



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

**SUPPLEMENTAL REPORT:
SOUTH CAROLINA
DEPARTMENT OF SOCIAL
SERVICES**

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

July 27, 2023

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INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUMMARY OF PLACEMENT CRISIS

The *Michelle H.* Final Settlement Agreement (FSA) stipulates that children cannot sleep overnight in state offices and requires that DSS inform the Co-Monitors in the rare instances that this occurs. For the first several years of the lawsuit, the Co-Monitors were notified of a child sleeping overnight in an office about 10 times per year. In April 2021, DSS reported that across the state, an increasing number of children in its custody were sleeping in offices overnight because placements could not be found, even though the total number of children in foster care had declined from prior years. Between April 1 and September 30, 2021, 34 unique children were reported to be subjected to this practice over 68 nights. During the following period, from October 1, 2021 – March 31, 2022, the number climbed to an unprecedented 107 children experiencing 273 nights sleeping in DSS offices. This increase triggered the Parties to jointly enter into an Overnights Plan on March 23, 2022.⁸

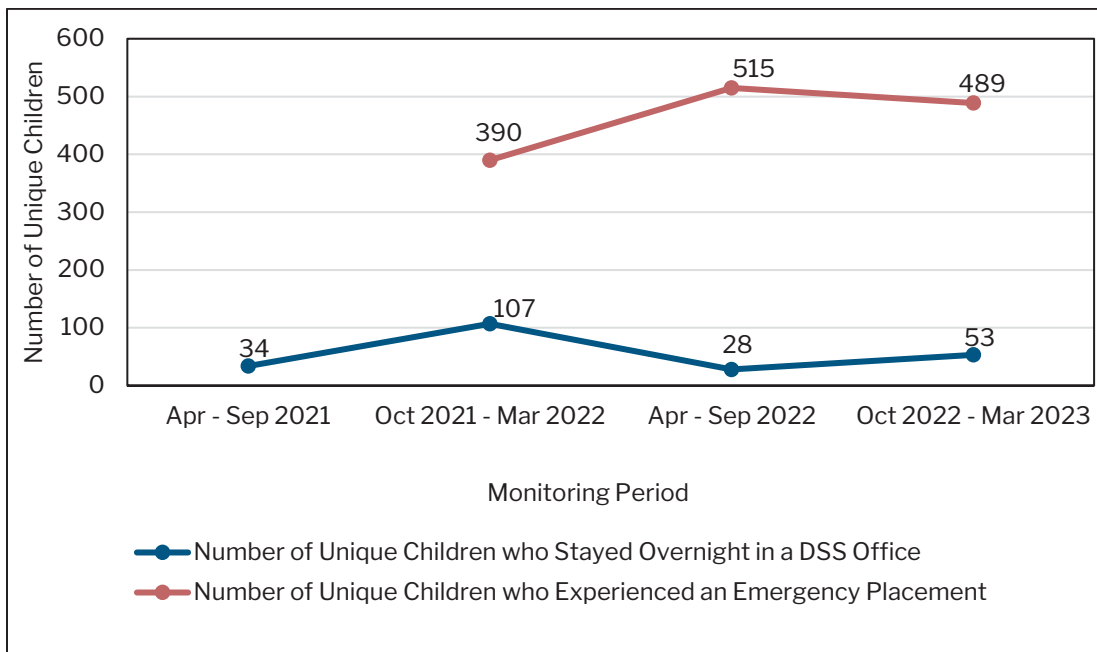
The Overnights Plan required DSS to accelerate several strategies already in place, such as updating policies and practice expectations for when approval of a Regional Director is required for placement decisions; increasing opportunities for training for kinship care coordinators; collecting more detailed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

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

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

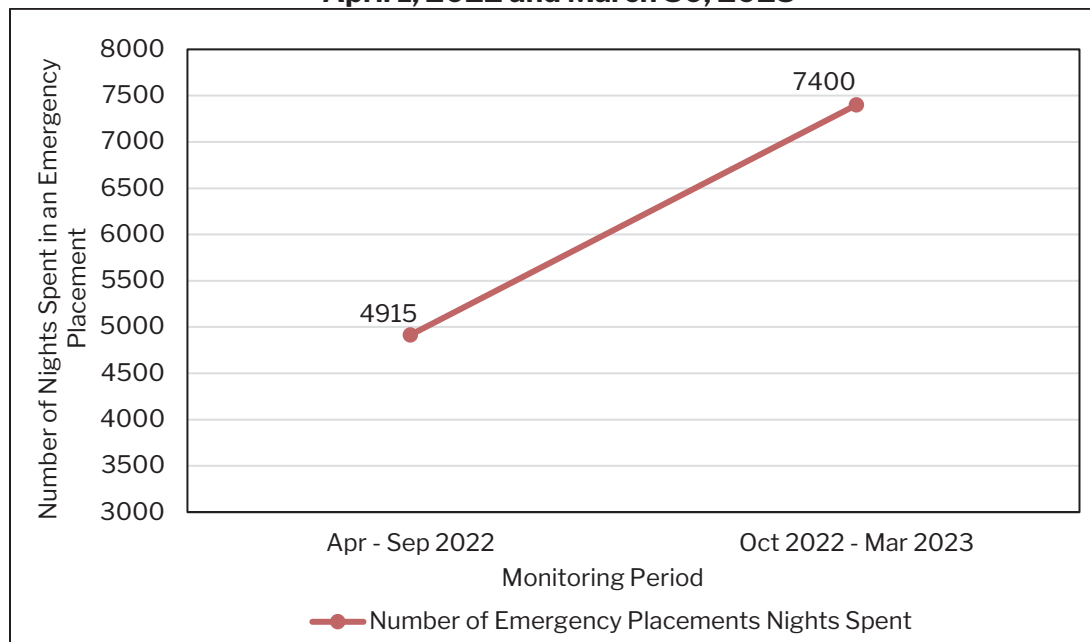
these children continued to spend their daytime hours in DSS offices, after being picked up early in the morning from their emergency placements, still waiting for a stable, welcoming placement to be found.

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



Source: DSS Data

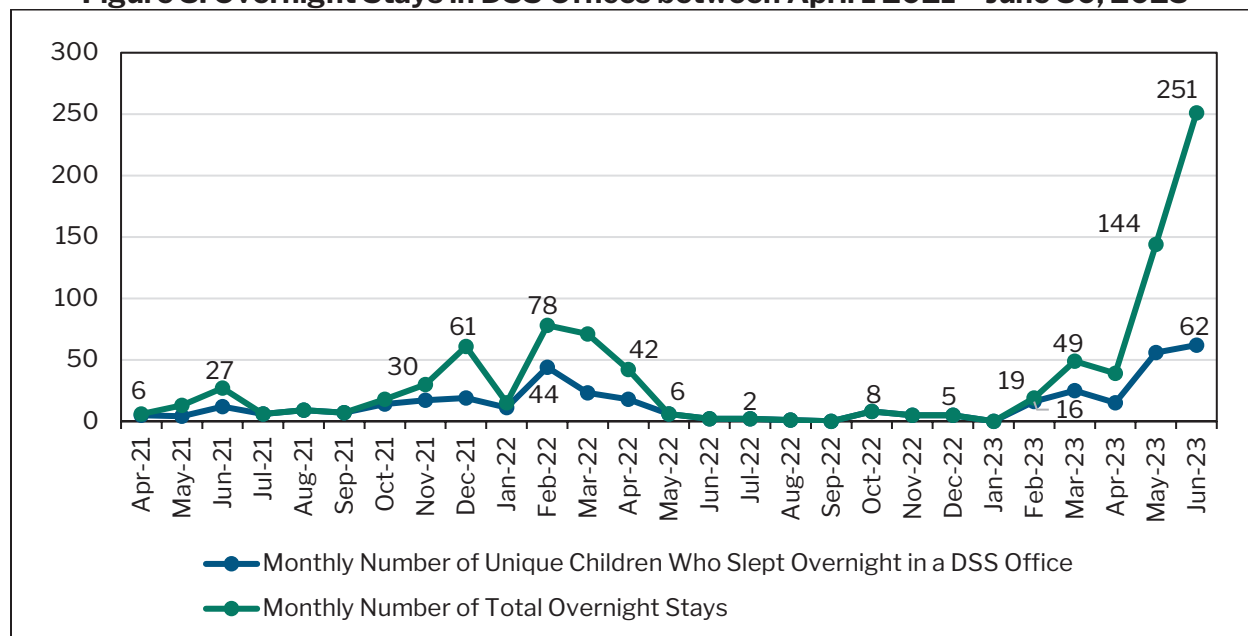
Figure 2: Number of Nights Spent in an Emergency Placement between April 1, 2022 and March 30, 2023



Source: DSS Data

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

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



Source: DSS Data

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

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

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

Source: UAs provided by DSS

*Totals may not equal 100% due to rounding

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

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

Source: UAs provided by DSS

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

Impact of Placement Crisis on Children and DSS Staff

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

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

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

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

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

Staff in one county reported to the Co-Monitors that they frequently work 12-hour days and could not recall a month when there was not a child living out of the office. One case manager expressed the dual emotional strain of feeling like she had failed the children on her caseload as well as her own family because she could not be present at home. A team leader¹⁰ agreed, "I am a single mom. My workers have small children of their own. I have workers saying, 'My husband told me to quit.' Some are separated [from their spouses] because [they say], 'My family can't handle me in this mindset,' or 'I can't address my own children's issues because I have to work.'" Workers who the Co-Monitors interviewed said that hiring additional workers to lower caseloads and increasing their salaries had helped them remain with DSS in these challenging times, but worried that these improvements would feel "meaningless" when children are living out of the office and there is no relief in sight.

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

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

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

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

FACTORS CONTRIBUTING TO PLACEMENT CRISIS

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

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

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

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

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

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

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

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

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

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

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

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

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

¹⁷ See *supra* FN 5

¹⁸ 2023 Annual Report. Joint Citizens and Legislative Committee on Children. (p.4) Retrieved from: https://www.sccommitteeonchildren.org/files/ugd/587cb7_d7971d16c4f14322810407008cb01fb_b.pdf

¹⁹ Ibid.

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

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

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

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

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

https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Improved Data Capacity to Capture Depth of a Placement Crisis

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

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

A Crisis that Feeds on Itself

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

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

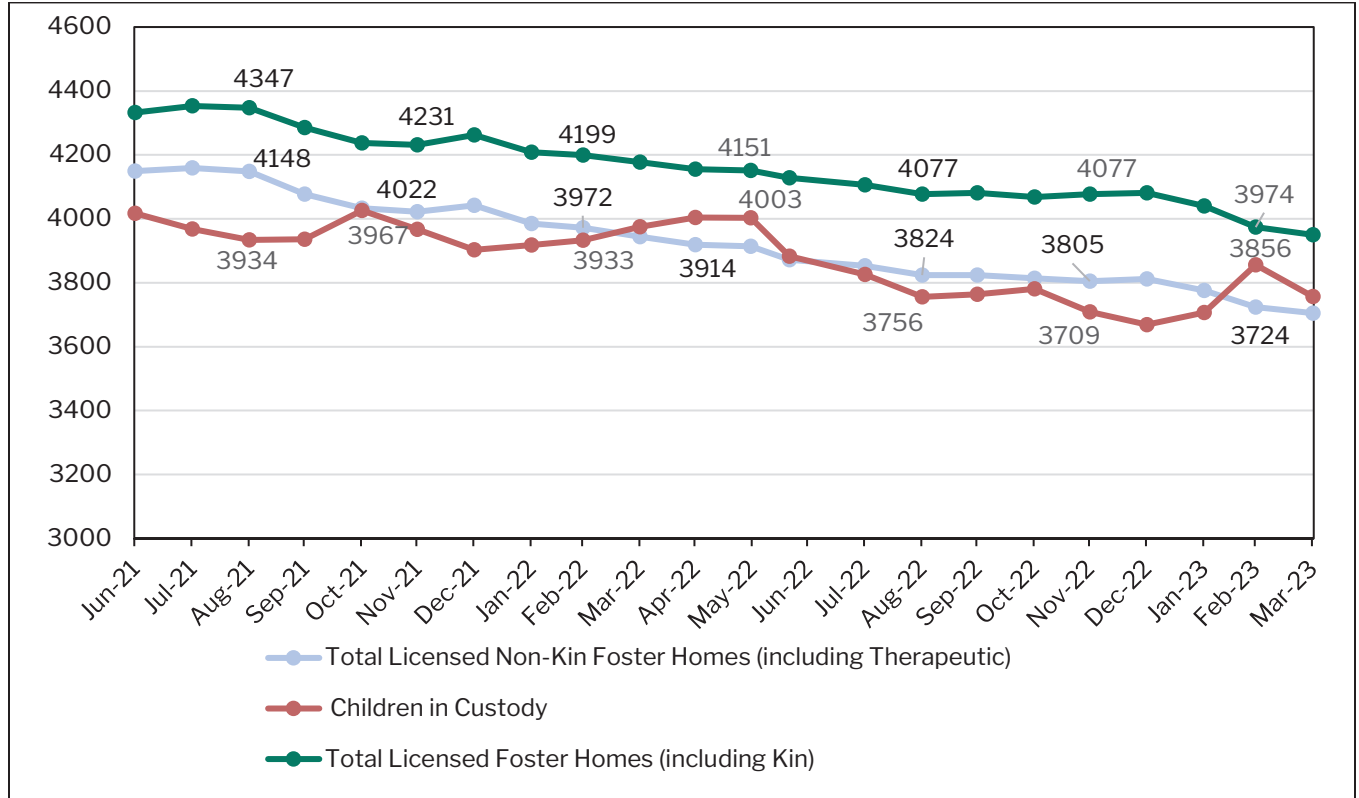
³⁰ Section 1905(i) of the Social Security Act defines an IMD as “a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”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

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

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

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

Figure 4: Total Licensed Foster Homes³⁴ as Compared to Number of Children in Custody³⁵ from June 31,2021 to March 31, 2023



Source: DSS Data

³² Though DSS requires foster families to have a child reside in their home during the prior 12 months to maintain their license, not all licensed homes accept children for placement at any given time.

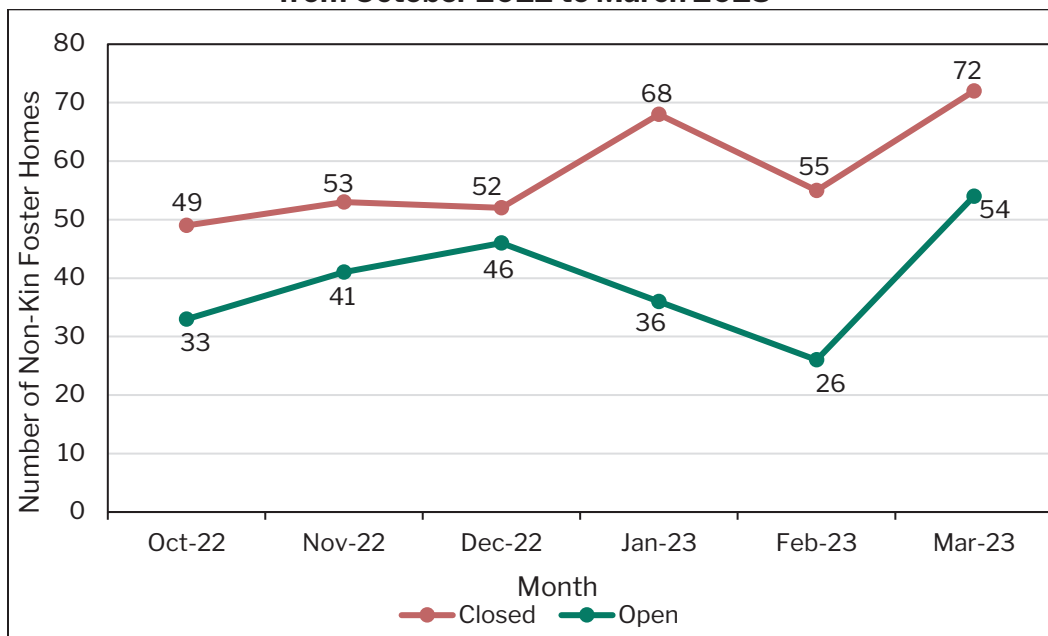
³³ The Co-Monitors have found that states that have worked to build up an adequate array of foster placements so that staff can match individual children with homes that can meet their needs and honor children's preferences have found that they need a buffer of at least twice the bed capacity as children in custody at any point in time. For example, as of June 2022, [New Jersey](#) had total bed capacity for 6,398 children in 2,834 licensed resource family homes (including kin homes), with 3,154 children in out-of-home placement. In 2019, [Oregon](#) calculated the additional capacity needed (with a buffer) for foster homes depending on level of care and average length of stay, and found that it needed 10,146 beds for the 7,500 children in custody.

³⁴ Approximately 10 percent of children are placed with kin in unlicensed placements. Data do not reflect these unlicensed kin placements.

³⁵ These data may include children in foster care who do not fall within the definition of Class Members ("all children who are involuntarily placed in DSS foster care in the physical or legal custody of DSS now or in the future" [FSA II.A.]) as per the FSA.

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

Figure 5: Total Non-Kin Foster Homes Opened and Closed Monthly from October 2022 to March 2023³⁶



Source: DSS Data

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

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

³⁶ These data exclude kin foster homes.

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

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

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

CURRENT DSS STRATEGIES TO ADDRESS PLACEMENT CRISIS

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

Prior to July 1:

- Targeted Foster Family Recruitment: DSS has been delivering training to private providers responsible for recruitment and licensing of foster homes on targeted practices for recruiting homes to support adolescents, youth who identify as LGBTQ+, and large sibling groups. After shifting its focus exclusively to the licensing of kin homes in July 2020, DSS re-initiated direct licensing of foster homes for these same populations in May 2023. DSS leadership is in the process of assessing the need for additional licensing staff to support these efforts.
- Access to Legal Representation for Parents: When parents have access to legal representation, their children are less likely to enter foster care and may be reunified in a timelier manner.³⁹ In January 2019, the Children’s Bureau revised its policies to allow child welfare agencies to claim administrative costs of legal representation for children who are candidates for title IV-E foster care and their parents in all stages of

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

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

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

- Small Test of Change (STOC) Strategic Co-Design: In Greenville, Anderson, and Spartanburg Counties, a national philanthropic consultant is supporting DSS and cross-sector stakeholders to design and test approaches to serve teens who may otherwise enter DSS custody related to status offenses, parent-child conflict, and/or allegations of behavioral issues. The STOC Design Team met at a two-day retreat in June 2023 to brainstorm priorities and solutions, and each county will begin implementing strategies discussed over the coming months.
- Implementation of Limited In-Home Supports to Prevent Foster Care Entry: DSS currently contracts with Homebuilders, Family Centered Treatment, and Brief Strategic Family Therapy (among others), and is planning to implement Intercept^{®41} – all evidence-based and well-supported trauma treatment models of home-based family therapy. These services are being used in accordance with FFPSA to help prevent entry into foster care, as well as to support children in custody through one-time Family First Transition Act (FFTA) funding. The number of contracted providers and availability for these services remains limited. In many states, these services are supported by Medicaid and such funding will be necessary to expand and sustain these contracts.

Beginning July 1, 2023:

- Increased Day Treatment Program Capacity: Though DSS recognizes that children are fundamentally in need of stable placements and normalized school experiences, DSS has launched a new day treatment program through a contractual arrangement with private providers, which began July 5, 2023. Contracts for the program include educational and treatment services to keep youth out of DSS offices during the day, or for youth in regular foster homes who cannot attend school. There will be capacity for 25 slots located in Columbia and 10 slots located in York County (beginning August) when at full capacity. The Columbia program currently has 15 slots.
- Case-level Support: A consultant has been engaged to review UAs and treatment information for youth with high placement instability to develop creative solutions to stabilize placement. In an effort to begin generating internal expertise, the consultant will work with a “Core Team” comprised of staff from Child Placement, Child Welfare Operations, and Child Health and Well-Being. This will begin with a review of five youth, with the possibility that the scope can be broadened.
- Sitter Support, Behavior Modification Specialist Support, and Licensed Therapist Support in selected DSS offices: A licensed therapist will be located in both Greenville and Richland counties to provide therapy services to youth in these and surrounding

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

⁴¹ See *supra* FN 26.

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

Beginning August 15, 2023:

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

Beginning Fall 2023:

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

RECOMMENDATIONS FOR ADDITIONAL STRATEGIES TO ADDRESS PLACEMENT CRISIS

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

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

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

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

Stop Gaps

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

1. Allow Local Flexibility in Placement Decision-Making for Best Interests of Child: Counties should be permitted flexibility in making local decisions to accept emergency placements if they are not in the child's best interest. Children should not be driven (nor should case managers be expected to drive children) significant distances at night for an emergency placement for the sole purpose of avoiding an overnight stay in an office. Additional staffing may also be temporarily needed in offices with high numbers of unplaced children.
2. Modify Expectations for Emergency Incentive Payment: DSS should adjust requirements for receipt of emergency incentive payments to foster parents, to include basic standards of care, including requirements around minimum stays, meals, and access to medications and showers. Consideration should be given to developmental needs of adolescents, including maintaining reasonable access to phones, and maximum times/month a single foster caregiver can be granted emergency incentive payment.

Other Immediate Actions

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

⁴³ The Co-Monitors acknowledge that this recommendation could reduce compliance with the *Michelle H.* settlement agreement for a short period of time, but believe it could reduce harm to children currently shuffled through emergency placements, and reduce driving time for staff.

⁴⁴ For more information on FAST and CANS see: <https://praedfoundation.org/tcom/tcom-tools/the-child-and-adolescent-needs-and-strengths-cans/> (retrieved Feb. 7, 2023)

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

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

Short-Term (3-6 months)

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

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

3. Develop and Implement Creative Approaches to Recruitment of Additional Foster Parents: Consideration should be given to the use of professional foster parents,⁴⁶ who could be paid full-time (whether beds in their homes are filled or not) to care for children without placement and those with higher needs. DSS should explore and adopt innovative ideas for targeted recruitment efforts,⁴⁷ quickly determine if additional staff are needed for foster home recruitment and, if so, create positions to increase internal staffing. DSS should add internal licensing staff as determined necessary to increase foster parent licensing, particularly in light of the additional tasks taken on by licensing unit in response to the placement crisis.⁴⁸
4. Expand and Improve use of Pre-Removal Child and Family Team Meetings (CFTMs) and Risk of Placement Disruption CFTMs: DSS leadership and staff report that convening a CFTM prior to a child's removal into foster care has been effective throughout the state at keeping families together and identifying kin and other family resources. These CFTMs should be mandated before or upon placement, with regularity and in accordance with the GPS case practice model. We recommend DSS engage technical assistance (TA) support in the form of external expert consultation around the assessment of underlying needs and innovative problem-solving strategies with families, including use of flexible funds that could meet the needs of families to avoid family separation. This work can begin in Richland, Spartanburg, and Greenville, and extend to counties that reach a designated level of overnight and emergency placements. Consideration should be given to the initial CFTM being in-person rather than virtual, unless it impedes the participation of the parent or child. Intensive TA support should be made available to these counties to craft individualized services and solutions.
5. Increase the Availability and Accessibility of Flexible Funds: Simple guidelines for use and access of flexible funds should be immediately available to staff, along with brief training to fiscal staff (which can be integrated into TA work described above). Successful implementation will require funds to be available to children experiencing instability in placement, to support families to prevent placement into foster care, and to speed up reunification. Funds should be used for things that are not currently funded through other state and federal funded programs and available for concrete supports and non-traditional services and supports to meet needs identified by children and their families. As described above, flexible funds should be available to

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

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

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

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

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

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

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

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

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

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

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

Medium-Term (6-12 months)

1. DHHS should fully remove the RBHS Moratorium to Allow for Expanded Therapeutic Supports: As discussed above, DHHS put a moratorium on the enrollment of new providers of RBHS in 2015, in response to concerns about a lack of quality and accountability controls after policy changes had been introduced in July 2014. DHHS subsequently extended the moratorium and, as the Co-Monitors understand it, it remains formally in effect. The moratorium has contributed to the inability of DHHS to assure that the services to which children are entitled under federal EPSDT provisions are available. Until the moratorium is lifted, DSS's ability to expand its service array will be severely limited, as providers have long advocated. In addition to lifting the moratorium, DSS and DHHS must make active efforts to engage potential RBHS providers through capacity building grants. Select Health will also be an important partner in enrolling new providers on its panel as needed, since RBHS became part of the MCO's responsibility in July 2016.
2. Begin Expanding Provision of Therapeutic In-Home Services, Funded Through Medicaid: Once the RBHS Moratorium is lifted in January 2024, capacity building to expand needed in-home services can begin with selected providers to ensure the development of adequate skills and capacity to stabilize placements. Therapeutic supports, including access to evidence-based services like Homebuilders, FFT, FCT, MST, and Intercept should be made available to children who do not have placements and/or who are at risk of instability in their placement setting. This work should be done collaboratively with DSS, DHHS, and private providers, with initial start-up costs covered through provider grants. All consideration should be given to how services developed could be funded through Medicaid (see long-term recommendation #1). Rollout can begin in Richland, Spartanburg, or Greenville, with statewide rollout to follow.
3. DHHS and DSS should Assess Use of Existing Waiver and Explore Potential Enhanced Partnership with Continuum of Care: In June 2021, the SC Continuum of Care (COC), through DCA, was granted a Medicaid Section 1915 (c) Palmetto Coordinated System of Care (PCSC) Home and Community Based Waiver for children. This allowed children and youth who would otherwise be served in inpatient psychiatric settings to receive a range of intensive behavioral health services and supports in their homes and communities. The waiver is intended to serve individuals up to age 21 with serious emotional disturbances who meet a hospital level of care, but it is unclear which and

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

4. Reassess Current Placement and Leveling System: DSS should work with the Co-Monitors and their internal CQI team on a process for assessing its system for placing children and assigning their levels of care. The assessment should include consideration of alternatives to the current leveling approach, frequently based on placement availability and a child's current behavior, rather than the underlying needs of children. The assessment should also include an analysis of the Interagency System for Caring for Emotionally Disturbed Children (ISCEDEC) clinical assessment and eligibility process, with input from private providers who utilize these assessments. Work to evaluate and improve this system can help inform a determination about a useful mechanism for measuring compliance with FSA therapeutic supports and placement measures⁵² and requirements from the Health Care Plan Addendum which assesses DSS's performance in meeting children's therapeutic and well-being needs.

Long-Term (12-24 months)

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

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

⁵¹Application for a §1915(c) Home and Community- Based Service Waiver: SC.1688.R00.02. (2021). To see the application, go to:

<https://www.scdhhs.gov/sites/default/files/documents/PCSC%20Waiver.PDF>

⁵² FSA IV.B.I(2-5)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Partner with Department of Education (DE) around School-Based Support: DSS should identify barriers to a more robust partnership with the school system to determine appropriate roles for intervention. For example, teachers are mandatory reporters to Child Welfare Services when they suspect child maltreatment, but do not necessarily receive effective training around the consequences of an investigation, or what services or supports could be made available to families to prevent maltreatment and entry into foster care. A more robust DSS – DE partnership could also improve coordination for supports to children in foster care with IEPs or 504 plans. This could build on the productive work on a case-level of the Regional DSS Well-Being teams.
4. DHHS should utilize “In Lieu of Services” Option (ILOS): On January 4, 2023, CMS issued guidance offering states the option of utilizing Medicaid managed care programs to reduce health disparities and address unmet health-related social needs (HRSNs), such as housing instability and nutrition insecurity, through the use of supports offered “in lieu” of a service or setting (ILOS) covered under the Medicaid State Plan. This makes ILOS an important tool for utilizing Medicaid funding to effectively support families through services for which reimbursement has not traditionally been available, including resources for permanent supportive housing, environmental modifications, medically-tailored meals, and lactation consultants, among other things.⁶² When used effectively, such services can be used to prevent entry into foster care, speed up reunification, and ensure families, particularly kin providers, have the supports to safely maintain their families. Though DHHS had previously expressed an interest in utilizing the ILOS option as a means of developing services for children in foster care, this has not occurred. South Carolina should consider models that have already been implemented in jurisdictions across the country that are effectively helping to meet families’ needs through the use of ILOS.⁶³

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

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

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

5. Expand Network of Behavioral Health Providers for Children in Foster Care: The expansion of a network of quality behavioral health providers available to children in foster care as well as in the community will require the sustained partnership of DMH, DDSN, DHHS, community healthcare providers, Select Health, hospitals, and other stakeholders. An important step will be a needs assessment to determine the extent to which Medicaid rates paid by Select Health are sufficient and/or impeding the availability of high-quality providers. It will also be important that providers understand the unique needs of children involved with a child welfare agency. DSS should consider models in other jurisdictions that leverage Medicaid's ability to establish standards for providers, in collaboration with contracted MCOs.⁶⁴
6. DHHS should ensure Select Health Performance with Respect to Obligations in Michelle H. Health Care Plan and Care Coordination Addendum: As the sole MCO serving the majority of children in foster care in South Carolina, Select Health took on significant obligations pursuant to Court-entered plans for ensuring the physical health and behavioral needs of these children are met.⁶⁵ These responsibilities include, among other things, accountability for building out an appropriate service array and serving as health care coordinators, ensuring that children and families have timely access to services without long waitlists, and working in partnership with DHHS and DSS. DSS should have access to detailed information about what services children in their custody are receiving under the MCO contract. An evaluation of whether Select Health is adequately performing the functions to which they committed is long overdue, and work should be done to ensure obligations are met.

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

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