* the

[75] In some investigations, more than one core witness was not contacted.
[76] SC DSS Human Services Policy and Procedural Manual, Chapter 7-721. p. 3 (effective date 11/29/2012).

investigation was appropriate in 44 (47%) of the 94 applicable investigations (see Figure 7). Case decisions to *unfound* the investigation were inappropriate in 50 (53%) investigations.

Figure 7: Decision to Unfound Investigation Deemed Appropriate
June – November 2016
N=94



Source: March – June 2017 Case Record Review, USC CCFS and Co-Monitor staff

Reviewers selected one of two reasons for their disagreement with the unfounded decision – in 36 (72%) investigations, the investigator did not collect all information critical to make an accurate finding and in the remaining 14 investigations, all necessary information was collected, but the decision to *unfound* was not supported by the information.

Timely Completion

The FSA includes the following three measures for timely completion of investigations, recognizing that some investigations may take longer than 45 days as policy requires:

- "At least 60% of 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. For the purposes of this section, an investigation is not completed if DSS determines the Report is *unfounded* because the deadline to complete the investigation has passed" (FSA IV.C.4.(d)).
- "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 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. For the purposes of this section, an investigation is not completed if DSS determines the Report is *unfounded* because the deadline to complete the investigation has passed" (FSA IV.C.4.(e)).

- "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. For the purposes of this section, an investigation is not completed if DSS determines the Report is *unfounded* because the deadline to complete the investigation has passed" (FSA IV.C.4.(f)).

The FSA and OHAN policy provide that the DSS Director or Director's Designee may authorize an extension of up to 15 days for "good cause" or compelling reasons.[77] Good cause means that, through no fault of the investigator, sufficient reason exists for delaying the case decision. Examples of good cause may be one of the following:

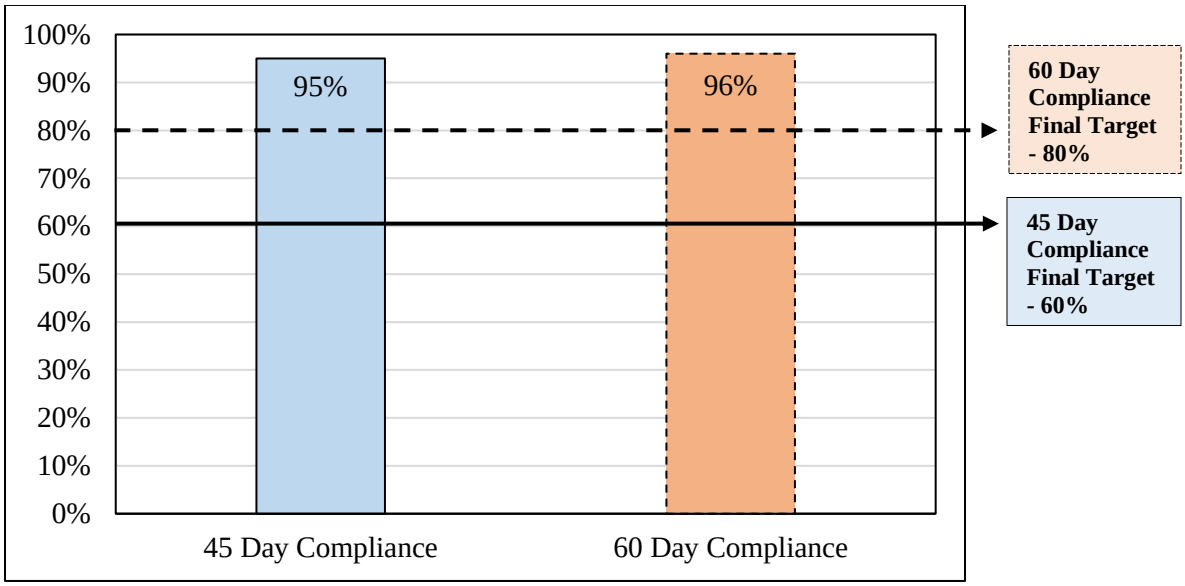
Table 7: Examples of Good Cause Reasons to Extend Investigation Timeframes

• 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 • Child has been too ill or traumatized to speak with investigator

Of the 107 investigations received between June and November 2016, two investigations are excluded from the 45 day compliance measure as an extension request for 15 days was submitted and approved by the OHAN Director.[78] Of the remaining 105 investigations, 104 investigations were completed within 45 days, however, reviewers determined that four of these investigations were closed as *unfounded* prematurely in an effort to meet the 45 day requirement which is not considered compliant by the FSA. Therefore, the review determined that 100 (95%) of the 105 applicable investigations were appropriately closed within 45 days. The remaining three investigations (two with an approved extension request and one without) were all closed within 60 days; performance for timely completion within 60 days is 96 percent (103 of 107).

[77] SC DSS Human Services Policy and Procedural Manual, Chapter 7-721. p. 12 (effective date 11/29/2012).
[78] In one investigation, the investigator was awaiting findings from a forensic interview and in the other investigation, the investigator was awaiting action by law enforcement.

Figure 8: Timely Completion of Investigation
June – November 2016
N=105 within 45 days; N=107 within 60 days



Source: March – June 2017 Case Record Review, USC CCFS and Co-Monitor staff

All investigations were completed within 60 days; therefore, the FSA measure which requires that investigations be completed within 90 days, if they are not completed within 60 days is not applicable this period.

As these data reflect, both the intake and investigation baseline reviews highlight significant OHAN policy and practice issues. The Co-Monitors identified a number of themes throughout the reviews, some of which DSS has already begun to address, and that became areas of focus in the development of the Investigations Implementation Plan. These are bulleted below:

- OHAN intake and investigation staff had incomplete access to providers' entire history of prior abuse or neglect referrals and investigations in CAPSS. During the review, OHAN began development of a comprehensive report, available to caseworkers and supervisors within CAPSS, which will address this issue.
- There were inconsistencies in intake screening decisions due to a lack of standardized instruments or tools. Since the review, DSS has adopted an interim intake tool which more clearly delineates which referrals should be accepted for investigation based upon safety and risk concerns and the factors to look for within each typology. OHAN is working with a national consultant to develop a new risk and safety assessment tool which should be finalized later this year.
- Information collected from the reporter by OHAN staff was limited and impacted a caseworker's ability to thoroughly assess the allegations and level of safety and risk. DSS

has begun the process of developing a formal training specifically for intake and investigation practice, something that was lacking before, which is scheduled to begin in September 2017.

- Interviews with alleged victim children were not consistently conducted in a manner that was likely to elicit reliable information, and many of the interactions with adult core witnesses occurred only via email and/or involved a brief set of questions that were too narrow to gather all necessary information relevant to the unique circumstances of each investigation. The Co-Monitors have discussed this concern with DSS and staff are currently working with USC CCFS to ensure interviewing techniques are included in the OHAN caseworker training.
- Some unfounded case decisions appear to have been based upon a facility or institution's decision to make changes in personnel. Though personnel changes may be appropriate actions by the institution, the decision by OHAN to indicate or unfound allegations should be unrelated and based upon a thorough investigation of facts and circumstances as they occurred at the time of the alleged incident. This specific feedback was provided to OHAN after completion of the review. DSS acknowledges and directs staff that decision-making in an investigation should be independent of personnel decisions or other findings by the institution.
- OHAN investigators sometimes used statements and findings collected during a congregate care facility's own internal investigation without independently interviewing those witnesses or verifying the information. This is a troublesome practice given that facilities have their own interest in investigation findings, and does not constitute thorough, unbiased investigative practice, which should always be undertaken directly by OHAN. The Co-Monitors have shared this feedback with OHAN and DSS represents that interviewing techniques will be included in the newly developed OHAN caseworker training.
- Some investigators make the decision to unfound allegations that might otherwise have been indicated because there was an expectation that an indicated finding would be reversed on appeal. Though there is always a risk that a finding will change based upon the appeal process, the role for OHAN investigators in all cases should be to conduct a thorough investigation and make the determination that is most supported by the evidence in front of them.

Though the Co-Monitors applaud DSS's efforts to begin addressing some of the issues identified with respect to OHAN policy and practice, reducing the incidence of abuse and neglect of children in foster care must involve changes that go beyond OHAN. It is imperative that, among other things, DSS work to ensure that caregivers for children in foster care are provided with the necessary training and support to reduce risk of harm, that DSS licensing staff thoroughly collaborate with OHAN and consistently vet foster and groups homes, that caseworkers closely

monitor children's safety and experience in placement and that data systems support easy, reliable access to historical information about prior reports and investigations.

VIII. PLACEMENTS

A. Placement Needs Assessment

The FSA requires that by February 1, 2017, with prior input from and subject to approval by the Co-Monitors, DSS perform a statewide and regional foster care Placement Needs Assessment "in order to determine the minimally adequate capacity and array of placements for meeting the placement needs of all Class Members..." (FSA IV.D.1.). The needs assessment must include "specific recommendations addressing all the assessment's findings, including but not limited to recommendations that address the capacity to place Class Members close to their home community, placing Class Members in the least restrictive, most family-like placement, the number and array of therapeutic foster care placements, a system of tracking availability of beds in family foster homes, and matching of Class Members to placements that can meet their needs" (FSA IV.D.1.).

In January 2016, DSS began work with the Co-Monitors to develop a methodology for conducting the placement needs assessment. DSS early on decided to engage USC CCFS, its training, research and QA partner, to conduct the assessment. After engagement of USC CCFS staff to conduct the assessment, discussion with the Co-Monitors about expectations and multiple iterations of the methodology, the Co-Monitors approved DSS's methodology on December 27, 2016. The methodology incorporates an analysis of CAPSS data and a qualitative data collection process, with the goals of understanding where children from each region are placed in proximity to their biological homes, the underlying needs that drive placement decisions, the available licensed placement resources in each county and the movement of children to higher levels of care. USC CCFS's analysis would also be informed by case-based data previously collected between March 2015 and October 2016 as part of DSS's annual Quality Assurance (QA) reviews[79], using the federal Child and Family Services Review (CFSR)[80] On-Site Review Instrument[81]. USC CCFS began its statewide placement needs assessment in February 2017, with an original completion date of June 30, 2017. On June 30, 2017, DSS notified the Co-Monitors that the assessment could not be completed and that a report would be completed and submitted by August 31, 2017. DSS submitted a report with data and findings from the placement needs assessment to the Co-Monitors

[79] DSS uses QA reviews to ensure services rendered to children and families by the child welfare system are of sufficient intensity, scope and quality to meet their needs. For more information see http://ccfs.sc.edu/looking-closely/qa-reviews.html

[80] CFSR's are periodic reviews of state child welfare systems conducted by the Children's Bureau. For more information see https://www.acf.hhs.gov/cb/monitoring/child-family-services-reviews

[81] For the on-site instrument and instructions, see https://www.acf.hhs.gov/cb/monitoring/child-family-services-reviews/instruments-tools-guides

on that date. The Co-Monitors expect to discuss the report with DSS in a meeting scheduled in late September 2017.

A core component of the placement needs assessment process was a qualitative review of 90 cases. The review consisted of in-depth interviews using a protocol developed in consultation with the Co-Monitors. The cases represent a stratified (for gender, race, age and ethnicity), random sample of children from 14 counties and five regions, including children who were: placed in congregate care or group care within the three months prior to the review (20 cases); placed in therapeutic foster care within the three months prior to the review (20 cases); placed in family foster care placements and experienced more than three placement moves (changes) in the past year (20 cases); or placed in other stable family foster or kinship home settings (30 cases). The review sample also included a mix of children residing with one or more of their siblings in foster care, children placed in and outside of their home county, children with a range of permanency goals and children placed with 20 distinct providers.

Between February and May 2017, USC CCFS teams consisting of trained reviewers reviewed one case per week. Team members read the case record and interviewed relevant persons including the child, parents, caregivers, assigned caseworker and, as applicable, therapist, school personnel and significant others. Where possible, children were interviewed in their placement setting and family and caregivers were interviewed in their own homes. At the end of each week, a meeting was held with each review team to discuss findings. Each review team also provided a written report.

Following the analysis of data from these qualitative case reviews, focus group interviews with DSS employees and external stakeholders were held to clarify issues identified through the quantitative data analysis and the case review process and to answer any questions which had not been answered through other avenues of data collection. The availability, quality and responsiveness of local intensive home-based mental health services to meet the individual needs of children and youth was assessed through surveys to each county. Data matching with Medicaid mental health claims was also completed as part of the placement needs assessment. The methodology for the placement needs assessment is attached to this report as Appendix D.

Although the Placement Needs Assessment was not fully completed by the time of drafting of this report, the Co-Monitors read summaries of the 90 cases reviewed and found common themes which should inform improvements in placement processes and experiences and outcomes for children, youth, families, caregivers, caseworkers and providers, including:

- The current placement process is primarily driven by the availability of beds, rather than by the needs of children. It is common for staff looking for placements to use a Universal Application that is sent out to multiple providers. Placement is frequently based on where there is a willingness to accept the child, with frequent separation of siblings.

- The needs of many of the children in congregate care and some in Therapeutic Foster Care (TFC) could have been met in a family foster care setting if a placement had been available.
- Many of the children had considerable trauma histories, with exposure during both their time in their biological homes and after placement in foster care. Separation from parents, separation from siblings, multiple placement moves and a lack of permanency all contributed to trauma responses that required skilled clinical therapeutic intervention and trained and competent caregivers.
- The limited availability of intensive home-based mental health services to address behavior related to trauma meant that some children were placed in congregate settings so that they could access more intensive services. Few emotional and behavioral challenges were noted that could not have been met in a less restrictive setting if such intensive home-based services were available.
- In-depth assessments of children were infrequent and those completed by DSS staff and providers did not adequately assess the needs underlying children's behavior.
- Responsive mental health services, especially trauma responsive supports, were insufficient. It was not unusual for children to receive some form of counseling, but not the type of trauma-focused engagement that would have been appropriate to their needs. Assessment and therapy for some children was delayed by lack of resources, placing them on waitlists.
- Many of the TFC placements appeared to be responsive to most of children's needs, though there was not a consistent focus on permanency. Some TFC providers did make a commitment to adoption.
- Generally, if the child was in a higher level of care, permanency efforts seemed less urgent, if important at all. In a few cases where adoption was an active consideration, there appeared to be limited coordination with adoption staff. For children in group care, facility staff had little involvement in permanency planning.
- Older children and youth reported having little input into the plans being made for them. For a number of youth and their biological parents, DSS staff were often described as developing the plans without their active involvement. Case plans were not consistently found in children's files.
- In some cases, the caseworker role was compliance driven, with a focus on meeting court requirements, rather than on actively engaging families to address underlying challenges. This impeded reunification decision-making.

- The use of a child and family team meetings for planning and coordination was mentioned infrequently, even where placement changes were being considered.

The Co-Monitors shared these themes with DSS and USC CCFS and they are being considered as DSS works to develop the Placement Implementation Plan that is required to follow the completion of the Needs Assessment.

B. Placement Implementation Plan

The FSA requires that "[w]ithin sixty (60) days of the completion of the needs assessment, DSS shall develop an Implementation Plan to implement the recommendations of the needs assessment within eighteen (18) months. The Implementation Plan shall have enforceable benchmarks with specific timelines, subject to approval by the Co-Monitors, to measure progress in executing the recommendations of the needs assessment" (FSA IV.D.1.(a)).

As presented above, DSS completed the placement needs assessment on August 31, 2017. Therefore, the Placement Implementation Plan is due by October 31, 2017. Pursuant to the FSA, the Co-Monitors will report on DSS's progress towards achieving Implementation Plan benchmarks in subsequent reports (FSA IV.D.1(b)).

C. Performance Data

1. Specific Placement Settings

Placement of Children in Congregate Care

The overwhelming majority of children in foster care do best when they are placed in stable, family-like settings. Placement in group settings and multiple moves for children can result in numerous disruptions in a child's life including with their caregiver, school and community that are damaging to a child's well-being. It is for these reasons that the FSA has multiple requirements related to placing children in the most family-like, least restrictive environments and, where possible, with their siblings.

The FSA requires that at least 86 percent of Class Members be placed outside of congregate care placements on the last day of the reporting period (FSA IV.E.2.). DSS data indicate that in March 2017, 78 percent (3,223 of 4,124) of the children in foster care were placed outside of a congregate care placement (to include residential treatment and emergency shelters) as indicated below in Table 8.[82]

[82] Data about the number of children in a congregate setting was submitted by DSS but have not been validated by the Co-Monitors.

Table 8: Types of Placement for Children in Foster Care
March 2017

	All children in foster care	Family-based Setting	Congregate Care, Emergency Shelter or Residential Treatment Facility	Congregate Care	Emergency Shelter	Residential Treatment Facility
# of children	4,124	3,223	901	780	41	80
% of children	100%	78%	22%	19%	1%	2%

Source: CAPSS Data Provided by DSS

Children 12 and Under

The FSA also includes placement standards specific to certain age groups of children, and requires 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" (IV.E.3.).

DSS data indicate that 91 percent (2,630 of 2,905) of children ages 12 and under in foster care were residing in a family-based setting as of March 2017.[83]

Table 9: Types of Placement for Children Age 12 and Under in Foster Care
March 2017

	All children in foster care age 12 and under	Family-based Setting	Congregate Care, Emergency Shelter or Residential Treatment Facility	Congregate Care	Emergency Shelter	Residential Treatment Facility
# of children	**2,905**	**2,630**	**275**	234	22	19
% of children	**100%**	**91%**	**9%**	8%	<1%	<1%

Source: CAPSS Data Provided by DSS

Children Six and Under

Placement in a family setting is especially important for young children. The Interim Order put provisions in place to immediately address the placement of children ages six and under in congregate care, requiring that by November 28, 2015, DSS "create a plan, subject to the approval of the Co-Monitors, for preventing, with exceptions approved by the Co-Monitors, the placement

[83] Ibid.

of any Class Member age six (6) and under in any non-family group placement (including but not limited to group homes, shelters or residential treatment centers)" (IO II.3.(a) & FSA IV.D.2.). The plan was to include "full implementation within sixty (60) days following approval of the Co-Monitors."

On October 31, 2015, DSS provided the Co-Monitors with a draft plan for meeting this FSA requirement. The plan included immediate actions to review and hold staffings for children ages six and under in congregate placements; amend contracts with existing therapeutic foster care providers who had or could develop family placements for these children; and improve recruitment, training and licensure of family foster placements through Regional Resource Teams. DSS also proposed exceptions to the placement requirement. On January 22, 2016, after conducting site visits to local county offices and speaking with caseworkers, service providers (including congregate care providers) and legal staff, the Co-Monitors provided feedback on these plans, including modifications to DSS's proposed exceptions. On March 15, 2016, the Co-Monitors approved DSS's plan, including acceptable exceptions (listed in Table 10 below), and DSS issued a directive outlining the procedure to be used by local and regional office staff to ensure the appropriate placement of children ages six and under in family placements.

Table 10: Exceptions for Placement of Children Ages Six and Under in Non-Family-Based Placements

Any group care placement for a child that is age 6 and under requires prior approval from the Deputy Director of Child Welfare Services upon the advice of the agency clinical staff that the child meets the following criteria:

- 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.
- The child coming into care is in a sibling group of four or larger and all efforts to secure foster home and Therapeutic Foster home placements have been completed and have not produced a home. In that 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.
- The child comes into care and is placed in congregate care with his or/her biological parent who is not in DSS care but who is receiving treatment at a facility.[84]
- Children who are voluntarily placed by their parent or caregiver are not subject to this requirement.

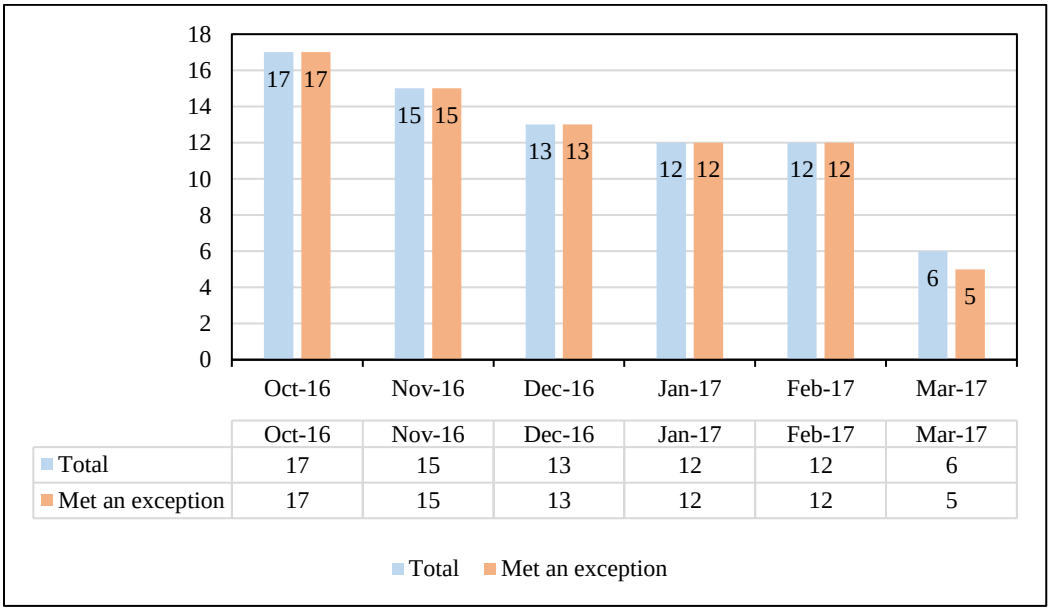
The Co-Monitors have requested and received monthly data from DSS on all children ages six and under who have been in congregate care since entry of the Interim Order and continuing with the entry of the FSA. These data include child-specific information regarding approved exceptions each month, with the reasons for the approval. DSS reports that on November, 1, 2015, there were 142 children ages six and under in a congregate care setting. By February 2016, the number of

[84] This exception was requested and approved by the Co-Monitors in May 2017, after the initial list of exceptions was approved.

children ages six and under in congregate care had been reduced to 108, and by August 2016 DSS has reported that the number fell to 34 children.

As illustrated in Figure 9 below, during this monitoring period, the number of children reported by DSS to be in a congregate care placement greatly decreased from 17 in October 2016 to six in March 2017. The circumstances of five of the six children ages six and under placed in a congregate care setting in March 2017 met an agreed upon exception. Data from DSS, which has not been further validated by the Co-Monitors during this review period, shows that from October 2016 to March 2017, children ages six and under in congregate care have ranged in age from 2-months old to just under 7-years old. Throughout this monitoring period, for the majority of children, their circumstance met one of the agreed upon exceptions for a congregate care placement – either the child was part of a sibling group of four children who were placed together or the child is residing with an adolescent parent in a program designed for teen mothers (for whom a family-based placement where they could be placed together could not be located). DSS has reported that approval was sought from the Deputy Director of Child Welfare prior to placement in only two instances during this monitoring period. Though the Co-Monitors have agreed that during this monitoring period these instances of placements prior to approval still meet the approved FSA exceptions, the expectation is that the Co-Monitors will recognize exceptions as such in future monitoring periods only if appropriate approval is sought from the Deputy Director of Child Welfare Services in advance of the child's placement.

Figure 9: Children Ages Six and Under in Congregate Care
October 2016 – March 2017



	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total	17	15	13	12	12	6
Met an exception	17	15	13	12	12	5

Source: CAPSS Data Provided by DSS

Placement in DSS Offices and Hotels

Children experience instability and uncertainty when they are removed from their homes and placed in foster care. Ideally, the transition should be eased by having a consistent and appropriate placement available for each child at any time during the day and night, with caregivers equipped to provide care and support, regardless of the needs with which the child presents. Due to limited availability of appropriate placements, including a continuum of placements to meet child-specific needs, there have been instances in which DSS offices or hotels have been utilized as overnight placements for children in foster care.

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.).

The Co-Monitors have been notified of three instances in which a child has stayed overnight at a DSS office or hotel in violation of this provision. The first two incidents were on January 6, 2016 and involved two children, ages 12 and 13. Both children presented with challenging placement requirements and placements were not secured until the following day. The third incident occurred on October 20, 2016. The child was age 14 and ordered into DSS custody during his Department of Juvenile Justice (DJJ) proceeding earlier that day. Numerous efforts were made throughout the day by DSS staff to find an appropriate placement for this child, however, placement was not secured and the child stayed overnight at the office. The Co-Monitors notified Plaintiffs' counsel of these occurrences and have determined they are violations of the FSA. Given that DSS has not yet developed a formal system for tracking overnight stays but relies on after the fact self-report by local county offices, the Co-Monitors were not able to independently validate these data to ensure they reflect all relevant violations of this provision.

The Co-Monitors will continue to review reports of overnight stays in DSS offices and hotel to better understand placement challenges across the state over time and will look closely at each instance to understand the circumstances and follow-up actions.

Emergency or Temporary Placements

The FSA requires that "Class Members shall not remain in any Emergency or Temporary Placement for more than thirty (30) days. Under exceptions approved by the Co-Monitors, if a child is initially placed in an Emergency or Temporary Placement that is not a Congregate Care Placement, and that placement is re-designated within thirty (30) days as a long-term foster home or therapeutic foster home, then the child's stay shall not be considered a violation of this provision and the re-designation shall not be considered a placement move…" (FSA IV.E.4.). Exceptions to this standard have not been approved by the Co-Monitors.

DSS has been unable to provide data on the number of children in emergency and temporary placements and has not yet been able to determine if these placements are re-designated as long-term or therapeutic foster homes; baseline data utilizing the methodology defined in the FSA are not available.

The FSA also requires that "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. Under exceptions subject to the Co-Monitors' approval, if a child's subsequent placement within twelve (12) months in an Emergency or Temporary Placement is not a Congregate Care Placement, and that placement is re-designated within thirty (30) days as a long-term foster home or therapeutic foster home, then the child's stay shall not be considered a violation of this provision and the re-designation shall not be considered a placement move…" (FSA IV.E.5.).

Exceptions to this standard have not been approved by the Co-Monitors and DSS has not been able to produce data for this measure.

Juvenile Justice Placements

The FSA, incorporating an Interim Order provision, requires "[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 please or adjudicated sentence for the reason that DSS does not have a foster care placement for the Class Member…" (FSA IV.H.1.).

DSS represents that youth are immediately taken into the physical custody of DSS upon exit from juvenile justice placement in almost all instances, but has acknowledged that there is no system in place for routinely tracking youth moving between the juvenile justice and child welfare systems. DSS has reported that it is aware of only two instances of violation of this provision since entry of

the Interim Order in September 2015. The first instance was in December 2015 when a youth remained in detention, at the order of a judge, because DSS was unable to find a placement for him. After more than a month, the youth was placed in an out-of-state facility. The second instance was in September 2016 when a youth remained in a detention center for seven days awaiting placement in a group home, upon judicial order.

Given the lack of a reliable mechanism for tracking compliance with this measure, occurrence may be understated. The Co-Monitors are committed to working with DSS and other stakeholders in future monitoring periods to both find alternative ways to monitor compliance with this measure and support the development of processes that will capture these important information about a child's status in a timely and reliable way.

2. Placement Stability

The FSA (IV.F.1.) requires that for all Class Members in foster care for eight days or more during the 12 month period, placement instability shall be less than or equal to 3.37.[85] DSS has not produced data to enable the Co-Monitors to assess performance for this measure for this period.

3. Sibling Placement

When children enter foster care they need to be placed with their siblings unless there are prohibitive reasons related to a child's safety or well-being. The FSA requires children who enter care with or within 30 days of their siblings to be placed with their siblings (FSA.IV.G.2. & 3.). The FSA sets two targets – one for placement with at least one of their siblings and the other placement with all siblings. 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 one or more siblings. Additional exceptions to this standard have not yet been approved by the Co-Monitors.

As of January 1, 2017, there were 2,459 children who had siblings in foster care.[86] Over one-third (37%/911 children) of these children were placed with all of their siblings.[87] In addition to the 911 children who were placed with all of their siblings, 812 (33%) children who had siblings in foster care were placed with at least one of their siblings. Thus, a total of 70 percent of children were placed with at least one of their siblings; the remaining 736 children (30%) were placed without a sibling.

[85] The formula used to calculate performance is provided in Section II.O. of the FSA.
[86] Sibling groups were identified utilizing data in CAPSS which defines a sibling group as a set of children with the same CAPSS case identifier.
[87] The majority of sibling groups in which all children were placed together were sibling groups with two children (652 children/72%). 183 (20%) of the children placed with all of their siblings were in sibling groups of three.

Table 11: Children Placed with their Siblings
January 1, 2017
N=2,459

	Number	Percent	Final Target
Placed with all siblings	911	37%	80%
Placed with at least one sibling	1,723	70%	85%
Not placed with any siblings	736	30%	--

Source: CAPSS Data Provided by DSS

IX. FAMILY VISITATION

Visitation is critical to maintaining family connections for children in foster care. The FSA includes measures specific to visits between children in foster care and their siblings and, where there is a goal of reunification, with the parent(s) with whom reunification is sought. The majority of children in DSS care did not visit with their siblings in care on a monthly basis this monitoring period. This information has been reviewed by DSS, which has reported using it to inform an ongoing plan to improve practice in this area. As discussed in more detail below, the Co-Monitors were not able to assess performance with respect to visitation between parents and children this monitoring period due to a lack of reliable data about children's permanency goals.

A. Visitation Implementation Plan

The FSA requires "[w]ithin 60 days of the entry of the Order approving the Settlement Agreement, Defendants shall develop an Implementation Plan to implement the achievement of the final targets in this subsection. The Implementation Plan shall have enforceable interim benchmarks with specific timelines, subject to consent by Plaintiffs and approval by the Co-Monitors, to measure progress in achieving the final targets in this subsection. Plaintiffs will not unreasonably withhold consent, and if the Co-Monitors approve and Plaintiffs do not consent, Plaintiffs will describe with sufficient detail, rationale, and recommendations that will lead to consent" (FSA IV.J.1.).

DSS convened a Visitation Workgroup in October 2016 to assess systemic barriers to family visitation, and develop and assist with the implementation of the Visitation Implementation Plan. DSS submitted a draft of the Visitation Implementation Plan on November 30, 2016, and upon receipt of feedback from the Co-Monitors and Plaintiffs' counsel, has completed several rounds of revisions and modifications. The Implementation Plan for visitation has not yet been approved by

the Co-Monitors, and the data required to set all interim benchmarks and final targets are not available.

B. Methodology, Data Collection and Validation

Although documentation of sibling visits is entered into CAPSS, the fields that capture this information were recently built, and have not yet been used to extract data or in management reporting. In order to ensure completeness and accuracy, in March 2017, DSS, USC CCFS and Co-Monitor staff began work to develop a methodology to collect baseline data for the FSA measures IV.J.2 and IV.J.3 related to family visitation. With the support of the DSS Visitation Workgroup, two review instruments were developed – the first to assess the frequency of visitation between siblings (IV.J.2.) and the second to assess visitation with parents for children with a reunification goal (IV.J.3.). These instruments were finalized in May 2017 utilizing Survey Monkey, a web-based survey tool used for collecting and analyzing data. An orientation for reviewers was conducted by Co-Monitor staff, and included training on review of a case file, appropriate documentation and instrument completion. A test case was completed to promote interrater reliability. Second level reviewers oversaw reviewers' completion of the instruments and any disparities in findings were conferenced and resolved accordingly.

Though reviewers were able to complete the review of cases with respect to sibling visitation and extract data as described below, a determination was made to halt the parent visitation review when concerns arose about the validity of the sample. DSS and the Co-Monitors agreed that DSS data with respect to cases of children statewide with a permanency goal of reunification was not accurate and needs to be verified before the review can proceed. This finding raised heightened concerns by the Co-Monitors about the accuracy of CAPSS data generally, as discussed more fully earlier in Section II of this report.

C. Performance Data

1. Sibling Visits

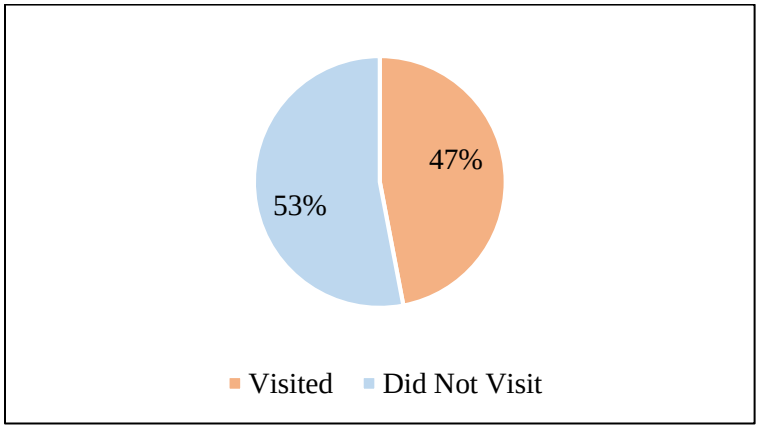
Section IV.J.2 of the FSA requires, "[a]t least 85% of the total minimum number of monthly sibling visits for all sibling visits shall be completed." The FSA also allows for exceptions if there is a court order prohibiting or limiting visitation, if "visits are not in the best interest of one or more of the siblings and the facts supporting the determination are documented in the case file," or with exceptions approved by the Co-Monitors. The Co-Monitors have approved the following exceptions to this visitation requirement:

Table 12: Approved Exceptions to Sibling Visitation Requirement

- Court order prohibits or limits sibling visitation
- Child or sibling is on runaway during a calendar month with best efforts to locate
- Child or sibling is incarcerated or in a facility that does not allow visitation despite efforts
- Child or sibling refuses to participate in the visit where age appropriate
- Sibling visit is infeasible due to geographic distance with efforts to provide alternative forms of contact. Geographic distance will only be allowed as an exception upon individual review of the applicable case by the Co-Monitors.
- County Director approval with legal consultation for determination that a visit poses immediate safety concerns for the child or sibling. If an immediate safety incident or concern occurs prior to or during a visit, the caseworker is to remove the child from the visit and notify the County Director afterward.
- Supervisory approval for determination that visitation would be psychologically harmful to the child [88]

In order to establish baseline performance, reviewers looked at a sample of 311 cases for which sibling visits were required in March 2017.[89] Reviewers determined that 143 children had visited with each of their siblings in the month and that there were nine cases to which a valid exception applied[90], resulting in a baseline of 47 percent. Of the 159 children who did not visit with all of their siblings, only 20 visited with any of their siblings. DSS will use this baseline to establish interim benchmarks and timelines to move toward the final target of 85 percent.

Figure 10: Visits Between Siblings Not Placed Together
March 2017
N=302



Source: June 2017 Case Record Review, USC CCFS and Co-Monitor staff

[88] A DSS supervisor must confirm the determination that visitation would be psychologically harmful to the child based upon written documentation of a clinical decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and who is not an employee of DSS. The LPHA's name, professional title, signature and date must be listed on the document to confirm the clinical decision.

[89] As of March 31, 2017, there were 1,609 children who had been in foster care for at least one month, with siblings in foster care with whom they were not placed. A statistically valid random sample of 311 cases was pulled based on a 95% confidence level and +/- 5% margin of error. Sibling groups were identified utilizing data in CAPSS which defines a sibling group as a set of children with the same CAPSS case identifier.

[90] One case was excluded because the child's adolescent sibling refused visitation and eight cases were excluded based on documentation that sibling visitation would be psychologically harmful to the child or sibling.

2. Parent Visits

The FSA requires, "[a]t 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…" (FSA IV.J.3.). The FSA also allows for exceptions if there is a court order prohibiting or limiting visitation, or with exceptions approved by the Co-Monitors.

Table 13: Approved Exceptions to Parent and Child Visitation Requirement

- Court order prohibits or limits parent visitation.
- Parent is missing or child is on runaway during a calendar month with best efforts to locate.
- Parent or child is incarcerated or in a facility that does not allow visitation in the calendar month despite best efforts.
- Parent refused to participate.
- Parent did not show up to visit despite attempts to successfully arrange and conduct the visit
- Parental rights were terminated in that month.
- Parent visit is infeasible due to geographic distance, with efforts to provide alternative forms of contact. Geographic distance will only be allowed as an exception upon individual review of the applicable case by the Co-Monitors.
- County Director approval with legal consultation for determination that a visit poses immediate safety concerns for the child. In addition, if an immediate safety incident or concern occurs prior to or during a visit, the caseworker is to remove the child from the visit and notify the county director afterward.
- Supervisory approval for determination that visitation would be psychologically harmful to the child.[91]

As discussed, data for this measure are not currently available. The Co-Monitors are deeply concerned about the lack of reliable data with respect to such a fundamental aspect of child welfare practice. DSS has informed the Co-Monitors of its plan to immediately update and validate these data within the second monitoring period.

X. HEALTH CARE

The provision of health care services to children in foster care is a fundamental obligation of child welfare systems. In order to fulfill this obligation, there must be reliable systems in place to determine when children are due for screenings and assessments, and, if treatment needs are identified, follow up to ensure the receipt of care. Though DSS has made significant efforts to update health information so that the needs of children in foster care can be appropriately tracked and addressed, there have been delays in the data collection and production, and DSS has struggled with planning for broader system and practice reform in this area. The Co-Monitors have

[91] A DSS supervisor must confirm the determination that visitation would be psychologically harmful to the child based upon written documentation of clinical decision issued by a Licensed Practitioner of the Healing Arts (LPHA) within the scope of their practice under SC State Law and who is not an employee of DSS. The LPHA's name, professional title, signature and date must be listed on the document to confirm the clinical decision.

continuously encouraged DSS to advocate for and engage all resources needed to move this essential work forward.

A. Health Care Improvement Plan

The FSA requires that by April 3, 2017, DSS, "with prior input and subject to approval by the Co-Monitors, shall develop a Health Care Improvement Plan with enforceable dates and targets for phased implementation and concerning initial screening services, periodic screening services, documentation, and health care treatment services for Class Members in the areas of physical health, immunizations and laboratory tests, mental health, developmental and behavioral health, vision and hearing, and dental health. The Plan shall address:

(a) Developing the capacity to track screening and treatment services for individual children and aggregate tracking data, including but not limited to screens that are due and past due;
(b) Assessing the accessibility of health care screening and treatment services throughout the State, including the capacity of the existing health care providers to meet the screening and treatment needs of Class Members; and
(c) Identifying baselines and interim percentage targets for performance improvement in coordinating screens and treatment services" (FSA IV.K.1.(a-c)).

The FSA provides that DSS may request an additional 60 days to complete the Improvement Plan if there is evidence of progress toward development of the Improvement Plan and approval by the Co-Monitors (FSA IV.K.2.). On March 31, 2017, DSS requested a 60 day extension until May 31, 2017, which the Co-Monitors approved with certain conditions, including that DSS engage an external health care consultant. The extension approval was based upon the work that DSS had completed in preparing the Improvement Plan, including creation of a Healthcare Work Group; improvements in the ability to track health assessments; completion of county surveys to identify providers being utilized for assessments and follow-up care; discussions with other states and two model assessment centers within South Carolina; and planned discussions with the Department of Health and Human Services (DHHS), South Carolina's Medicaid agency and representatives from Select Health, the Medicaid Managed Care Organization (MCO).

On June 1, 2017, DSS filed a Motion for Extension of Time for submission of the Improvement Plan, requesting an additional 120 days to submit the Improvement Plan. The Court approved this request and the new deadline for the Improvement Plan is on or before September 30, 2017. The Co-Monitors engage in frequent conversations with DSS around work to complete the Plan.

In addition to the Improvement Plan requirement, the FSA includes two compliance measures with deadlines set shortly after entry of the Agreement (FSA IV.K.4.(a)&(b)), both of which are

discussed below. All final health care outcome measures related to initial screening services, periodic screening services, documentation, treatment and other corrective services, will be identified by the Co-Monitors, with input from Parties, within 120 days after completion of the Health Care Improvement Plan (FSA IV.K.5.).

B. Performance Data

1. Initial Health Assessments

The FSA requires that by December 5, 2016, DSS "identify Class Members who have been in DSS custody for more than sixty (60) days as of the date of final court approval of the Final Settlement Agreement, and who have not had initial health assessments (physical/medical, dental or mental health). Within thirty (30) days after the identification period, Defendants shall schedule the initial health assessment for at least 85% of the identified Class Members" (FSA IV.K.4.(a)).

In May 2016, DSS began an effort to document, track and produce data reports for both health and educational outcomes for children in foster care, primarily through use of an Education and Health Passport. A Directive Memo issued on May 6, 2016 required a passport for every child in care be entered into CAPSS by July 1, 2016. In August 2016, a CAPSS redesign was implemented, providing discrete fields in CAPSS to capture physical and mental health screenings and follow-up and to produce data reports to track compliance, among other things. DSS has been responsive to Co-Monitor feedback about ongoing data issues in this area and the process to improve CAPSS functionality is ongoing.

On December 5, 2016, DSS provided reports to the Co-Monitors of children who were in DSS custody for more than 60 days on October 4, 2016 and had not had an initial health/medical, dental or mental health screening date entered into CAPSS. DSS acknowledged that the report was not fully accurate, as healthcare data for many children still needed to be entered. On January 9, 2017, DSS provided updates on the children initially identified in the December 5, 2016 cohort as requiring an assessment. These data subsequently required numerous rounds of data clean-up and validation by DSS, USC CCFS and Co-Monitor staff. For the majority of cases, between December 2016 and January 2017, information was entered into CAPSS that demonstrated that the child had the required health assessment (medical, dental or mental health) prior to October 4, 2016 but the data had not been timely entered. Performance data reported below reflects final analysis by DSS provided to the Co-Monitors on September 4, 2017.

Data analysis produced concerning results (Table 14). Performance for initial medical assessments was 10 percent, initial dental assessment was 15 percent and initial mental health assessment was

six percent[92]. For those children who did not have the necessary assessment completed by January 5, 2017, as of August 28, 2017, 54 percent had an initial medical assessment, 62 percent had an initial dental assessment and 59 percent had an initial mental health assessment. Further action to meet the health care needs of children in foster care continues to be a high priority for DSS.

Table 14: Completion of Initial Medical, Dental and Mental Health Assessments for Children
October 5, 2016 – January 5, 2017

	Total Applicable Children	Assessment Completed prior to 10/4/2016	Children requiring assessment after 10/4/2016	Assessment completed between 10/4/16 – 1/5/2017	Assessment Not Completed as of 1/5/2017	Compliance with FSA K.4.a. – Target 85%
Medical	2,918	2,750	168	16	152	10%
Dental	2,773[93]	2,083	690	102	588	15%
Mental Health	2,918	2,178	740	42	698	6%

Source: CAPSS Data Provided by DSS

2. Immediate Treatment Needs

The FSA requires that by January 2. 2017, DSS "identify Class Members with Immediate Treatment Needs (physical/medical, dental or mental health) for which treatment is overdue. Within forty-five (45) days of the identification period, DSS shall schedule the necessary treatment for at least 90% of the identified Class Members. (Immediate Treatment Needs means immediate non-elective physical/medical, dental or mental health treatment needs and documented assessment needs, excluding routine periodic assessments.)" (FSA IV.K.4.(b)).

This performance measure has not been met. DSS has informed the Co-Monitors that data for this measure are not currently available. The Healthcare Workgroup has been assigned the task of defining "immediate treatment needs" and DSS represents that enhancements are underway within CAPSS to capture and collect the necessary data. In the Co-Monitors and DSS's view, this is an area that demands urgent attention.

[92] For children under the age of three, completion of an initial medical assessment was considered compliant for the mental health assessment measure as a developmental assessment and screening is a component of their examination with a primary health care provider.
[93] For purposes of this analysis, children under the age of one were not considered applicable for an initial dental assessment. An oral examine is a component of their examination with a primary health care provider.

APPENDIX A

Glossary of Acronyms

CAPSS: Child and Adult Protective Services System
CFSR: Child and Family Services Review
CQI: Continuous Quality Improvement
DHHS: Department of Health and Human Services
DSS: Department of Social Services
FSA: Final Settlement Agreement
GAL: Guardian ad litem
IFCCS: Intensive Foster Care and Clinical Services
IO: Interim Order
MCO: Managed Care Organization
OHAN: Out-of-Home Abuse and Neglect Unit
QA: Quality Assurance
SC: South Carolina
TFC: Therapeutic Foster Care
USC CCFS: University of Southern Carolina's Center for Child and Family Studies

APPENDIX B

Co-Monitors Initial Monitoring Plan (February 1, 2017)

February 1, 2017

The Honorable Richard M. Gergel
United States District Judge
Post Office Box 835
Charleston, SC 29402

Via electronic mail

Re: ***Michelle H. v. Haley, et al. 2:15-cv-00134-RMG***
Initial Monitoring Plan

Dear Judge Gergel,

As court-appointed Co-Monitors pursuant to the Final Settlement Agreement ("FSA") in the above-referenced matter, Paul Vincent and Judith Meltzer are responsible for conducting a factual investigation and verifying documentation necessary for the issuance of public record reports on the state's performance with respect to the FSA performance requirements. *FSA, III.D.* The FSA requires that the Co-Monitors prepare an initial monitoring plan within 120 days of Court approval of the FSA. Since entry of the Consent Interim Relief Order ("Interim Order") entered on September 28, 2015, the Co-Monitors and Co-Monitor staff, Rachel Paletta and Elissa Gelber, have been working consistently and in collaboration with the Department of Social Services ("DSS") to implement the Interim Order and early FSA requirements, and gain a thorough understanding of the DSS child welfare system and related data. The attached table includes our preliminary decisions with respect to a monitoring plan.

As indicated in the attached table, there are a number of areas in which precise methodology has not yet been determined because decisions regarding relevant practice or measurement issues or interim benchmarks still need to be made and/or because of the absence of reliable baseline data. As such, we anticipate modifying the monitoring plan as needed over the next several months. The monitoring plan submitted to the Court today has been shared with both Plaintiffs and Defendants in draft form and incorporates their feedback. We will continue to involve both Parties as the plan evolves.

In addition to the specific monitoring activities described in the attached table, the following is a list of general monitoring responsibilities and functions that have been identified by the Co-Monitors after consultation with Parties. They reflect the interests of both Parties and the Court in regular, open communication and information sharing, and are integral to the Co-Monitors ability to assess progress and positively support DSS as it moves forward with the changes contemplated by the FSA.

Monitoring Functions and Responsibilities

- Meet regularly with DSS monitoring team and DSS leadership to discuss implementation progress and challenges: During the early phases of implementation, the Co-Monitors and key DSS staff charged with managing the implementation of the FSA reforms are meeting every two weeks by telephone or in person.

- Meet regularly with Plaintiffs' counsel to share information on FSA implementation progress and challenges, and to obtain their input on those areas requiring consultation and consent: Plaintiffs have requested, and the Co-Monitors have agreed to, quarterly meetings to keep them apprised of progress and discuss any issues related to FSA implementation and monitoring. We will also be sharing data and information related to implementation progress.

- Convene joint meetings with Parties: We expect to convene and facilitate joint meetings with Plaintiffs and Defendants three to four times a year. The first of such meetings will be focused on discussing Plaintiffs' feedback in regard to the Court ordered Implementation Plans.

- Continue to work with DSS to reach agreement on the definitions and appropriate application of exceptions to certain FSA requirements: Once these exceptions are agreed upon, data validation will be necessary to verify appropriate use.

- Support DSS in establishing and analyzing baseline data for those measures for which data are not currently available: Some measures will require a qualitative review or case record level analysis and validation.

- Consult with Judge Gergel and Judge Duffy: The Co-Monitors will inform the Court of FSA implementation progress and, if necessary, engage assistance in mediating disputes among Parties.

- Provide technical assistance and support to DSS as requested: The Co-Monitors have been working closely with DSS staff to establish the relationships necessary for effective monitoring and to support technical assistance. We have and will continue to facilitate peer learning with other states and localities that have approached similar issues and to connect DSS, where possible, with national and philanthropic resources. We also expect to support implementation through direct technical assistance by the Co-Monitors and their staff, in consultation with DSS.

- Meet with interested Parties and stakeholders throughout the state: The Co-Monitors have begun and will continue, in consultation with DSS staff and Plaintiffs, to meet with providers, including congregate care providers, and other relevant partners and stakeholders involved in child welfare system services and supports to Class Members.

- Conduct local office site visits as needed for monitoring: Monitoring activities with respect to many of the FSA requirements will include local office site visits to learn firsthand about implementation progress, barriers and challenges impacting Class Members.

- Participate/observe work group and other kinds of implementation meetings related to FSA implementation progress: The Co-Monitors and staff have already begun and will continue, in consultation with DSS staff, to participate in DSS led workgroups charged with developing Implementation Plans and strategies required under the FSA.

- Respond to inquiries: The Co-Monitors will respond to phone calls, letters and other inquiries from the public related to lawsuit progress and Class Members.

- Prepare required written monitoring reports to the Court and Parties.

- Engage in required dispute resolution functions as a result of findings.

- Participate in Court status conferences as needed.

We are available to discuss any questions you may have related to what is outlined above or in the attached document.

Sincerely,

Judith Meltzer

Paul Vincent

Judith Meltzer
Deputy Director
Center for the Study of Social Policy

Paul Vincent
Director
Child Welfare Policy and Practice Group

APPENDIX C

Workload Estimation Study Methodology (February 22, 2016)

METHOD FOR FOSTER CARE WORK LOAD STUDY

A. DSS seeks the approval by the Co-Monitors of the proposed Workload Study method. This method would include review and consideration of:

1. Caseload and workload provisions, standards and best practices from organizational publications including the Council on Accreditation and Child Welfare League of America
2. Data concerning current South Carolina Department of Social Services workloads and placement locations and other factors affecting workloads and time to conduct work in South Carolina
3. Data and case load limits in other areas, specifically including Tennessee, New Jersey, Washington, D.C. and Mississippi.
4. Workload study completed by Casey Family Programs in 2015
5. The workload study will include focus on the time needed and time available for workers to manage and complete current work and work anticipated as a result of the Michelle H. v. Haley Settlement Agreement but will not be a "time study." Rather, the time needed and time available portions will be considered based upon data regarding caseloads, current system performance, out-of-county placements and other trends; conclusions from other time studies and best practices; ancillary data from the placement study; input from workers, supervisors and administrators; comparison of worker tasks from other states; and specific conclusions concerning time needed/time available for South Carolina Department of Social Services as analyzed by Casey Family Programs
6. Casey Family Programs to conduct evaluation and enhanced analysis of information and data of sections 1-5 above specific to South Carolina.

B. The caseload study proposed would be followed with submission to the co-monitors of specific caseload/workload limits based upon the findings of the study to be completed by Casey Family Programs.

APPENDIX D

Placement Needs Assessment Methodology (December 27, 2016)

South Carolina Department of Social Services (DSS) Placement Needs Assessment

The Center for Child and Family Studies

February 1, 2017[94]

As part of its contract with the SC DSS, the Center for Child and Family Studies (CCFS) will conduct the Placement Needs Assessment following a plan approved by the SC DSS Internal Monitoring Team and the Co-Monitors. The needs assessment will be conducted to assist DSS in meeting its obligations under the Final Settlement Agreement in *Michelle H et al. v. Haley and Alford,* specifically determining the minimally adequate capacity and array of placements for meeting the placement needs of all Class Members. The Final Settlement Agreement requires the following:

> *D. Placement Resources*
> *D.1 Placement Needs Assessment. Within one hundred twenty (120) days, DSS, with prior input from and subject to approval by the Co-Monitors, shall perform a statewide and regional foster care placement needs assessment in order to determine the minimally adequate capacity and array of placements for meeting the placement needs of all Class Members. The needs assessment shall include specific recommendations addressing all the assessment's findings, including but not limited to recommendations that address the capacity to place Class Members close to their home community, placing Class Members in the least restrictive, most family-like placement, the number and array of therapeutic foster care placements, a system of tracking availability of beds in family foster homes, and matching of Class Members to placements that can meet their needs.*
>
> *Class Certification and Definition: Pursuant to the terms of this Settlement Agreement, this case shall be certified as a class action under Fed. R. Civ. P. 23(a) and (b)(2). The "Certified Class" shall be defined as follows: all children who are involuntarily placed in DSS foster care in the physical or legal custody of DSS either now or in the future.*

Both quantitative and qualitative strategies will be used in conducting the needs assessment. An in depth analysis of data on foster care placements from the DSS Child and Adult Protectives Services system (CAPSS) data system will lay the foundation for the assessment by providing information as to where SC DSS places its children in foster care. This quantitative data analysis and review will be followed by a qualitative data collection effort to assess the decision-making process, how

[94] The Placement Needs Assessment was approved on December 27, 2016 and was updated on February 1, 2017.

children are faring in foster care, and the impacts on children receiving higher levels of care. Findings will be reported to the agency and federal monitors on a monthly basis.

Quantitative Review of Foster Care Placements (Complete by January 31, 2017)

Analysis of Data from the DSS Child and Adult Protectives Services System (CAPSS) Data System

In order to determine where foster children are currently being placed, CCFS will conduct an depth analysis of placement data in CAPSS. CCFS statisticians will use SAS software to conduct an in depth analysis of CAPSS data to explore where children are placed by region and county and by various characteristics such as race, sibling group, age, level of care, type of placement, etc. DSS identified the following questions to be answered through the placement assessment process. Data analysis will be provided to the team on Excel spreadsheets. Each spreadsheet will be consistently documented as to the variables used, type of analysis conducted, sources and dates that the data represents. In addition, a booklet will be developed to document all of this information for all data analyses.

The in depth analysis will attempt to answer these questions as the data permits.

- Where are our children placed geographically?
  - Where children from each region are placed
  - The number of children placed out-of-home county/region
  - For out of county placements, location by county and region of placement and approximate distance from the home county
  - The types of placements in which children are currently residing
  - The number of placement resources, by type in each county
  - The licensed capacity of foster care providers in each county/region compared to the current census in the county/region
- How many children are placed with some or all of their siblings?
- What are the demographic trends for children placed in higher level of care as a whole?
- What percentage of children in foster care are discharged to a higher level of care?
- What are the trends around which children are placed in higher levels of care?

All quantitative data will be provided to the team on Excel Spreadsheets. Each spreadsheet will be consistently documented as to the items used, type of analysis conducted, sources and dates that the data represents.

Analysis of Available Data from the SC Quality Assurance (QA) Annual County Review Process (January 31, 2017)

In South Carolina, each county receives an annual QA review. Reviewers use the federal 18-item Onsite Review Instrument to rate cases. Where available 10 foster care and 10 family preservation cases are reviewed in each county. Results of these annual county reviews are compiled annually into a summative report. This report includes quantitative and qualitative data from the review process. SC began using the new 18-item federal onsite review instrument in March 2015; therefore, summative reports from March 2015 through October 2016 will be reviewed to glean

some preliminary information regarding the following questions relevant to the placement needs assessment study. A summary of item ratings for 2016 county QA reviews indicate:

System Strengths:

- Item 1 (Timeliness of Initiating Investigation) - 80% strengths
- Item 21 (Educational Needs of the Child) - 74% strengths
- Item 17 (Physical Health of Child) - 65% strengths
- Item 7 (Placement with siblings) - 65% strengths

Areas in Need of Improvement:

- Item 12 (Needs and Services to Child, Parents, and Caregivers) - 20% strengths
- Item 15 (Caseworker Visits with Parents) - 24% strengths
- Item 13 (Child and Family Involvement in Case Planning) - 31% strengths

Qualitative data from the 2016 QA reports will be analyzed and provided to DSS. DSS will examine the review findings for answers to the following questions:

- Why are children placed in level 2 or level 3 congregate care? Is it because of behaviors or a shortage of resources?
- If children are not placed with their siblings, why not?
- Why are children placed out of the county/region? Is it simply a lack of placement options? Is it because children from other regions are taking those beds? Are there resource or support shortages in certain areas? If yes, then what areas?

Qualitative Assessment of Foster Care Placements

Individual Interviews

A qualitative case study approach is proposed as the method of study to facilitate a better understanding of the experiences of those most directly involved in foster care as consumers, care providers, services providers, and agency staff. These cases studies tied with the broader statistical analysis will capture not only what is occurring in placement decision-making but also why it is occurring. The primary data collection method used in the case study approach will be individual interviews of the consumers, care providers, services providers, and agency staff involved in each case.

Qualitative case reviews of 90 children/youth will be conducted to assist the agency in learning more about the placement decision-making process and its impact on children in foster care across the state. Interviews will be designed to identify practice influences on placement decisions as well as an effort to reveal the effects of placement selection on children's current status. In addition, it

is anticipated that interviewers will learn how caregivers are sustaining stability as well as what caregivers need in external supports.
As described in greater detail below, in January 2017, the study team will finalize the interview protocol, sampling and training plan in consultation with the Co-Monitor. The interview protocol and case study analysis will be designed to answer the following questions:

- What are the child's underlying needs
- Does the child's current placement and placement history reflect a good understanding of the child's needs
- To what extent does the child's current placement provide the services and support needed to insure the child's, safety, well-being and permanency?
- What if any, additional supports/services are needed to stabilize the child's placement?
- If children are not placed with their siblings, why not?
- Why are children placed out of the county/region? Is it simply a lack of placement options? Is it because children from other regions are taking those beds? Are there resource or support shortages in certain areas? If yes, then what areas?
- What can we learn about the transition of children from placement to placement regarding group homes and foster homes? For example, from all placement moves? From group care placements to post-group care placements? Are there specific behaviors or characteristics present in these children?
- What is the decision-making process for placing children in a higher level of care?
- What are the resources needed and what shortages of resources exist that keep children from being placed in lower levels of care? At the outset when the placement is first being considered? After a child has been initially placed and a step-down to birth family or another less restrictive placement is being considered?
- Why are children placed in level 2 or level 3 congregate care? Is it because of behaviors or a shortage of resources? If it is because of the behavior of the child, what kinds of behaviors? Externalizing? Internalizing? Or an equal mixture of both? What supports are needed and, if those supports were available, how many of these children could be maintained in a therapeutic foster home placement?
- Why are children who are approved for therapeutic foster homes placed in congregate care instead? How often does this happen?
- Why would a child who is ISCDEC-approved for therapeutic foster care be placed in a congregate care placement instead?
- What are the permanency outcomes for children in therapeutic foster care compared with children in conventional family foster homes?

Sample selection. Ninety foster children from 10 counties will be selected for participation in the case study interview process. Two counties will be selected from each of the five regions across the state. This will facilitate a broad geographic representation of the state in the sample. Three steps are involved in the sampling process.

1. Extract the universe of children in foster care by county and by:
   - #/% of out of county placements
   - # of placements experienced by foster care children
   - #/% of siblings in care
   - #/% of placements in congregate care facilities
   - #/% of children in therapeutic foster care
   - # of licensed foster care families in the county by the length of time the foster home has been licensed
   - #/% of children in licensed kinship care
2. In collaboration with DSS staff, CCFS will select ten counties representing those with the high and low percentages of the variables listed above. This will allow a broad representation of these key variables in the sample.
3. Once the 10 counties have been selected, the universe of all children in foster care in these 10 counties will be extracted. These data will be stratified by placements in congregate care, therapeutic foster care, foster care homes, and relative foster care homes, and number of placements while in care. The sample will be chosen within each strata as follows:
   - 20 children who are placed in congregate care (other than short-term emergency shelter) or who were in group care within the past three months of the review
   - 20 children in therapeutic foster care or who were in therapeutic foster care within the past three months of the review
   - 20 children in family foster care placements who have experienced more than three moves in the past year
   - 30 children from other stable family foster home settings (including kinship care providers and foster parents who are caring for children with health and developmental issues)

   At this third step, a purposeful selection process will occur in an attempt to achieve a sample that includes children from each of the 10 counties of various ages, genders, races, and in and out of county placements. It is anticipated that foster parents who are known to provide long periods of stability for children in their care as well as foster parents who have recently experienced a child moving to a higher level of care or placement disruption will be interviewed as part of our sample. If not, these types of foster parents will be identified (possibly from counties other than those in the sample) and interviewed.

Development and Training of Review Teams. (February 2017)
USC CCFS will identify sufficient review staff to conduct the case reviews in February and March 2017 in pairs of two reviewers per case. Co-Monitors will support USC CCFS in this process by providing resources (people and curricula) for training reviewers. DSS wants to build capacity of DSS staff and partners by conducting the interviews with resources available in South Carolina.

Conduct qualitative case reviews (February through May 2017)
QA Review staff will conduct a Strategic Review of all 90 cases selected for interviews using the review protocol developed in consultation with Co-Monitor. Data collection for each case review

is expected take 2 days. Prior to the on-site review, USC CCFS will coordinate the process by identifying persons to be interviewed for each case and working with the assigned workers to obtain consents and schedule interviews. Review teams will begin review by reading the child's case record and then proceed to interview relevant persons in including child, parent, caregiver, assigned worker, and as relevant, therapist, school personnel and significant others. Priority will be given to interviewing the child in their placement setting
and family/parents/caregiver in their own homes.

Interview teams. A team will be selected to interview those associated with each of the 90 targeted cases. CCFS staff will be recruited as available to serve on teams and conduct interviews. If possible, additional interviewers may be recruited in specific areas of the state to assist with completing the qualitative case reviews. All interview teams will be trained in interview protocol as to how to ask questions and what prompts to use in soliciting needed details. The interview teams will first review the child's case record to help them better understand the circumstances of the child coming into care and current assessment results. Having this background information will help them focus their questions. Interview appointments for each person involved in the case (foster parents, clinicians, etc.) will be made and team members assigned to conduct the interviews. Teams will complete the interview protocols and narrative case summaries immediately following the case interviews. Each interview team will send the entire package of interview responses to the Needs Assessment Coordinator within five days of completing the interviews.

Data Collection. The entire interview process will be piloted with two cases to ensure processes are effective and efficient and produce the information needed for the placement needs assessment. After the pilot, interviews will be scheduled and conducted by county as much as possible.

Qualitative case review development process. Information collected from qualitative case reviews for each of the 90 cases will be reported using a case narrative format to include demographic information, a description of each child's issues, the manner in which placements were selected, and the child's current status (permanency, emotional well-being, educational progress, etc.). The case narrative form will be developed as part of the protocol development in consultation with the Co-Monitor. It will include a recommendations section to suggest whether the current placement option is appropriate to the child's needs identifying better options to the current placement. At the end of each review week, each interview team will present their case to the QA Director, research facility and other CCFS staff and reviewers to discuss information gathered to include the child and family history, case planning, caregiver supports and needs and to identify themes and trends. It is anticipated that the development of each qualitative case review narrative could take up to five days to complete including travel, case file review, interviews, development of the narrative, and debriefing.

Qualitative data analysis. The narratives will be summarized monthly answering questions posed in this proposal and describing trends regarding placement decision-making, child needs, services needed, placement settings needs and system effectiveness. A final summary report will be developed after the conclusion of the interview process.

Focus Group Interviews (Complete by May 31, 2017)

Focus group interviews with DSS employees and external stakeholders will be held at or near the end of the data collection process to bring together DSS staff or others who can help clarify questions identified through the case study process and to answer any of the questions posed in this needs assessment proposal that have not been answered through other avenues of data collection. All data collected through focus group interviews will be confidential except as otherwise required by law. Data from the focus group interviews will be analyzed and included in the final report.

Identification of the At-risk Population (Completed by June 30, 2017)

In addition, review of Medicaid data on the recent use of mental health services by Class Members will provide information on the approximate number/percentage of children in different counties who may be at risk for needing higher level placements or placement supports.

Service Array Surveys (Complete by May 31, 2017)

In order to assist the agency in determining the role insufficient clinical supports have on placements of children in distant, temporary, and non-family-based settings, the availability of intensive home-based mental health services in each county will be assessed. Each county will be surveyed about the local availability of such services, their quality and their responsiveness to individual needs. The service array survey will assist in answering the following question relevant to the placement needs assessment study as data permits.

- What resources exist across the state?

The service array survey developed in coordination with the SC DSS in 2009 will be adapted to assess the service array pertinent to placement. This online survey will rate services (grouped into categories) on their availability, quantity, quality, and importance. The online codebook will be adapted as needed to provide specific definitions and examples for each category of services. The code book will be shared with county staff completing the survey. Each DSS county office will be asked to form a team composed of up to five human service caseworkers, program coordinators, and/or supervisors to respond to the survey. Regional Adoption and Intensive Foster Care and Clinical Services staff will be included in various county office teams as directed by the State DSS Leader in charge of these areas. This will result in a unified survey response for each county. A summary report will be developed to document all of this information.

Report Findings (ongoing with final product due June 30, 2017)

The CCFS Team will provide monthly updates through phone conferences or face-to-face meetings with the Deputy Director of Child Welfare, the Director of Child Welfare Operations,

the DSS Internal Monitoring Team and the Co-Monitors. Summary reports of findings including trends will be shared monthly.

This process will provide the data needed for DSS staff to develop the Implementation Plans. CCFS staff will provide the findings and Recommendations will be developed through a discussion of findings with the DSS Internal Monitoring Team and the Co-Monitors.

Findings from all data sources will be compiled and discussed with the Deputy Director of Child Welfare, the Director of Child Welfare Operations, the DSS Internal Monitoring Team and the Co-Monitors at least quarterly. Recommendations will be developed jointly by CCFS project staff, the Deputy Director of Child Welfare, the Director of Child Welfare Operations, the DSS Internal Monitoring Team, and Co-Monitors. These recommendations will be included as part of the final report.

The final report will include recommendations in the following areas:

- the capacity to place Class Members close to their home community,
- placing Class Members in the least restrictive, most family-like placement,
- the number and array of therapeutic foster care placements,
- a system of tracking availability of beds in family foster homes, and
- matching of Class Members to placements that can meet their needs.