COMMITTEE *on* CHILDREN

2022 Annual Report

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Governor Henry D. McMaster
President Thomas C. Alexander
Speaker James H. Lucas
Members of the General Assembly,

We believe how we treat children is the most accurate indicator of our state's future.

The Joint Citizens and Legislative Committee on Children is pleased to present its 2022 Annual Report. The Committee is charged with identifying and studying key issues affecting South Carolina children and making recommendations to the Governor and General Assembly.

The 2022 Annual Report includes topics of concern identified by Committee members, stakeholders, partners, and constituents. The Committee on Children's statewide public hearings are an important source of information and provide insight on citizens' concerns regarding our state's children. Stakeholders made clear the COVID-19 pandemic's wide-ranging impacts on children and their caregivers. The pandemic has exacerbated existing issues affecting children and created new ones.

This year's report is organized by three themes: children's mental health, juvenile justice reform, and child well-being. These three issues were raised repeatedly to the Committee by parents, constituents, and professionals. The report outlines needed efforts to:

- expand access to and better coordinate children's mental health services;
- provide youth better access to birth certificates and counsel in child welfare cases;
- adopt the Committee-endorsed Juvenile Justice Reform Act and add statutory factors recognizing "kids are different" for family court judges to consider in determining whether to transfer juveniles to General Sessions court.

The Committee's recommendations range from narrow statutory improvements to broader, long-term reform; all address current issues affecting South Carolina children. We are honored to work on their behalf and aim to improve their lives, expand their choices, and facilitate their ability to thrive in this state.

Brad Hutto

Brad Hutto, Chair

Neal A. Collins

Neal A. Collins, Vice-Chair

Committee Membership

APPOINTED BY THE PRESIDENT OF THE SENATE

- **Senator Brad Hutto**, Orangeburg
- **Senator Katrina F. Shealy**, Lexington
- **Senator Darrell Jackson**, Columbia

APPOINTED BY THE SPEAKER OF THE HOUSE

- **Representative Neal A. Collins**, Easley
- **Representative Beth E. Bernstein**, Columbia
- **Representative Raye Felder**, York

APPOINTED BY THE GOVERNOR

- **Mr. W. Derek Lewis**, Greenville
- **Dr. Kay W. Phillips**, Summerville
- **Mrs. Bronwyn McElveen**, Sumter

EX OFFICIO

- **Michael Leach**, Director - *Department of Social Services*
- **Michelle Fry, JD, PhD, LLM**, Director - *Department of Disabilities and Special Needs*
- **L. Eden Hendrick**, Director - *Department of Juvenile Justice*
- **Kenneth Rogers, MD**, Director - *Department of Mental Health*
- **Molly M. Spearman**, State Superintendent of Education

COMMITTEE STAFF

- **Shealy Reibold**, Senior Resource Attorney
- **Morgan Maxwell**, Legislative Resource Attorney

CHILDREN'S LAW CENTER LEADERSHIP, UNIVERSITY OF SOUTH CAROLINA SCHOOL OF LAW

- **L. Michelle Dhunjishah**, Director
- **Carolyn S. Morris**, Assistant Director

2021: Year in Review

JCLCC LEGISLATION ENACTED

During the first year of the 2021-2022 session, the Committee on Children worked toward legislative and policy reforms to improve protections for children and use limited public resources more effectively. The Committee sponsored or endorsed the following bills that ultimately passed:

ACT NO. 24 (H 3567)

- Aligns child welfare practices with **federal requirements** in the Family First Prevention Services Act to ensure that South Carolina receives associated federal Title IV-E funding for preventative services that will keep children at home instead of in foster care.

ACT NO. 28 (S 229)

- Mandates the use of the **statewide child abuse response model protocol** during the investigation and prosecution of a known or suspected crime against a child.

ACT NO. 45 (S 231)

- Requires public schools and public and private institutions of higher learning to add the phone number for the **National Suicide Prevention Lifeline** to student identification cards.

A number of other committee bills received hearings and prompted discussion, public debate, and study of key children's issues including recognizing fictive kin, extending foster care, extending professional licensure to those lawfully present in the US, and increasing sex buyer penalties.

2021 PUBLIC HEARINGS

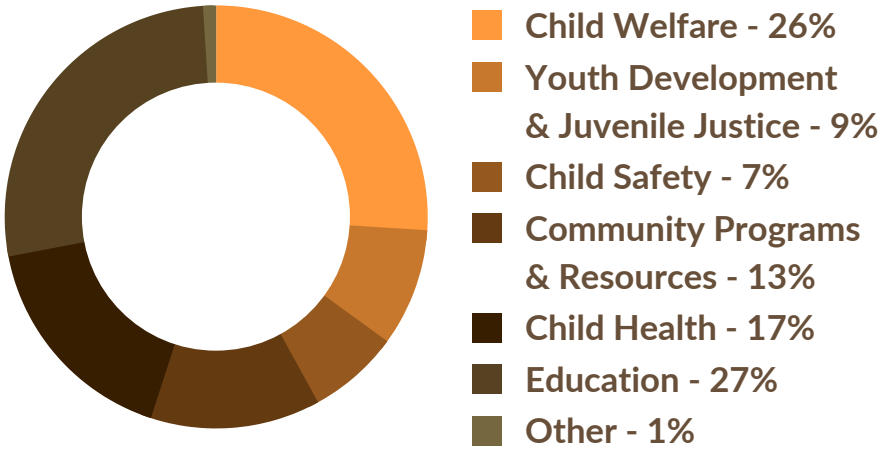
Each fall, the Committee on Children holds public hearings across South Carolina to receive testimony from parents, local stakeholders, and other children's advocates. These open-forum, town hall-style hearings allow committee members to hear directly from the public about children in local communities and yield vital information to guide future decisions.

Five regular public hearings were held in 2021– two in Columbia and one each in Charleston, Greenville, and Florence. Those testifying were able to do so virtually or safely in-person adhering to appropriate health protocols. The Committee heard nearly 10 hours of testimony on a range of topics: the pandemic's effects on schools and children, juvenile justice reform, affordable childcare, compensation and benefits for childcare workers, youth homelessness, child sex trafficking, and much more. Additionally, the Committee received over 40 pieces of written testimony totaling nearly 400 pages.

COMPENDIUM

The Committee on Children annually produces a compendium of all child-related legislation introduced in session that year to keep members updated about additional bills that may warrant their attention and support. At the close of each legislative year, the compendium is also shared with stakeholders interested in following the work for children at the S.C. State House.

2021 PUBLIC HEARING TESTIMONY TOPICS



School-Based Mental Health

THE ISSUE

Mental health is an important part of child and adolescent well-being and has the potential to influence child outcomes and experiences.[1] Mental health concerns among children are linked to adverse outcomes such as poor academic performance, behavior, and relationship building skills.[2] Approximately 1 in 6 children (ages 6 to 17) experience a mental health disorder annually.[3] Mental health concerns among children and adolescents have grown at an alarming rate since January 2020, demonstrating the detrimental effects of the COVID-19 pandemic on children's mental health.[4]

75% of children who receive mental health services access them in schools.[5]

Schools are an ideal setting for addressing student mental health. Children are **21 times more likely** to receive mental health services when offered at school as opposed to community health clinics.[6] School mental health (SMH) services offer students the ability to receive mental health counseling from trained professionals without having to leave their school for appointments.[7] **School-based mental health** removes key barriers to receiving services, such as lack of transportation and scheduling conflicts.[8] The benefits of SMH services include improved academic performance, social outcomes, and overall health outcomes.[9]

The South Carolina Department of Mental Health (DMH) provides SMH services in approximately half of South Carolina's schools.[10] Traditionally, master's level therapists render these services while embedded in schools.[11] Approximately twelve school districts are approved to offer their own Rehabilitative Behavioral Health Services (RBHS), which include SMH services, in house; only a few bill for these services.[12] Other districts use a combination of school employees, DMH, and third-party providers.[13] Mental health services are not available in every school.

While fully-insured plans in South Carolina tend to cover these services, other insurance plans vary.[14] Despite the services being covered by policy, insurance plans can deny reimbursement for SMH services for a variety of reasons: the provider is not accepted as in-network, the services are not provided in the correct setting, the medical necessity determination is not approved, or deductibles have not been met, among others.[15] These denials mean many families with private insurance have to pay out of pocket.[16]

As to coverage by other insurance policies in the state, the state employee State Health Plan, which Blue Cross Blue Shield South Carolina (BCBSSC) administers, covers SMH if DMH provides the services.[17] Medicaid covers SMH services for children as well, and Medicaid beneficiaries make up the majority of students currently receiving services.[18] The State Health Plan and Medicaid can deny payment for a claim for many of the same reasons as private insurance. However, Medicaid-contracted providers cannot bill patients for the outstanding balance after Medicaid pays its rate, which protects this population from receiving bills.[19]

Finally, approximately five percent of South Carolina children remain uninsured.[20] Others have insurance that does not cover SMH services. These families are offered payment on a sliding scale when costs are discussed up front with parents.[21] DMH does not deny services to any child regardless of ability to pay, and many families cannot afford to pay for school-based mental health services.[22]

> **When parents cannot pay, DMH absorbs the loss - $1.87 million in FY2020, and $1.85 million in FY2021 – in its budget.[23]**

DMH struggles to hire and retain licensed master's level therapists for school-based services.[24] DMH loses many therapists to school districts, which offer ten months of work, higher salaries, and the opportunity to pursue additional roles like school counselor.[25] In contrast, DMH therapists work twelve months at a lower salary as a master's level therapist.[26] The increase of telehealth and other opportunities outside the agency with higher pay also contributes to workforce shortages.[27] School districts also report difficulty retaining staff to perform these services.[28]

The pandemic combined with the increasing need for SMH services and workforce shortages created a perfect storm for children's mental health. In response, Governor McMaster ordered the Department of Health and Human Services (DHHS) to conduct a comprehensive review of DMH's SMH program by Executive Order dated January 12, 2022. The General Assembly must be prepared to address SMH services after reviewing the DHHS audit recommendations and conducting additional research and investigation to ensure children can access SMH services without fear of out-of-pocket costs.

OUR RECOMMENDATIONS

We recommend continued investigation of school mental health services, including the current framework and funding. This review should include but not be limited to:

- **The DHHS audit report and recommendations stemming from** Governor McMaster's executive order. These results will be available in spring 2022.
- **The state Department of Education's school district survey on school mental health services and resulting data.** These results should be available in spring 2022.
- **Other data or resources informing all aspects of school mental health services in South Carolina.**

PUBLIC HEARING INPUT

"[T]he less visible but equally devastating impact on our children is the social and emotional toll of the pandemic. Across our state, teachers and medical professionals can tell you we are seeing increased numbers of children suffering from stress, anxiety, and depression . . . And even in schools that do provide mental health services, oftentimes families find themselves faced with an out-of-pocket expense for an in-school service."

Coordination of Mental Health Services

THE ISSUE

Children receive mental health services from a variety of providers, such as the child's primary care provider, a school mental health counselor, or through public and private community mental health services.[1] The mental health services a child receives from a primary care provider and school are often different but complementary.[2] The primary care provider is likely to provide mental health services by screening for conditions, educating parents, and determining whether the child would benefit from medication and/or therapy services.[3] A school-based mental health therapist from the Department of Mental Health can assess, diagnose, intervene, and treat with services on site at school or in a community setting.[4] A school district employee can also provide some of these services depending on his or her licensure and school resources, including assessing the relationship between a child's mental health issues and student performance and developing an Individualized Education Plan (IEP) to address the educational and psychosocial needs of students.[5]

While expanding access to mental health services is a laudable goal, providers often experience difficulty collaborating and communicating in order to provide consistent services to a child due to:

- administrative and fiscal pressures that limit the time for collaboration;
- differences in expectations, culture, and language between educational and health professionals that make it difficult for them to communicate;
- privacy laws that may pose challenges for the exchange of information across systems; and
- the absence of organizational structures to facilitate communications between systems.[6]

When these services are siloed by provider and location, parents are often left to coordinate their child's care and facilitate communication between different providers when they are not equipped or lack the resources to do so.[7] The fractured nature of treatment by multiple providers, with a lack of communication between them, can result in disjointed, fragmented, and inconsistent treatment for children.[8]

While collaborative methods, such as patient-centered medical homes, are utilized in South Carolina, communication and integration of records and systems remain a challenge.

SOUTH CAROLINA EFFORTS

The **MUSC Boeing Center for Children's Wellness (BCCW)** implements School-Based Wellness Initiatives in the Lowcountry and other districts across the state[9] to address the lack of communication and collaboration between providers inside and outside the school system as part of a new $2 million grant to address mental health needs in the Charleston County School District.[10] BCCW is developing a unique communication tool that will allow schools, providers, agencies, and organizations caring for an individual student to communicate and collaborate on the student's care.[11] This tool will require electronic consent from a child's parent or guardian given at one time for all the providers involved with the child's care.[12] It will not include the child's entire chart, but instead, share a confidential and relevant selection of records with the child's providers in common.[13]

The Department of Health and Human Services' (DHHS) **Quality through Technology and Innovation in Pediatrics (QTIP)** program through South Carolina Medicaid works with self-selected pediatric providers to improve health care for children in South Carolina by working on quality measures and incorporating mental health screening and coordination into a medical home.[14] QTIP works with pediatric and community providers on a case-by-case basis to facilitate the sharing of information between providers.[15] Program staff often share the American Academy of Pediatrics' Primary Care Referral and Feedback Form[16] as an example of how to coordinate information sharing between the referring entities and the provider to whom a patient is referred.[17] While this form is helpful, it is a piecemeal process and potentially cumbersome, given the move in health care to electronic health records.[18]

OUR RECOMMENDATIONS

Coordination of student mental health services is more imperative than ever because of the COVID-19 pandemic.

The General Assembly may consider future changes to the state's school mental health services program after DHHS releases its audit recommendations. Anticipating these changes, **we recommend the General Assembly, agencies, and school districts prioritize coordination of mental health services by**:

- **Tracking the development and results of the MUSC BCCW's work on a tool to measure its viability** - whether it is successfully adopted by providers, its ease of use and access, and whether it could be scaled statewide at a cost acceptable to all parties. Any tool selected for broader use should be able to interact with different electronic health records systems utilized by SC providers so they can enter changes to patient care or prescriptions, and other providers can view them.
- **Developing a universal electronic privacy release** acceptable to all agencies involved in school mental health and major health systems in South Carolina that is compliant with HIPAA, FERPA, Medicaid privacy laws, and other applicable privacy laws. If separate releases are necessary, they should be drafted while keeping in mind the already cumbersome number of forms involved and the goal of increasing the accessibility of documents.
- **Developing a universal record sharing form** along the same lines as the privacy release, with the goal of encouraging collaborative care and sharing of information.

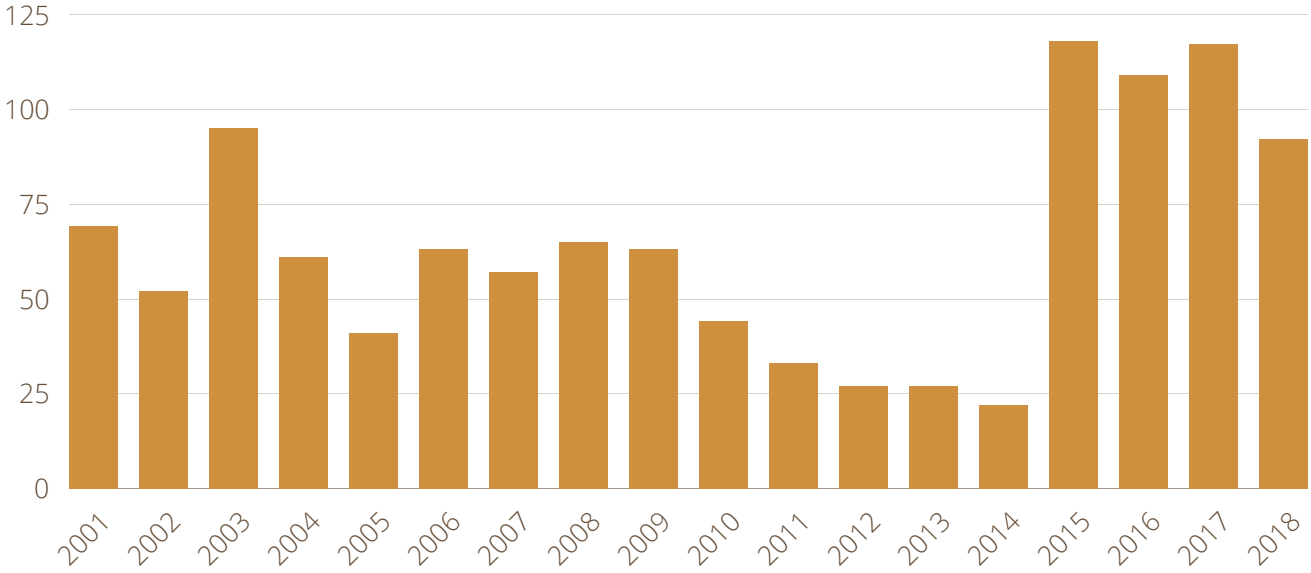
Lack of Youth In-Patient Treatment Programs

THE ISSUE

The need for children's mental health services is at an all-time high.[1] The COVID-19 pandemic has driven the number of children and adolescents struggling with their mental health to a crisis level, leading three organizations to declare a national emergency.[2] Depending on the level of services required, a child can receive mental health treatment in community settings from a mental health counselor in school, a community mental health provider, or a primary care practice, or in more intensive inpatient settings, such as treatment facilities and Psychiatric Residential Treatment Facilities (PRTF).[3]

Youth who are seriously mentally ill (SMI) often require more intensive mental health treatment that can last for months. These youth are **more appropriately treated at inpatient facilities**, where they can have intensive rehabilitation, stability, medication management, and appropriate mental health treatment to effectively address their mental health issues.[4] Inpatient treatment is necessary when a child poses a threat to themselves or others, including suicidal threats, drug overdose, threats of violence to caretakers, or psychosis.[5]

Seriously Mentally Ill Youth Housed at DJJ



The increase in the year 2015 represents, in part, improved recognition of complex PTSD among youth and their difficulty maintaining stability in a correctional setting; however, the increase is due primarily to changes in the diagnosing of mental illnesses in a new edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).
Information provided by the Department of Juvenile Justice (Feb. 9, 2022).

South Carolina **lacks sufficient inpatient beds** to meet the needs of children requiring this level of mental health treatment. As a result, children are often housed in emergency rooms or inappropriate state agency placements for months at a time while they wait for a bed to become available, and they are not receiving the mental health treatment they need.[6] Medical staff in emergency rooms and hospitals are generally not able to adequately treat children with acute psychiatric needs.[7] Children who have been sent to be evaluated at the Department of Juvenile Justice (DJJ) are stuck waiting in detention facilities until placement becomes available, and often they complete their sentence in the juvenile justice facility before receiving mental health services.[8] **Trauma and exacerbation of mental health issues can occur** when children do not receive timely, adequate access to services that address their critical mental health needs.[9]

STATE PRTFs[10]

The Department of Mental Health (DMH) closed the last state-run PRTF in 2015 due to a decrease in demand for PRTF placements.[11] At that time, private facilities had ample space available for SMI youth. Since 2015, **demand for PRTF placements has increased dramatically**. More children are being diagnosed with mental illnesses due to changes in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in 2015.[12] Additionally, DHHS restructured Rehabilitative Behavioral Health Services (RBHS) in July 2014 to expand access to services, so state agencies no longer acted as "gatekeepers" for RBHS.[13] As a result, the number of RBHS providers and utilization of RBHS services "dramatically increased."[14]

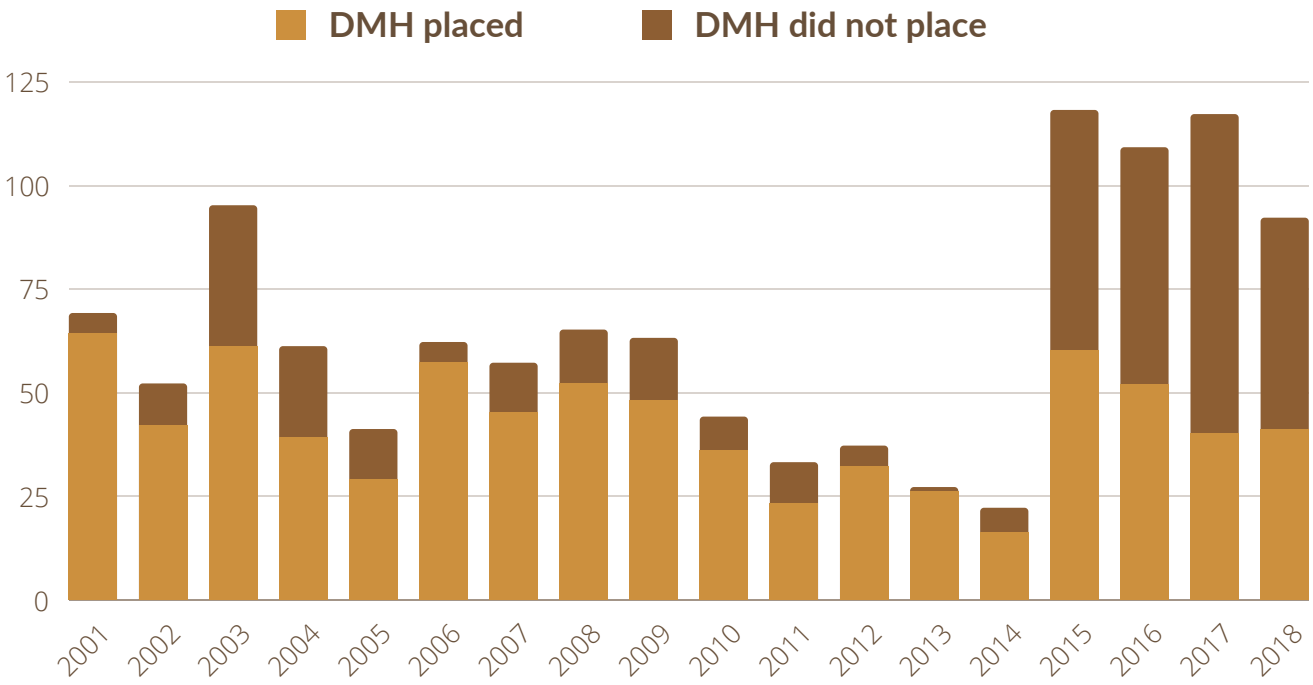
South Carolina children face barriers to placement at PRTFs.[15] Private entities operate all current PRTFs in South Carolina. Privately-run facilities are more likely to accept children with private insurance or out-of-state Medicaid insurance due to South Carolina Medicaid's lower reimbursement rates.[16] South Carolina children, particularly those on Medicaid and in state custody, fall to the bottom of South Carolina PRTFs' waiting lists. As a result, children languish in inappropriate treatment settings, such as hospitals or DJJ, without receiving appropriate treatment services. Furthermore, when children are sent to out-of-state facilities by necessity, the rates paid by the state Medicaid program are much higher than the rates for an in-state facility, resulting in higher costs to South Carolina Medicaid and taxpayers.[17]

POLICY & LEGAL LANDSCAPE

State law prohibits children identified as SMI or intellectually disabled from being committed to DJJ and requires they be transferred to the appropriate state agency.[18] SMI youth must be transferred to DMH, and intellectually-disabled youth must be transferred to the Department of Disabilities and Special Needs (DDSN).[19] SMI and intellectually-disabled youth are at much higher risk of exploitation and victimization from other youth in DJJ facilities.[20] Furthermore, DJJ staff are not equipped to address the needs of these youth, and the youth are often disruptive, destructive, and struggle to take direction from staff or interact with others.[21]

DJJ and DDSN executed a Memorandum of Understanding (MOU) that outlines a timeline for transferring SMI and intellectually-disabled youth to DMH or DDSN custody within 90 days of being identified as SMI or having an intellectual disability.[22] **However, children linger in DJJ facilities past the 90 day timeline due to the lack of available placements for these youth.**[23] Notably, youth are not receiving services during this 90-day or longer period or during the 45 days DJJ has to evaluate youth for mental health needs.[24] As of February 2022, 26 youth in various DJJ facilities would likely be recommended for treatment in a PRTF.[25] DMH must provide mental health services for these youth because South Carolina Medicaid does not reimburse for mental health services delivered at DJJ while youth are detained.[26]

Furthermore, **it is difficult for DMH or DDSN to place** these children at South Carolina's eight privately-owned PRTFs.[27] These facilities treat a variety of youth from different states with varying mental health needs, and tend to prefer to admit youth from states with higher Medicaid reimbursement rates and youth with less difficult behaviors.[28] In 2019, DMH published a Request for Proposal entitled "Accelerated Admission to Community PRTF for DJJ-Committed Youth w/Serious Mental Illness" in order to "ensure timely access to a PRTF bed for DJJ-committed youth" and to guarantee priority access to 15 PRTF beds through the state for DJJ-committed youth with SMI.[29] Only one PRTF provider responded and offered DMH four guaranteed-access beds for these youth.[30] However, this facility is frequently unable or unwilling to accept certain youth based on difficult behaviors, previous interactions with the youth, and/or safety concerns of the staff if the youth is placed at the facility.[31]



Information provided by the Department of Juvenile Justice (Feb. 9, 2022).

Out-of-state facilities accept South Carolina youth, and they provide quality psychiatric treatment, but **it comes at a cost**.[32] The cost to South Carolina Medicaid to send youth out of state to places such as Tennessee and Virginia is as much as $750 a day (compared to the in-state rate of up to $370), plus thousands of dollars in transportation costs.[33] Medicaid considers these placements on a case-by-case basis and must consider several factors before placing a youth at a specific facility.[34] **Out-of-state treatment also creates barriers for families** who want to visit and participate in the youth's treatment plan and complicates post-release coordination of community resources to support the youth.[35]

PROPOSED SOLUTIONS

1. Increase South Carolina Medicaid **reimbursement rates** to private PRTF providers to be competitive with other states' rates.

» South Carolina Medicaid increased PRTF rates on October 1, 2021 and scheduled another increase effective April 1, 2022.[36] However, DHHS recognizes increasing the Medicaid in-state rate will not resolve the issue of lack of placements for South Carolina children when more children need services than there are placements available.[37] Furthermore, the increased rate does not resolve the issue of facilities refusing to accept placement of certain children or ejecting them from the facility during treatment.[38]

2. Build/Lease a **new state PRTF(s)** with guaranteed services.

» The state could also construct a new state-run PRTF staffed by DMH or a contractor experienced in the treatment needs of SMI youth, as proposed by the director of DJJ and the State Child Advocate from the Department of Children's Advocacy with support from the director of DMH.[39] This facility could accommodate and treat SMI youth in the State's custody, and SMI youth would not be discharged until there was a clinical recommendation for discharge and transition, therefore creating a "no reject/eject policy."[40]

3. Decrease the **length of time** for youth to receive a mental health evaluation.

» Ideally, youth should be identified as SMI prior to commitment to DJJ. Once youth are committed to DJJ, the evaluation process is so slow that youth can complete their term with DJJ before receiving mental health services.[41] To resolve this issue, youth should be evaluated as soon as possible, ideally as soon as they arrive at a detention center. We recommend support for legislation that decreases the 45-day window for evaluation, such as **S 988** and **S 53**.

Juvenile Justice Reform

THE ISSUE

In the last several years, the South Carolina Department of Juvenile Justice (DJJ) has struggled to adequately serve and rehabilitate youth in its custody.[1] DJJ is undergoing an administrative transition, and Director Eden Hendrick stated "almost every aspect of what the troubled agency [was] doing will need to be reformed."[2] Reports from oversight agencies found the DJJ facilities at the Broad River Road Complex (BRRC) lacked consistent procedures related to education, rehabilitative services, recreation programs, and personal hygiene access.[3] In addition, youth were often subjected to solitary and seclusion methods.[4] Many of these issues stem from low staffing levels and a lack of resources to adequately meet youth's basic needs.[5] Before DJJ can implement additional reforms, it must meet the basic needs of children in its custody. Meeting those needs requires adequate staffing and resources.

Decrease the number of children entering DJJ custody through increased use of community-based programs.

Studies show children have better outcomes when served in their communities.[6] In one study, youth who received an evaluation within their community were 33 percent less likely to recidivate compared to those in residential settings.[7] In light of the lack of sufficient staffing at many DJJ facilities, staff are more likely to utilize punitive methods with the youth, rather than rehabilitative, because staff are constantly focused on the safety of youth and staff.[8] Community-based sanctions of non-violent misdemeanor offenders would result in less children being sent to larger DJJ detention facilities. An improved staff-to-child ratio would allow staff to focus on rehabilitation and education.

South Carolina should develop community-based pre-trial diversion programs with local courts to avoid detaining youth. A pre-trial diversion program would address youth who commit non-violent misdemeanors, status offenses, or technical probation violations. These youth are not best served in DJJ facilities, and they need support within their communities to rehabilitate. Similar measures have been implemented in other states, such as Kentucky, which began incarcerating only the most serious offenders in secure facilities and utilizing evidence-based practices in local communities.[9] This shift to community-based programs is similar to programs adopted in Missouri, Texas, and Georgia.[10]

Research shows children experience negative mental health impacts from incarceration in large facilities.[11] A correlation exists between short-term incarceration (defined as less than one month) and significantly worse mental health outcomes as an adult, even after controlling for baseline health and other variables.[12]

Improve the conditions within DJJ facilities and eliminate the use of solitary confinement.

DJJ youth should be placed in the least restrictive appropriate placement. DJJ should prohibit the use of solitary confinement for incarcerated/detained children and utilize corrective room restrictions while youth are in custody. Low staffing levels limit staff's ability to protect youth and other staff,[13] which translates into youth being placed into solitary confinement to control behaviors.[14] In 2020, the Department of Justice (DOJ) Civil Rights Division reported youth at DJJ were frequently placed in solitary confinement for up 23 hours a day for behaviors such as having playing cards, using profanity, or drawing on themselves.[15] Additionally, DOJ found DJJ failed to help when youth with serious mental illness threatened to harm themselves after being kept in solitary confinement for months at a time, and at least three youth attempted suicide by hanging.[16] The report further found youth were subjected to violence on a daily basis, and staff failed to intervene to protect youth under their supervision.[17]

Decrease the amount of time children spend waiting for mental health evaluations.

Youth should receive mental health evaluations as soon as possible to ensure they receive proper treatment, and youth with serious mental illness or intellectual disabilities should not be placed in DJJ custody, per state law.[18] The rates of mental illness are much higher for youth in juvenile detention facilities compared to the general population; detained youth particularly need high-quality mental health interventions.[19] While the general population of children and adolescents experience mental illness at rates of around 20 percent,[20] approximately 50 to 75 percent of incarcerated youth experience mental illness.[21] Additionally, a correlation exists between a reduction in recidivism rates and juvenile justice programs that provide mental health treatment.[22] Studies have shown that juvenile justice programs focused on therapeutic counseling, skill building, and case management improved recidivism outcomes by a statistically significant amount,[23] and the best mental health-oriented programs could improve recidivism outcomes by 25 to 80 percent.[24]

Prepare youth exiting the DJJ system for reentry into the community.

A youth's ease of reentry into the community is paramount to his or her future success and the safety of his or her community.[25] Reentry refers to "…the process and experience of reentering society after a term of incarceration."[26] Youth are often sent back to families struggling with domestic violence, substance abuse, unresolved mental health issues, and poverty.[27] Additionally, youth often lack the necessary skills to readjust to their communities after release and often face unemployment, school re-enrollment challenges, and homelessness.[28]

Reentry programs in South Carolina communities should be fiscally supported and focus on connecting youth with mentors or employment opportunities to reduce recidivism.[29] Youth can build resiliency through improved family relationships and functioning, reintegration into school, and mastery of independent life skills.[30] Youth reentry includes services tied to achieving the following outcomes:

- Social integration into family and community systems of care;
- Reduction in recidivism;
- Advancement in school studies;
- Development of healthy relationships;
- Master of life skills for greater self-determination;
- Residential stability; and
- Connection to workforce training and/or stable employment.[31]

Reentry services begin with youth successfully transitioning back into the school system.[32] School policies, such as expediting records for a student who has changed schools due to juvenile justice placement and providing a liaison to assist students transferring due to involvement in the juvenile justice system, would support a youth's reentry into his or her community.[33] Furthermore, if possible, youth should return to their school of origin and not be automatically placed in alternative schools after returning from the custody of DJJ.[34]

OUR RECOMMENDATIONS

- **Support S 53, the South Carolina Juvenile Justice Reform Act. The Bill:**
  - Expands community-based programs to divert low-level child offenders from prosecution in the juvenile justice system.
  - Limits school-related offenses that can be referred to DJJ and for prosecution in juvenile court.
  - Restricts use of secure detention and incarceration to the more serious and violent offenders when necessary to protect the community.
  - Prohibits the use of secure detention, secure evaluation, and incarceration for children charged with non-criminal status offenses.
  - Limits the length of secure confinement of children and the length of time a child can be placed on probation.
  - Prohibits the use of solitary confinement.
  - Establishes a bill of rights for children in state custody.
  - Revises sex offender registry requirements as they pertain to child offenders.
  - Ends automatic enrollment into alternative schools for children released from DJJ.
  - Raises the age requirements for waiver to general sessions court.

- **Support funding requests for staffing and resources to improve conditions at DJJ facilities.**

- **Support legislation that requires timely evaluations, a biopsychosocial assessment, and a determination of the child's mental health functioning.**[35]

- **Support programs targeted at the de-institutionalization of status offenders, such as work from the Department of Children's Advocacy (DCA) focused on promoting alternatives to detention and eliminating racial and ethnic disparities in the juvenile justice system. The DCA is working with Short Term Alternative Placements (STAPs) across the state regarding placement diversion.**

PUBLIC HEARING INPUT

"Throughout all the failures of the department, throughout our failure to pass restorative juvenile justice reform, throughout our failure as a community to address these issues sooner, the youth who have been in the care of the department have been negatively impacted the most. We have to change that. Each day that we do not pass this legislative reform, we are placing more youth into the care of an institution that is withering at the root, an institution crippled by outdated legislation."

Waiver for Youth

THE ISSUE

When certain juveniles commit a crime in South Carolina, the family court considers several factors to determine whether it should waive its jurisdiction and move the case to general sessions court, where the juvenile will be tried and sentenced as an adult with limited protections. South Carolina's waiver procedure relies on factors established over 50 years ago and is inconsistent with what we now know about the adolescent brain and how it differs from adults.

The family court has exclusive jurisdiction over cases involving children accused of criminal activity, as well as individuals 18 and older accused of engaging in criminal activity prior to turning 18.[1] However, under certain circumstances, jurisdiction of a child's case can be transferred to general sessions court where the child will be tried and, if convicted, sentenced as an adult.[2] S.C. Code Ann. § 63-19-1210 allows children as young as 14 who have been charged with certain criminal offenses to be transferred or waived into general sessions court.[3] Some offenses have no statutory minimum age for waiver, such as murder.[4]

Before it can waive jurisdiction of a case, the family court must determine whether a transfer to adult court is in the best interest of the child and community.[5] Statutory law does not provide the family court with any guidelines for this determination. However, in 2007 the S.C. Supreme Court instructed family court judges to apply the eight factors set forth in *Kent v. United States*, 383 U.S. 541 (1966), to determine whether waiver of the family court's jurisdiction was appropriate.

The "*Kent* factors" are:

- the seriousness of the alleged offense;
- whether the alleged offense was committed in an aggressive, violent premeditated, or willful manner;
- whether the alleged offense was against persons or property;
- the prosecutive merit of the complaint;
- the desirability of trial and disposition of the entire offense in one court;
- the sophistication and maturity of the juvenile as determined by consideration of his home, environmental situation, emotional attitude, and pattern of living;
- the record and previous history of the juvenile, including previous contacts with law enforcement agencies, juvenile courts and other jurisdictions, prior periods of probation, or prior commitments to juvenile institutions; and
- the prospects for adequate protection of the public and the likelihood of reasonable rehabilitation of the juvenile by the use of procedures, services, and facilities currently available.

The *Kent* factors focus primarily on the nature of the offense committed, the child's record, and judicial economy. They do not, as discussed further below, account for advancements in research on adolescence and children's brain development, nor for more recent rulings by the U.S. Supreme Court.

> **Since *Kent*, advances in social science and neurological research show children are "fundamentally distinct from adults in ways that reduce culpability."[6]**

Generally, adolescents are not as mature as adults and engage in risky behaviors such as drunk driving and drug use at disproportionate rates.[7] Adolescents are particularly vulnerable to peer pressure, peaking around age 14.[8] Biologically, the practical functions of the adolescent brain, such as executive control and impulse control, are underdeveloped, and adolescents are overwhelmed by the emotional part of their brains, the amygdala.[9] In other words, adolescents' biology limits their "abilities to regulate their moods, impulses, and behavior compared to adults, which may contribute to the observed increase in impulsivity and sensation-seeking during adolescence."[10] This biological mayhem normally sorts itself out as an adolescent grows into adulthood.[11]

Additionally, adolescents show much greater promise of rehabilitation and reform because their character is still being developed during adolescence and can change.[12] Studies show more than 90 percent of justice-involved youth are no longer criminally involved after their mid-20s.[13] These studies show youth have much greater capacity to change than adults, whose behavior may already be a fixed trait.[14]

The U.S. Supreme Court relied on this research in ruling on what some experts call its "kids are different" cases.[15] The U.S. Supreme Court determined children are constitutionally different from adults for sentencing purposes due to their lack of maturity, underdeveloped sense of responsibility, vulnerability to negative influences and outside pressure from family and peers, lack of control over their environments, and possibility for rehabilitation.[16] **South Carolina could amend its current waiver statute to include specific factors acknowledging "kids are different" and requiring family court judges to consider them when addressing a potential waiver.**

While children show greater chance of rehabilitation than adults, studies tracking youth tried and sentenced as adults detail the negative repercussions. Research shows children who are transferred to the adult system are more likely to reoffend, and with more serious offenses.[17] In one meta-analysis, children transferred to the adult system were 34 percent more likely to reoffend.[18] Waiving jurisdiction of juveniles' cases threatens their future ability to live and thrive outside the system.

OUR RECOMMENDATIONS

South Carolina's waiver procedure requires updates to bring it in line with current jurisprudence and widely accepted findings about children's culpability. We recommend the following:

- **Eliminate the option for waiver** except in the most serious cases.
- Amend § 63-19-1210 (allowing discretionary transfer to adult court) to **require family court judges to consider** and make findings on the following factors:
  - The child's age;
  - Whether the child acted under the influence of older co-defendants and whether the child is charged as a principal or as an accomplice;
  - Whether the child has mental health, intellectual, or developmental issues;
  - Whether the child has a history of abuse, neglect, other trauma, or adverse childhood experiences; and
  - The type of treatment most likely to be amenable to the child or the child's family and its accessibility in the criminal versus the juvenile justice system.

Counsel for Children

THE ISSUE

When a child is removed from his or her home due to abuse or neglect, the family court conducts hearings to determine whether safety concerns exist within the home, if the child should be placed into foster care or a different environment, and whether the family needs intervention services. Children have much at stake based on the outcomes of these cases—their family ties, their safety, and whether they are placed with kinship caregivers, with strangers, or in institutions.[1] Children are appointed a Guardian ad Litem (GAL) to represent their best interests.[2] However, children are not automatically appointed an attorney to provide legal representation in child welfare proceedings in South Carolina. State law currently grants the judge discretion on whether to appoint an attorney to represent a child during a case.[3] However, attorney appointments for children are rare.[4]

States have different approaches to legal representation for children. South Carolina implements GALs,[5] housed within the Department of Children's Advocacy (DCA). A GAL is a community volunteer supported and supervised by staff, who completes a 30-hour training course, investigates the case, and makes recommendations to the judge based on what he or she believes to be in the best interest of the child.[6] The court appoints an attorney to represent the GAL's position, but that attorney is prohibited from acting as legal counsel for the child.[7]

Volunteer GALs can offer a unique perspective in court cases, as well as emotional support for the child, but they **cannot replace the role of an attorney representing the child's legal rights** in court proceedings.[8] Every other party to these proceedings, including the Department of Social Services (DSS) and parents, has direct representation unless they choose to represent themselves.[9] Courts appoint attorneys for parents who cannot afford one.[10] Yet, children, the ones who arguably have the most at stake, are typically the only party-in-interest in these cases without an attorney.

RESEARCH AND FISCAL IMPLICATIONS

Research suggests **a child represented by an attorney is likely to achieve permanency sooner** than a child who is not provided legal representation.[11] Studies show permanency is important because it allows children to develop healthy, secure relationships, and reduces the potential stressors that arise from being displaced multiple times.[12] Additionally, when children have expedited permanency, they are less likely to experience placement disruption, which results in:

- Stability in school attendance;
- Decreased trauma and distress;
- Decreased mental health problems;
- Decreased behavioral problems;
- Increased probabilities for academic achievement; and
- The ability to form a lasting positive relationship with an adult.[13]

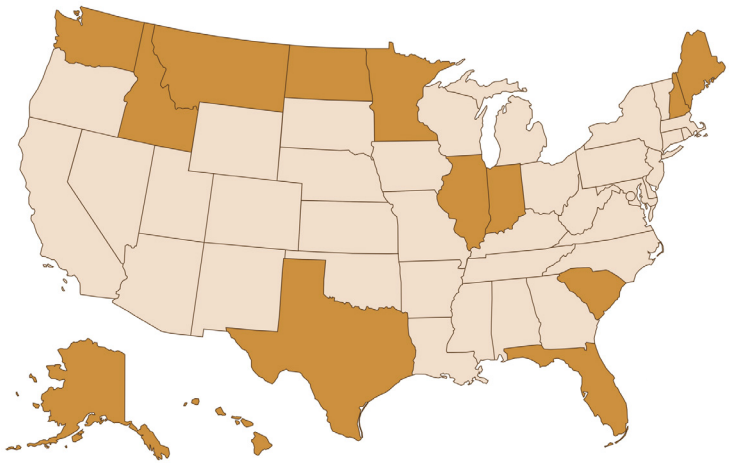
Furthermore, studies that address children's mental and emotional well-being demonstrate children have less anxiety about the court process when provided client-directed attorney counsel, and a correlation exists between a child's feelings of the foster care experience and perception of legal representation.[14] Additionally, by being involved with the court process, youth report having a **stronger sense of control over their lives**, and they avoid feelings of powerlessness and fear when they are able to express their views.[15] Children's lack of agency and voice can lead them to take drastic actions, such as running away or increasing risky behaviors in order to get attention.[16]

A study from Palm Beach County, Florida, examined the impact of the Foster Children's Project (FCP) on children's permanency; the FCP model included ten attorneys, two permanency planners, and a number of other support personnel.[17] This study measured the outcomes of FCP-represented children in comparison to a control group of children not represented by an attorney.[18] The study found children with FCP attorneys achieved expedited permanency with less time in foster care and no significant decrease in reunification.[19] The FCP attorneys improved outcomes through a combination of filing motions and status checks, making service referrals, initiating TPR proceedings, and examining closely the content of case plans.[20]

NATIONAL LANDSCAPE

South Carolina is **one of only 14 states** that does not guarantee appointment of counsel for all children in child abuse proceedings.[21]

All states that require the appointment of an attorney for the child continue to utilize volunteer GALs in the court process.[22] The national standard for GALs or Court Appointed Special Advocate (CASA) is to be supervised by CASA staff, not represented by an attorney.[23] South Carolina is only one of three states that uses an attorney to represent the GAL's position.[24]



Guaranteed Counsel for Children

Does Not Guarantee Counsel for Children

Direct representation for children in child abuse and neglect proceedings reflects a national trend. Currently, the Child Abuse Prevention and Treatment Act (CAPTA) requires family court judges appoint a GAL to children involved in child welfare proceedings, and this person can be an attorney or a trained volunteer.[25] The CAPTA Reauthorization Act of 2021 (S 1927), which is **pending in the US Senate**, includes an amendment mandating a child receive "legal representation by a trained attorney in all cases involving an allegation of child abuse or neglect that results in a judicial proceeding."[26] **If this language becomes law, South Carolina will be required to provide attorney representation for children as a condition of receiving federal CAPTA grant funding.**[27]

Additionally, the Children's Bureau issued formal guidance in 2017 affirming high-quality attorneys for children as "critical to a well-functioning child welfare system."[28] In December 2018, the federal government changed policy to allow state agencies to tap into Title IV-E funds to pay for as much as half of both parent and child representation for eligible populations.[29] This shift **allows South Carolina to be reimbursed** for a percentage of the cost of counsel for children.[30]

OUR RECOMMENDATION

Create a study committee to explore the feasibility of providing direct representation to children in child abuse and neglect cases.

The study committee should be composed of DCA, DSS, family court judges, current and former foster youth, and other community stakeholders. Discussion should include, but not be limited to: how to pay for attorneys for children, what agency would house these attorneys, whether the attorneys would be contractors or FTEs, and how to address workforce capacity and retention.

Birth Certificate Access

THE ISSUE

UNACCOMPANIED HOMELESS YOUTH

Many important milestones on a youth's journey to adulthood require access to a birth certificate, such as obtaining a job or a driver's license. State laws can often **create barriers to access of these documents**.[1] Current South Carolina law limits issuance of a minor's birth certificate to a parent, guardian, or other legal representative.[2] A minor who has been abandoned or has run away from abusive parents or guardians is unable to obtain a birth certificate under the statute's current language. The Department of Social Services (DSS) can assist children in its custody with obtaining copies of birth certificates, but some youth avoid or run away from DSS custody and are considered unaccompanied or homeless.[3]

Organizations that work with homeless youth - including shelters, nonprofits, and school districts - often assist unaccompanied youth with obtaining jobs, finding resources, or furthering their education.[4] These entities are **unable to help unaccompanied youth** with obtaining their birth certificates because they are not a parent, guardian, or legal representative. Without access to their birth certificate, minors are also unable to apply for a state ID – a crucial piece of identification for obtaining employment, opening a bank account, and other services.[5]

As of January 2020, South Carolina reports **1,020 unaccompanied homeless students** and **202 unaccompanied young adults** aged 18 to 24 experiencing homelessness.[6]

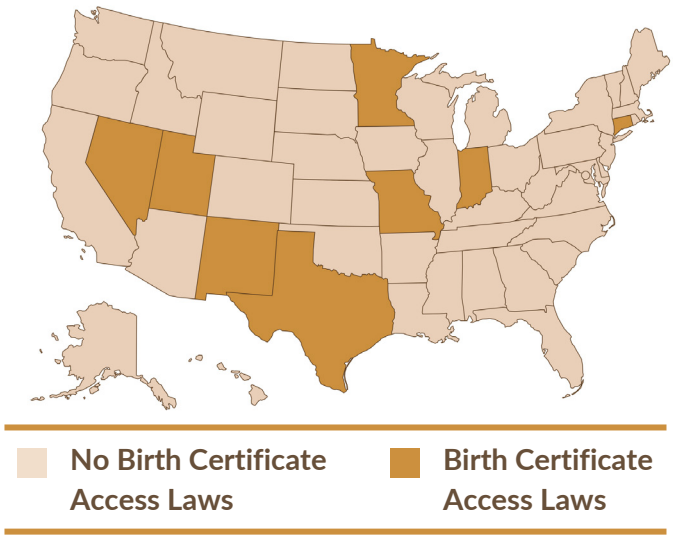
KINSHIP CAREGIVERS

The statute's narrow language also creates difficulty for kinship caregivers with a temporary custody order for a child.[7] Some kinship caregivers go through the traditional adoption process for children in their care but often cannot access the child's birth certificate until they obtain full custody.[8] Kinship caregivers often need a birth certificate in order to enroll a child in school or childcare, add them to the kinship caregiver's health insurance, or obtain the child's medical records.[9] Kinship caregivers can operate a year or more under a series of temporary orders before final custody is granted.[10] While DSS can request and provide birth certificates for children in its custody, this option is **not available for kinship caregivers** who do not have an open case with DSS.[11] In the meantime, the statute's limitations make every-day parental tasks more difficult for kinship caregivers.

DSS has **727 licensed kinship placements** as of February 7, 2022,[12] but that number is small compared to the **approximately 69,000 South Carolina children who live in kinship care** and could benefit from expanded access.[13]

NATIONAL LANDSCAPE

Eight states – Connecticut,[14] Indiana,[15] Minnesota,[16] Missouri,[17] Nevada,[18] New Mexico,[19] Texas,[20] and Utah[21] – grant homeless youth access to their birth certificates. South Carolina currently does not.



As for access to birth certificates, Indiana allows a government entity or a school liaison for homeless youth to obtain a homeless youth's birth certificate on their behalf.[22] Texas, which utilizes authorization agreements between a parent(s) and an adult caregiver of the child in these situations, authorizes the adult caregiver to obtain health insurance for the child and enroll the child in daycare or school, among other tasks.[23] Texas amended the statute in 2017 to include the adult caregiver's ability to obtain "copies or originals of state-issued personal identification documents for the child, including the child's birth certificate."[24]

OUR RECOMMENDATIONS

Pass H 4834 and S 1025, which expand the definition of "other legal representative" to include: kinship caregivers with temporary custody orders, verified entities who work with homeless youth, and McKinney-Vento coordinators for each school district.

Additionally, these bills streamline the ability of DSS to obtain birth certificates for children in the state's custody.

Reinstatement of Parental Rights

THE ISSUE

When a parent or guardian abuses or neglects a child in his or her custody and child welfare services becomes involved, the state may offer services to help the family to resolve the issues that led to the abuse or neglect while the child remains in the home or with another caregiver. In some cases, the child may be removed from the parent or guardian's custody if the child's life, health, or safety is in imminent and substantial danger.[1] Courts have the authority to terminate parental rights for a variety of reasons and if it is in the child's best interest. Once parental rights have been terminated, a child is legally free for adoption.[2]

Children legally freed for adoption are not always adopted soon after parental rights are terminated.[3] Children with the permanency goal of adoption may never find an adoptive family due to the child's age, special needs, or a desire to remain in a sibling group.[4] Youth that are not adopted eventually end up "aging out" of the foster care system, with no parental relationships.

In some cases, parents are able to improve their circumstances after their rights have been terminated. A parent may have improved to the point where he or she is fit to care for the child again, but **South Carolina has no legal mechanism for parental rights to be reinstated**. The result is a child lingering in the foster care system when his or her biological parent can provide care for him or her outside the system. In this situation, providing a parent the opportunity to petition for reinstatement of their parental rights supports the foster care system's ultimate goal of family reunification and removes children from the foster care system – a better result for the child and the family and a reduction in the number of state-supported children in foster care.

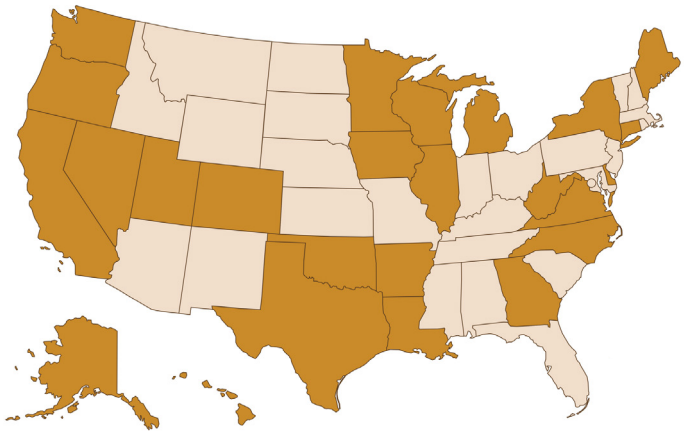
Factors to consider in determining whether parental rights should be reinstated include:

- Rehabilitation of the parent;
- Age of the child;
- How much time has passed since the termination order;
- Who may file a petition for reinstatement of parental rights;
- Likelihood of permanency in the future for the child;
- Success of some period of trial reunification; and
- Best interest of the child.[5]

Reinstating parental rights may be appropriate under circumstances such as: extraordinary circumstances preventing the biological parent's earlier involvement, caregiver illness and the biological parent is already re-involved, an aging-out youth is already planning to live with a biological parent, and youth with an emancipation goal and the biological parent is known.[6]

NATIONAL LANDSCAPE

South Carolina is one of 25 states that does not currently have a mechanism for parents to reinstate parental rights.[7]



States take different approaches to address this situation and to keep children from lingering in foster care. **Twenty-five states have a reinstatement/restoration law**,[8] and 18 of those states allow parental rights to be reinstated if the child does not achieve permanency within a set amount of time, which varies from one to four years.[9] Of the 25 states, 12 states limit reinstatement to older children (12 years and older) who have not attained a permanent placement.[10] In Arkansas, Utah, and West Virginia, the statute only applies to cases in which an adoptive placement has been disrupted.[11] In some states, child welfare agencies must submit a permanency plan to the court that describes the transition services to be provided to support the child and family, with reintegration as a permanency goal.[12] Other protections include the court ordering a trial home placement before the restoration of rights is finalized.[13]

In states that utilize reinstatement laws, the reinstatement of parental rights can be a useful permanency tool for a limited number of children in specific situations and has not proven to be a burden on resources or to have a negative effect on the number of adoptions.[14]

OUR RECOMMENDATION

Support legislation to create a legal avenue for parents to request reinstatement of parental rights.

Guardianship Assistance Program

THE ISSUE

Children in the foster care system who are unable to reunify with their parents or be adopted can sometimes exit the foster care system through a guardianship placement. Guardianship placements are often with relatives or fictive kin who are not willing or able to adopt the child but are willing to take legal custody of the child. Guardianship may also be appropriate in cases in which reunification is not possible or in the child's best interest and no grounds exist for termination of parental rights.[1] Unlike adoption, guardianship does not require termination or relinquishment of parental rights.[2]

While guardianship placement may be the best option for a child, South Carolina **does not provide legal guardians any kind of financial stipend or subsidy to care for the child**. Subsidized guardianship programs provide an ongoing subsidy to guardians who are granted legal custody through the court.[3] Guardianship Assistance Program (GAP) payments are available in states with subsidized guardianship programs.[4] These subsidy programs are funded through a variety of means including Title IV-E funding, federal grants, and state and local funding.[5] These subsidies are monthly payments made directly to the guardian to support additional expenses incurred by taking the child into their home.[6]

Importantly, subsidized guardianship programs provide many benefits to the children involved including:

- promoting family ties;
- respect for shared cultural and societal norms;
- limited state oversight and intervention in the lives of children;
- giving caregivers the necessary legal decision-making authority for children, including the ability to consent to routine activities such as field trips, sleepovers, and school pictures;
- allowing able birth parents to regain custody of the children later, provided the courts and DSS approve; and
- giving the courts flexibility to limit or expand the legal guardians' and parents' authority as necessary to best serve the changing needs of the children and family.[7]

The placement of a child into a guardianship is only considered by the family court in particular circumstances. **Family courts consider facts such as**: reunification and adoption were carefully considered first and ruled out, the prospective guardian evidences a "strong commitment" to the child, the child has a strong attachment to the prospective guardian, and the court finds that the guardianship is in the best interest of the child.[8]

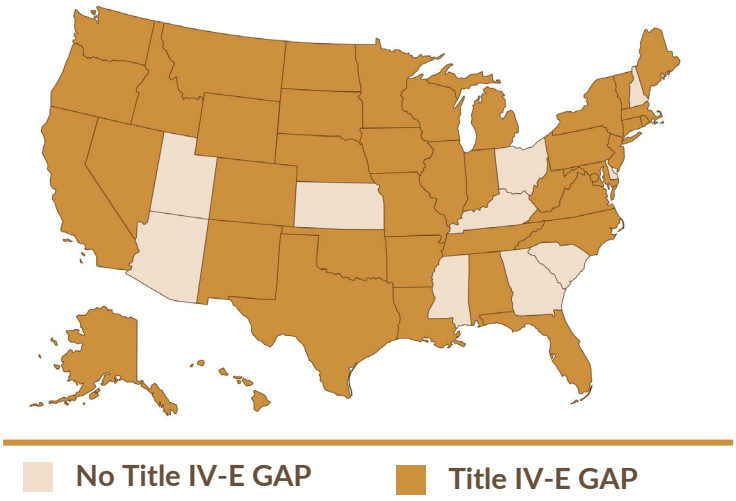
FISCAL IMPACT

Studies have shown GAP payments **ultimately decrease state spending**.[9] Placing children in legal guardianships helps lower administrative costs and reduces DSS and court caseloads, resulting in cost savings for the state.[10] Subsidy payments usually end when the guardianship terminates or the child turns 18.[11] Furthermore, GAP payments cannot exceed the foster care rate.[12] The current foster care rate in South Carolina ranges from $605-$747 per month, depending on the age of the child.[13] For states with an approved Title IV-E guardianship assistance program, the average maximum subsidy monthly payment is $679.[14] Furthermore, states that opt into Title IV-E GAP receive federal dollars to supplement the program, freeing the state to redirect state dollars which entirely supported their state guardianship programs previously.[15]

NATIONAL LANDSCAPE

South Carolina is one of 10 states that does not currently have an approved Title IV-E Guardianship Assistance Program.[16]

Although no state legislation is required to implement a Title IV-E GAP option, some states have passed laws as a first step.[17] In order to start a GAP, states are required under the Fostering Connections Act[18] to submit an amended Title IV-E Plan to the U.S. Department of Health and Human Services/Children's Bureau for approval.[19] As of June 2021, **40 states and the District of Columbia** have approved Title IV-E funded guardianship assistance programs.[20]



OUR RECOMMENDATION

Conduct further research and consider potential legislation to establish a Title IV-E GAP in South Carolina.

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[13] Email from Rochelle Caton, Director, Office of Client Advocacy, S.C. Dep't of Mental Health, to Shealy Reibold, Senior Resource Attorney, Joint Citizen and Legislative Committee on Children (March 7, 2022, 8:22 EST) (on file with author).
[14] *Id.*
[15] *Supra note 11*.
[16] S.C. House of Representatives Ways and Means Committee, *supra* note 8.
[17] S.C. House of Representatives Ways and Means Committee, Criminal Justice Budget Subcommittee (statement of Robert Kerr, S.C. S.C. Dep't of Health and Human Services Acting Director).
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[20] Shannon E. Reid & Shelley Johnson Listwan, *Managing the Threat of Violence: Coping Strategies Among Juvenile Inmates*, J. of Interpersonal Violence, 33.8 (2018), 1306-1326.
[21] Zak Koeske, *Ending Imprisonment of S.C. Youth with Mental Illness May Transform DJJ, Agency Says* (Feb. 22, 2022), The State, https://www.thestate.com/news/politics-government/article258375383.html#storylink=cpy (last visited Feb. 22, 2022).
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[24] Email from Joshua Gupta-Kagan, Professor of Law at the University of S.C. School of Law (Feb. 8, 2022).
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[26] S.C. House of Representatives Ways and Means Committee, *supra* note 17.
[27] Amanda Whittle, *Report Regarding Psychiatric Residential Treatment Facility (PRTF) Capacity for S.C. Children and Adolescents*, S.C. Dep't of Children's Advocacy (2022).
[28] S.C. House of Representatives Ways and Means Committee, *supra* note 17.
[29] *Accelerated Admission to Community PRTF for DJJ-Committed Youth w/Serious Mental Illness*, S.C. Dep't of Mental Health, Request for bid entitled "Solicitation 5400016359 (4/16/2019)"(obtained from *Report Regarding Psychiatric Residential Treatment Facility (PRTF) Capacity for South Carolina Children and Adolescents* (Jan. 2022)).
[30] S.C. House of Representatives Ways and Means Committee, *supra* note 17.
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] Genevieve Graaf & Lonnie Snowden, *The Role of Medicaid Home and Community-Based Services Policies in Organizing and Financing Care for Children with Severe Emotional Disturbance*, (2017), https://rc.library.uta.edu/uta-ir/handle/10106/28288 (last visited Feb. 20, 2022).
[36] S.C. House of Representatives Ways and Means Committee, *supra* note 17.
[37] *Id.*
[38] *Id.*

[39] S.C. House of Representatives Ways and Means Committee, Criminal Justice Budget Subcommittee (statement of Amanda Whittle, State Child Advocate, Director of S.C. Dep't of Children's Advocacy).
[40] S.C. House of Representatives Ways and Means Committee, *supra* note 14.

II. JUVENILE JUSTICE

Juvenile Justice Reform

[1] *See* Joshua Gupta-Kagan, et al., *Effective Solutions to South Carolina's Juvenile Justice Crisis: Safety, Rehabilitation, and Fiscal Responsibility*, Protection & Advocacy for People with Disabilities, Inc., Nelson Mullins (2017), http://www.pandasc.org/wp-content/uploads/2017/04/Juvenile-Justice-Report.pdf (last visited, Feb. 24, 2022).
[2] S.C. Senate Corrections and Penology Subcommittee, Oct. 19, 2021 (statement of Eden Hendrick, S.C. Dep't of Juvenile Justice Acting Director).
[3] Amanda Whittle, *2021 Annual Report*, S.C. Dep't of Children's Advocacy (2022), https://childadvocate.sc.gov/sites/default/files/Documents/_Annual%20Report%202020-2021%20FINAL.pdf (last visited Fed. 20, 2022).
[4] *Id.*
[5] S.C. House of Representatives Ways and Means Committee, Criminal Justice Budget Subcommittee (statement of Eden Hendrick, S.C. Dep't of Juvenile Justice Acting Director).
[6] Elizabeth S. Barnert, et al., *How Does Incarcerating Young People Affect Their Adult Health Outcomes?*, 139 Pediatrics No. 2, 5-6 (2016); *See* Gupta-Kagan *supra* note 1.
[7]S.C. House of Representatives Ways and Means Committee, *supra* note 5.
[8] *Id.*
[9] *See* Julia Durnan, et al., *State-Led Juvenile Justice Systems Improvement*, Washington, DC: Urban Institute (2018), https://www.urban.org/sites/default/files/publication/98321/state-led_juvenile_justice_systems_improvement_3.pdf.
[10] *See Id.*
[11] Barnert, s*upra* note 6.
[12] *Id.*
[13] Whittle, s*upra* note 3.
[14] *Investigation of S.C. Department of Juvenile Justice's Broad River Road Complex*, U.S. Dep't of Justice Civil Rights Div. and U.S. Attorney's Office Dist. of S.C. (2020), https://www.justice.gov/opa/press-release/file/1245181/download, at 9 (last visited Feb. 24, 2022).
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[16] *Id.* at 12.
[17] *Id.* at 5.
[18] S.C. Code Ann. § 63-19-1450(A).

[19] Lee A. Underwood & Aryssa Washington, *Mental Illness and Juvenile Offenders*, Int'l J. of Envtl. Research and Pub. Health (2016), 13, 2; *See also note 1.*
[20] *Key Substance Use and Mental Health Indicators in the U.S.: Results From the 2020 National Survey on Drug Use and Health*, Substance Abuse and Mental Health Services Admin. (2021), https://www.samhsa.gov/data/ (last visited Feb. 24, 2022).
[21] Underwood & Washington, *supra* note 19 at 228.
[22] *Id.*; *See also* Gupta-Kagan, *supra* note 1.
[23] Mark W. Lipsey, *The Primary Factors that Characterize Effective Interventions with Juvenile Offenders: A Meta-Analytic Overview*, 4 Victims & Offenders 124, 139 (2009); *See also* Gupta-Kagan, *supra note 1.*
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[26] Daniel P. Mears & Jeremy Travis, *The Dimensions, Pathways, and Consequences of Youth Reentry*, Urban Institute (2004) https://www.urban.org/sites/default/files/publication/57861/410927-The-Dimensions-Pathways-and-Consequences-of-Youth-Reentry.PDF.
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[28] *Id.*
[29] *Id.*
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[31] *Id.*
[32] *Id.*
[33] *Id.*
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[35] S.C. General Assembly, General Bill S. 53, https://www.scstatehouse.gov/sess124_2021-2022/bills/53.htm(last visited Feb. 24, 2022).

Waiver

[1] S.C. Code Ann. § 63-3-510(A)(3).
[2] *See* S.C. Code Ann. § 63-19-1210.
[3] S.C. Code Ann. § 63-19-1210 (2010 & Supp. 2021).
[4] *State v. Corey D.*, 339 S.C. 107, 113, 529 S.E.2d 20, 23 (2000).
[5] *State v. Pittman*, 373 S.C. 527, 558, 647 S.E.2d 144, 160 (2007).
[6] Amanda NeMoyer, *Kent Revisited: Aligning Judicial Waiver Criteria with More Than Fifty Years of Social Science Research*, 42 Vt. L. Rev. 441, 477 (2018).
[7] *Roper v. Simmons*, 543 U.S. 551, 569, 125 S. Ct. 1183, 1195 (2005) (quoting Jeffrey J. Arnett, *Reckless Behavior in Adolescence: A Developmental Perspective*, 12 Dev. Rev. 339, 339 (1992)).
[8] Elizabeth S. Scott & Laurence Steinberg, *Rethinking Juvenile Justice*, (Columbia Law School, Working Paper No. 09-194, 2008), https://scholarship.law.columbia.edu/faculty_scholarship/1567.

[9] *See* Laurence Steinberg, *The Influence of Neuroscience on US Supreme Court Decisions About Adolescents' Criminal Culpability*, 14 Nature Rev. Neuroscience 513, 516 (2013).
[10] Laurence Steinberg & Elizabeth S. Scott, *Less Guilty by Reason of Adolescence: Developmental Immaturity, Diminished Responsibility, and the Juvenile Death Penalty*, 58 Am. Psych. 1009, 1013 (2003).
[11] *Id.*
[12] *See Graham v. Florida*, 560 U.S. 48, 68, 130 S. Ct. 2011, 2026 (2010) (citing *Roper*, at 70, 125 S. Ct. at 1195); Avshalom Caspi & Brent W. Roberts, *Personality Development Across the Life Course: The Argument for Change and Continuity*, 12 Psych. Inquiry 49, 62 (2001).
[13] *Graham v. Florida*, 560 U.S. 48, 68 (2010) (quoting *Roper*, 543 U.S. at 569–70).
[14] *See* Avshalom, *supra* note 12 at 51.
[15] *See* NeMoyer, *supra* note 6 at 448.
[16] *See Miller v. Alabama*, 567 U.S. 460, 471-72, 132 S. Ct. 2455, 2464-65 (2012) (citing *Roper*, 569-570, 125 S. Ct. at 1195; citing *Graham*, 560 U.S. at 68, 130 S. Ct. at 2026).
[17] U.S. Dep't of Health and Human Services, *Effects on Violence of Laws and Policies Facilitating the Transfer of Youth from the Juvenile to the Adult Justice System: A Report on Recommendations of the Task Force on Community Preventive Services*, 56 Ctrs. for Disease Control and Prevention, 9 (Nov. 30, 2007), available at: http://www.cdc.gov/mmwr/pdf/rr/rr5609.pdf.
[18] *Id.* at 6-7.

III. CHILD WELL-BEING

Counsel for Children

[1] *Kenny A. v. Perdue*, 356 F. Supp. 2d 1353, 1360 (N.D. Ga. 2005).
[2] Cody Lidge, MPA, CIP Director, Children's Law Center, University of S.C. School of Law.
[3] S.C. Code Ann. § 63-7-1620(2) (2016).
[4] Lidge, *supra* note 2.
[5] S.C. Code Ann. § 63-7-1620(2).
[6] *A Child's Right to Counsel*, First Star (2019), http://www.caichildlaw.org/Misc/RTC4.pdf (last visited Feb. 22, 2022).
[7] S.C. Code Ann. § 63-7-1620(1) (2016).
[8] *See generally*, *Representation of Children in Child Abuse and Neglect Proceedings*, Child Welfare Information Gateway (2021), https://www.childwelfare.gov/pubpdfs/represent.pdf (last visited Feb. 23, 2022).
[9] S.C. Code Ann. § 63-7-1620(3) (2016).
[10] *Id.*

[11] Andrew E. Zinn & Jack Slowriver, *Expediting Permanency: Legal Representation for Foster Children in Palm Beach County*, Chapin Hall Ctr. for Children at the U. of Chicago, 1, 2-14 (2008) https://www.issuelab.org/resources/1070/1070.pdf. This study took place in Palm Beach County, Florida, over five years from 2001-2006, based on a sample size of 1,333 children represented by an attorney team (FCP) and 132 children not provided representation. "In the analyses based on DCF administrative data and court record review {data}, respectively, FCP children exited to permanency at rates 1.38 and 1.59 times higher than comparison children." Most of this difference, however, appears to be a function of much higher rates of adoption and long-term placement.
[12] Erik S. Pitchal, W*here Are All the Children?: Increasing Youth Participation in Dependency Proceedings*, 12 U. Cal. Davis J. Juv. L. & Pol'y, 233 (2008).
[13] Yvon Gauthier, Gilles Fortin, & Gloria Jéliu, *Clinical Application of Attachment Theory in Permanency Planning for Children in Foster Care: The Importance of Continuity of Care*, 25(4) Infant Mental Health J., 379-396 (2004).
[14] Zinn & Slowriver, *supra* note 11.
[15] Anna M. Cody, *Children's Participation Rights in Children Welfare Systems: Identifying Opportunities for Implementation*, V.a. Commonwealth U. (2020), https://scholarscompass.vcu.edu/cgi/viewcontent.cgi?article=7617&context=etd (last visited Feb. 23, 2022).
[16] *Id.*
[17] Zinn & Slowriver, supra note 11.
[18] *Id.*
[19] *Id.*
[20] *Id.*
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[23] *See The CASA/GAL Model*, Nat'l CASA/GAL for Children (2022), https://nationalcasagal.org/our-work/the-casa-gal-model/(last visited Feb. 23, 2022).
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[25] Child Abuse Prevention and Treatment Act, 42 U.S.C.A. § 5106a(b)(2)(B)(xiii).
[26] *See* S. 1927, CAPTA Reauthorization Act of 2021, 117th Cong. (2021), https://www.congress.gov/bill/117th-congress/senate-bill/1927/text?q=%7B%22search%22%3A%5B%22S.+1927%22%5D%7D&r=1&s=4#toc-id98cda5e994df4e76ba8db294c67ccaa1 (last visited Feb. 23, 2022).

[27] In FY 2021, South Carolina received $1,348,573 of Federal CAPTA grants. *See Justification of Estimates for Appropriations Committees Administration for Children and Families*, Dep't of Health and Human Services, Admin. for Children and Families (2022), https://www.acf.hhs.gov/sites/default/files/documents/olab/fy_2022_congressional_justification.pdf (last visited Feb. 23, 2022).
[28] *High Quality Legal Representation for All Parties in Child Welfare Proceedings*, Admin. of Children, Youth, and Families (2017), https://www.acf.hhs.gov/sites/default/files/documents/cb/im1702.pdf (last visited Feb. 23, 2022).
[29] *Title IV-E Funding for Legal Representation: U.S. Children's Bureau Permits Funding for Child and Parent Legal Representation*, Nat'l Ass'n of Counsel for Children (2021), https://www.naccchildlaw.org/page/TitleIVforLegalRepresentation (last visited Feb. 23, 2022).
[30] *See* John Kelly, *Trump Administration Rule Change Could Unleash Hundreds of Millions in Federal Funds to Defend Rights of Parents, Children in Child Protection Cases*, The Imprint (2019), https://imprintnews.org/child-welfare-2/how-the-fight-for-family-legal-support-was-won/33631 (last visited Feb. 23, 2022).

Birth Certificate Access

[1] Dylan Waguespack & Brandy Ryan, *2019 State Index on Youth Homelessness*, True Colors United and the Nat'l L. Ctr. on Homelessness & Poverty1, 109 (2019), https://homelesslaw.org/wp-content/uploads/2020/02/2019-State-Index.pdf.
[2] S.C. Code Ann. § 44-63-80 (1976).
[3] *Id.*; *See* Misaela A. Bailey, et al., *Disparate Experiences: Highlighting the Health and Well-being of Youth Exiting the Foster Care Sys. in S.C.*, S.C. Nat'l Youth in Transition Database, https://www.nytdstayconnected.com/media/1031/bm-rt-nytd2019_clyburnposter_final.pdf (last visited Feb. 9, 2022).
[4] *See e.g.*, *Youth Servs.*, Mental Illness Recovery Ctr, Inc., https://www.mirci.org/about-us/our-programs/youth-services/ (last visited Feb. 9, 2022); *The Oaks Unaccompanied Youth Program*, Palmetto Place, https://www.palmettoplace.org/theoaks (last visited Feb. 9, 2022); *ESSA Title IX, Part A McKinney-Vento Homeless Assistance Act*, S.C. Dep't of Educ., https://ed.sc.gov/policy/federal-education-programs/essa-title-ix-part-a-mckinney-vento-homeless-assistance-act/ (last visited Feb. 9, 2022).
[5] *See Identification Cards*, S.C. Dep't of Motor Vehicles, https://www.scdmvonline.com/Driver-Services/Identification-Cards (last visited Feb. 9, 2022) (among required documents to obtain a state ID is your original birth certificate).
[6] *S.C. Homelessness Statistics*, U.S. Interagency Council on Homelessness, (Jan. 2020), https://www.usich.gov/homelessness-statistics/sc/.
[7] Joint Citizens and Legislative Committee on Children, *Greenville 2021 Fall Public Hearing*, S.C. Legislature (Sept. 30, 2021, 5 PM), https://www.scstatehouse.gov/video/archives.php (statement of Dr. Jessica Britt).
[8] *Id.*

[9] *Id.*
[10] *Id.*
[11] S.C. Code Ann. § 44-63-80 (1976).
[12] *Foster Care Dashboard*, S.C. Dep't of Soc. Servs., http://reports.dss.sc.gov/SSRSReportServer/Pages/ReportViewer.aspx?%2fFoster+Care (last visited Feb. 9, 2022).
[13] *Children in Kinship Care in S.C. 2019-2021*, The Annie E. Casey Foundation Data Center, (Sept. 2020), https://datacenter.kidscount.org/data/tables/10455-children-in-kinship care?loc=42&loct=2#detailed/2/42/false/2097/any/20160,20161.
[14] Conn. Gen. Stat. Ann. § 7-51 (West 2015).
[15] Ind. Code § 31-36-3-4 (2019).
[16] Minn. Stat. Ann. § 144.2255 (West 2021).
[17] Mo. Rev. Stat. § 193.265 (2020).
[18] Nev. Rev. Stat. § 440.700 (2020).
[19] N.M. Stat. Ann. § 24-14-28 (2021).
[20] Tex. health & safety Code Ann. § 191.0049 (West 2019).
[21] Utah Code Ann. § 26-2-12.6 (West 2021).
[22] Ind. Code § 31-36-3-4 (2019).
[23] Tex. Fam. Code Ann. § 34.002 (West 2017).
[24] Tex. Fam. Code Ann. § 34.002(a)(8)(A)-(B) (West 2017).

Reinstatement of Parental Rights

[1] S.C. Code Ann. § 63-7-660 (2012).
[2] S.C. Code Ann. § 63-7-2570 (2014).
[3] Randi J. O'Donnell, *A Second Chance For Children And Families: A Model Statute To Reinstate Parental Rights After Termination*, 48(2) Family Court R. 362-379 (2010).
[4] Meredith L. Schalick, *The Sky is Not Falling: Lessons and Recommendations from Ten Years of Reinstating Parental Rights*, 51(2) Am. Bar Assoc. Family Law Quarterly, (Apr. 2018), https://www.americanbar.org/groups/family_law/publications/family-law-quarterly/volume-51/issue-2/5102-03-schalick/ (last visited Feb. 17, 2022).
[5] *Id.*
[6] *Id.* "For example, in one case, a father's parental rights were reinstated for a thirteen-year-old boy who had not yet been adopted after his parents' rights were terminated five years before. The background to this story was that after a severe natural disaster in his hometown, the boy had moved with his mother to a new state and lost contact with his biological father, whom he had seen only a few time before. When the child was removed from his mother due to neglect, child welfare officials were unable to locate the father or other relatives."
[7] *Grounds for Involuntary Termination of Parental Rights*, U.S. Dep't of Health and Human Services Admin. for Children and Families (2021), https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/groundtermin/.

[8] Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Iowa, Louisiana, Maine, Michigan, Minnesota, Nevada, New York, North Carolina, Oklahoma, Oregon, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.
[9] Arkansas (3 years), California (3 years), Colorado (3 years), Delaware (2 years), Georgia (3 years), Hawaii (1 year), Illinois (3 years), Maine (1 year), Minnesota (4 years), New York (2 years), North Carolina (3 years), Oklahoma (3 years), Oregon (18 months), Texas (2 years), Utah (2 years), Virginia (2 years), Washington (3 years), and Wisconsin (1 year).
[10] Delaware (age 14), Hawaii (age 14), Illinois (age 13), Louisiana (age 15), New York (age 14), North Carolina (age 12), Oklahoma (age 14), Oregon (age 12), Texas (age 12), Utah (age 12), Virginia (age 14), and Washington (age 12).
[11] U.S. Dep't of Health and Human Services Admin. for Children and Families, *supra* note 7.
[12] *Id.*
[13] *Id.*
[14] Schalick, *supra* note 4.

Guardianship Assistance Program

[1] *Guardianship Assistance Program (GAP)*, National CASA Ass'n (2019), https://advocacyinaction.casaforchildren.org/permanency/guardian-assistance-program-gap/ (last visited Feb. 21, 2022).
[2] *Id.*
[3] *Id.*
[4] *The Title IV-E Guardianship Assistance Program (GAP): An Update on Implementation and Moving GAP Forward*, Grandfamilies.org (2015), https://www.grandfamilies.org/Portals/0/Title%20IV-E%20GAP%20Update.pdf (last visited Feb. 18, 2022).
[5] *Subsidized Guardianship – Summary & Analysis*, Grandfamilies.org (2022), https://www.grandfamilies.org/Topics/Subsidized-Guardianship/Subsidized-Guardianship-Summary-Analysis (last visited Feb. 18, 2022).
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[7] *Id.*
[8] *Id.*
[9] *Family Ties: Supporting Permanence for Children in Safe and Stable Foster Care with Relatives and Other Caregivers*, Fostering Results (2004).
[10] Grandfamilies.org, *supra* note 5.
[11] *Id.*
[12] *Id.*
[13] *Board Rate*, S.C. Dep't of Social Services, (Jul. 2021), https://dss.sc.gov/child-well-being/foster-care/current-foster-parent/board-rate/ (last visited Feb. 21, 2022).
[14] *See Guardianship Assistance Policy and Implementation: A National Analysis of Federal and State Polices and Regulations*, Casey Family Programs (2018), https://caseyfamilypro-wpengine.netdna-ssl.com/media/Guardianship-Assistance-Policy-and-Implementation_Technical-Report.pdf (last visited Feb. 21, 2022).

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[16] *Id.*
[17] Arkansas, Colorado, Michigan, New York, Texas, Vermont, and Washington.
[18] Pub. L. No. 110-351, 110th Cong. (2008), *Fostering Connections to Success and Increasing Adoptions Act of 2008*.
[19] Grandfamilies.org, *supra* note 5.
[20] *Id.*

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