



COMMITTEE *on* CHILDREN

2020 Annual Report



Joint Citizens and Legislative Committee on Children

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Senator Katrina Shealy, Lexington

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There is no keener revelation of a society's soul than the way in which it treats its children.
- Nelson Mandela



STATE OF SOUTH CAROLINA
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On behalf of the Joint Citizens and Legislative Committee on Children, we are pleased to present the 2020 Annual Report of the Committee. The Committee offers a forum for citizens, legislators, and agency directors to identify and study the needs of children and to promote sound strategies for the development of children's policy. The report is also available on the Committee's website at sccommitteeonchildren.org.

The Committee is charged with the important responsibility of identifying and studying key issues facing the children of South Carolina and making recommendations to the Governor and General Assembly. Our 2020 Annual Report addresses areas of concern related to children with disabling conditions and special healthcare needs in our state, a topic raised annually by stakeholder partners and by constituents at the Committee's Public Hearings held across the state last fall.

This Committee sincerely appreciates the individuals who have given this Annual Report the substance it contains. South Carolina is fortunate that its leaders are concerned about children's issues. This Committee is grateful for the opportunity to address the needs of children and encourages your continued input and support as the State of South Carolina establishes public policies and priorities for children.

Thank you for your consideration of the research and recommendations contained in this report.

Katrina Shealy, Chair

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Neal Collins, Vice-Chair

Handwritten signature of Neal Collins in cursive.

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Committee Overview for 2020

This Annual Report of the Joint Citizens and Legislative Committee on Children provides information to the Governor and the General Assembly in the consideration of policy, funding, and legislation that affects children. The Committee looks forward to working with legislators and other elected officials, citizens, and all who serve or who are interested in promoting the well-being of children.

Based on input provided at the Committee's public hearings, and building on the Committee's previous work, this Annual Report gives attention to: **Children with Special Needs in South Carolina.**

Additionally, the Committee supports policy implementation and legislation to address:

- **Background Checks for Group Home Employees**
- **Children's Safety in Afterschool Programs and Summer Camps**
- **Incarceration of Children Sentenced to Life Without Parole**
- **Incarceration of Status Offenders**
- **Increasing Penalties for Sex Buyers**
- **Penalizing Torture of Children**
- **Placement of Children on the Sex Offender Registry**
- **Prohibiting Children from Using Tanning Beds**
- **Safe Harbor for Child Victims of Human Trafficking**
- **Teen Dating Violence Prevention**
- **Tobacco Products Marketed to Children**

For the second regular session of the 123rd South Carolina General Assembly, the Committee on Children has introduced three additional pieces of legislation to further the work of supporting and protecting children:

- **Tobacco Retail Licensing (H 4798/S 872)**
- **Child Abuse Response Protocol (H 4799 /S 892)**
- **Reauthorization of the JCLCC (H 4800/S 865)**

The Joint Citizens and Legislative Committee on Children has identified a number of issues that affect multiple areas of child development that are in need of policy and legislative initiatives. These initiatives will make our state safer and healthier so that children can flourish. It is the priority of the Committee on Children to ensure that our state promotes policies and passes legislation that ensures children can meet their full potential. Please consider our recommendations, accompanying legislation, and the Committee position on them as you act this legislative session.

Updates on Committee Initiatives

The Committee on Children continues to work toward legislative and policy reforms that will improve protection for children and more effectively use limited public resources. In 2019, the Committee on Children sponsored or endorsed the following bills that ultimately passed:

- **Fathers' Names on Birth Certificates (Act 42 of 2019)** mandates that birth certificates are automatically amended to include father's name when paternity determination is made by administrative proceeding or court action; describes procedure for such; and authorizes data collection by DHEC for Maternal Morbidity and Mortality Review Committee.
- **Background Checks for Childcare Facilities (Act 52 of 2019)** expands and clarifies current law regarding background checks for DSS licensed and registered childcare to include state and federal background checks, sex offender and child abuse registry checks, previously omitted crimes, and frequent re-checks; and includes prohibition for registered sex offenders to be employed where they would supervise, instruct, or care for minors without court approval.
- **Child Marriage (Act 33 of 2019)** repeals law that allows issuance of a marriage license for an unmarried female and male under 18 years old when the female is pregnant or has a child, effectively creating a minimum age of marriage of 16.
- **Youth Access to Tobacco (Act 25 of 2019)** requires third-party age verification for internet sales of tobacco products or alternative nicotine products to minors made through the internet and increases penalties for noncompliance; prohibits minors from entering vape shops without adult supervision; updates statutory definitions related to alternative nicotine products; and requires school districts to adopt policies prohibiting use of tobacco or alternative nicotine products on school property.

Resolutions:

- **Recognizing National School Breakfast Week (H 4170/S 625)**
- **Recognizing School Breakfast Champions from Calhoun, Colleton, Darlington, Richland and Sumter Counties (H 4556)**

Other 2019 Committee on Children legislation and initiatives received hearings and prompted important discussion, public debate, and study of key children's issues. In 2019, the Committee selected three candidates for presentation to the Governor for the new role of State Child Advocate as charged by Act 160 of 2018. Additionally, the Committee convened informational briefings on improving outcomes for youth with dual-system involvement and received an agency update from First Steps.

Data Highlights

South Carolina was ranked 39th in the nation on overall child well-being by the Annie E. Casey Foundation in its 2019 *KIDS COUNT Data Book*.¹ There are more than 1.1 million children under age 18 living in South Carolina, which is 22% of the total population.² The most recent available data shows that in South Carolina:

- **56,668** children were born in 2018, and **879** of the children were born to girls under age 18.³
- **668** children died in 2018.⁴
- **90,149** child non-fatal injuries requiring a hospital or emergency room visit occurred, incurring total hospital charges of **\$266,602,382** in 2018.⁵
- **643,122** or **58%** of children in the state were enrolled in Medicaid in 2018.⁶
- **19,269** children were victims of maltreatment in 2019.⁷
- **8,581** children were served in foster care in 2019.⁸
- **101,618** children ages 3 to 17 were identified as having a disabling condition in 2019.⁹
- **26,070** infants and **36,565** children on average participated monthly in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) in 2019.¹⁰
- **241,192** or **22.1%** of children under age 18 lived in poverty, which is higher than the national level (18%) in 2018.¹¹

¹ *The 2019 KIDS COUNT Data Book*, THE ANNIE E. CASEY FOUND. (2019), <https://www.aecf.org/m/resourcedoc/aecf-2019kidscountdatabook-2019.pdf> (last visited Jan. 8, 2020).

² *Population Data*, S.C. DEP'T OF HEALTH AND ENV'T CONTROL (2020), <http://scangis.dhec.sc.gov/scan/bdp/tables/populationtable.aspx> (last visited Jan. 8, 2020).

³ *Birth Certificate Data*, S.C. DEP'T OF HEALTH AND ENV'T CONTROL (2020), <http://scangis.dhec.sc.gov/scan/bdp/tables/birthtable.aspx> (last visited Jan. 8, 2020).

⁴ *Death Certificate Data*, S.C. DEP'T OF HEALTH AND ENV'T CONTROL (2020), <http://scangis.dhec.sc.gov/scan/bdp/tables/death2table.aspx> (last visited Jan. 8, 2020).

⁵ S.C. REVENUE AND FISCAL AFFAIRS OFFICE. South Carolina pediatric emergency department visits (ages 0-17), includes emergency department visits that resulted in an inpatient admission, non-fatal injuries for South Carolina residents, calendar year 2018. Unpublished report generated in Nov. 2019.

⁶ *Medicaid Enrollment*, S.C. HEALTHVIZ (2018), <http://www.schealthviz.sc.edu/medicaid-enrollment> (last visited Jan. 8, 2020). These data are current as of December 31, 2018. Numbers may vary based on data processing date. The year represents data for one incurred month during each state fiscal year. Duplication across groups is minimized by pulling data for a single month; the data may still be subject to duplication.

⁷ *Children in Founded CPS Investigations During SFY 2018-2019 Based on the Date the Intake was Accepted for Investigation*, S.C. DEP'T OF SOCIAL SERVICES – DIV. OF ACCOUNTABILITY, DATA, AND RESEARCH (data from CAPSS on August 1, 2019), <https://dss.sc.gov/media/2150/ages-of-children-in-founded-investigations-for-sfy-2019.pdf> (last visited Jan. 8, 2020). Data includes only children in the household who were determined to be the direct victims of one or more specific founded maltreatments.

⁸ *Total Children Served in Foster Care by Office of Case Management During SFY 2018-2019*, S.C. DEP'T OF SOCIAL SERVICES – DIV. OF ACCOUNTABILITY, DATA, AND RESEARCH (data from CAPSS on August 1, 2019), <https://dss.sc.gov/media/2133/total-children-served-during-sfy-19.pdf> (last visited Jan. 8, 2020).

⁹ *2018-2019 Child Count Data*, S.C. DEP'T OF EDUC., <https://ed.sc.gov/districts-schools/special-education-services/data-and-technology-d-t/data-collection-and-reporting/sc-data-collection-history/idea-child-count-data/2018-2019-child-count-data/> (last visited Jan. 9, 2020). These data are reflective of students with disabilities, ages 3-17, in special education and related services through Individualized Education Programs or Individualized Service Plans under the coverage of the Individuals with Disabilities Education Act, 2004. These counts would not include children with disabilities who do not have IEPs or ISPs. The child count date for the 2018-2019 school year was Tuesday, October 23, 2018.

¹⁰ *WIC Data Tables, Monthly Data – State Level Participation by Category and Program Costs, Fiscal Year 2019*, U.S. DEP'T OF AGRIC., FOOD AND NUTRITION SERVICE (Dec. 2019), <https://www.fns.usda.gov/pd/wic-program> (last visited Jan. 9, 2020).

¹¹ *Small Area Income and Poverty Estimates (90% Confidence Interval)*, U.S. CENSUS, https://www.census.gov/data-tools/demo/saie/#/?map_geoSelector=u18_c&s_measures=u18_snc (last visited Jan. 9, 2020).

Helping All Children Reach Their Fullest Potential

The Committee on Children is charged with the important responsibility to identify and study key issues facing the young people of South Carolina and make recommendations to the Governor and General Assembly. The Annual Report is intended to create awareness of the status of children in South Carolina, stimulate informed discussion of children's issues, and encourage sound public policy that promotes child well-being. The Committee on Children seeks resourceful, innovative ways to inform and engage all South Carolinians to encourage and support the well-being of children for a brighter future and a better State.

The Children's Policy of South Carolina charges us to cooperatively identify strategies that maximize all available resources to protect children and recommend actionable policy changes to help all children reach their highest potential. Protecting children's physical and mental health and improving overall child well-being have been priority concerns for the Committee since its formation and is the reason the Committee dedicates the entirety of this annual report to **Children with Special Needs in South Carolina**.

Informing our process is the study of relevant state and national data, emerging trends in child-related policy improvements and best practices, as well as the input of stakeholders during the series of Annual Public Hearings held each fall. Since the inception of its Hearings, the Joint Citizens and Legislative Committee on Children has received testimony each year about children in our state with disabling conditions. The public has raised awareness about their health needs, their educational needs, the need for related services and supports, and most importantly, their potential for great contributions and accomplishments as they grow into adult citizens of our state.

Over the years, the Annual Report has covered numerous topics that necessarily impact children with special needs but never solely focused on those children. This year's report explores issues of childhood disability in the context of the trends in disabling conditions, the impact on families and our state systems that serve these children, and the challenges for families over a life span from early opportunities to identify special needs to the transition into successful adulthood. Additionally, the report focuses on how we identify the children and students with disabilities served under public health and health insurance programs, by our educational programs, and ultimately as part of our state's workforce. We also consider the importance of mental health alongside that of physical health.

The report identifies major issues that bear further study and consideration by leaders and policymakers including the challenges in accessing services, in the growing workforce needed to provide children's services, and in the barriers to successful independent living. Ultimately, the life outcomes we desire for children with disabilities are the same as those we wish for all South Carolina's children - that they be physically and mentally healthy, able to meet their daily needs, educated, employed, and able to participate in community life. Overcoming barriers to help ensure those outcomes for children is our highest calling.

Defining Disability and Service Eligibility

Definitions of childhood disability vary from broad to narrow, meaning there is no standard legal definition to which one can point.¹² This variability can pose an issue for youth with disabilities and their families because access to and eligibility for services are often different across federal and state agencies.¹³ Specifically, since there is no cohesive system of care available for children with disabilities, families must navigate a complex array of benefits and services, each governed by different areas of the law. Thus, it is important to understand the basic legal framework that mandates certain protections, programs, and services. The following section will discuss select federal and state laws that are in place to serve children with disabilities and their families.

Federal Laws

Section 504

Section 504 is a federal law that prohibits discrimination based on disability by recipients of federal financial assistance, including all public schools as well as public charter and magnet schools receiving financial assistance from the federal Department of Education.¹⁴ Section 504 provides a wide range of protections against discrimination on the basis of disability. For example, all qualified elementary and secondary public school students who meet the definition of an individual with a disability under Section 504 are entitled to receive regular or special education designed to meet their individual educational needs.¹⁵ The Office of Civil Rights monitors compliance with Section 504.¹⁶

For the purposes of Section 504, “student with a disability” is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment.¹⁷ Major life activities include caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.¹⁸ In order to qualify for protection under Section 504, the child must be of an age during which persons without disabilities are provided such services, of an age during which it is mandatory under state law to provide such services to persons with disabilities, or a person for whom a state is required to provide a free appropriate public education under the

¹² Amy J. Houtrow, Frank R. Valliere & Emily Byers, *Opportunities for Improving Programs and Services for Children with Disabilities* (2018) 2 NAT’L ACAD. OF SCI., ENG’R, AND MED. i, ix <https://www.ncbi.nlm.nih.gov/books/NBK518922/> (last visited Feb. 1, 2020).

¹³ *Id.*

¹⁴ *Parent and Educator Resource Guide to Section 504 in Public Elementary and Secondary Schools*, ¹⁴ U.S. DEP’T OF EDUC. (2016), <https://www2.ed.gov/about/offices/list/ocr/docs/504-resource-guide-201612.pdf> (last visited Feb. 5, 2020).

¹⁵ 34 C.F.R. § 104.33 (2000).

¹⁶ U.S. DEP’T OF EDUC., *supra* note 14.

¹⁷ 29 U.S.C. § 705 (2014). A physical or mental impairment is defined as any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; or any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

¹⁸ 34 C.F.R. § 104.3 (2017).

Individuals with Disabilities Education Act.¹⁹ In other words, a school-aged child with disabilities would be protected because the state provides public education for their peers without disabilities.

Under the Section 504 regulation, a preschool, elementary, secondary, or adult education school receiving federal public school funds has several responsibilities toward qualified persons with disabilities in its jurisdiction such as:

- Annually identify and locate all unserved disabled children;
- Provide a free appropriate public education (FAPE) to all students with disabilities;
- Ensure students with disabilities are educated with students who do not have a disability to the maximum extent appropriate to the needs of the students with disabilities;
- Establish nondiscriminatory evaluation and placement procedures;
- Establish procedural safeguards to enable parents and guardians to participate meaningfully in decisions regarding the evaluation and placement of their children; and
- Afford children with disabilities equal opportunities to participate in nonacademic and extracurricular services and activities.²⁰

Section 504 Plan

A Section 504 Plan, or “504 Plan,” is the term used to describe the regular or special education, and related aids and services, a student needs as well as the appropriate setting in which to receive those services.²¹ The Office of Civil Rights encourages schools to utilize written documentation for plans to avoid misunderstandings or confusion about what services the school offered the student.²² A Section 504 Plan should not be confused with an Individualized Education Plan (IEP) which will be discussed in a subsequent section.²³

The goal of a 504 Plan is to ensure that a student with a disability receives a free appropriate public education (FAPE) and to determine what services the school will provide the student. By law, a school district must evaluate a student in a timely manner if it has reason to believe the student has a disability and may need special education or related services as a result of that disability, regardless of whether the student exhibits academic challenges.²⁴

Individuals with Disabilities Act (IDEA)

The Individuals with Disabilities Act (IDEA) is a four-part piece of legislation (A-D) that serves as the basis for special education in the United States.²⁵ Part A defines the terms of the Act as well as the establishment of the Office of Special Education Programs.²⁶ Part B determines the

¹⁹ *Id.*

²⁰ *The Civil Rights of Students with Hidden Disabilities Under Section 504 of the Rehabilitation Act of 1973*, ²⁰ U.S. DEP’T OF EDUC. (1995), <https://www2.ed.gov/about/offices/list/ocr/docs/hq5269.html> (last visited Feb. 5, 2020).

²¹ U.S. DEP’T OF EDUC., *supra* note 14.

²² *Id.*

²³ *See infra* p. 9.

²⁴ U.S. DEP’T OF EDUC., *supra* note 14 (citing 34 C.F.R. § 104.35).

²⁵ Houtrow, Valliere & Byers, *supra* note 12.

²⁶ 20 U.S.C. §§ 1400-1409 (2019).

educational guidelines for school children ages 3-21.²⁷ Guidelines regarding the services for very young children, ages birth to two, are the emphasis of Part C.²⁸ Finally, Part D pertains to national activities that must be undertaken in order to improve the educational experiences for youth with disabilities.²⁹ The IDEA guarantees all children access to a free and appropriate public education (FAPE) through specially designed instruction, supplementary aids, and services.³⁰

For the purposes of the Individuals with Disabilities Education Act, “child with a disability” is defined as a child with intellectual disabilities, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities and who due to their impairment, needs special education and related services.³¹ The qualifying disability criteria for the IDEA is slightly more specific than Section 504 but broader than the Social Security Administration criteria.

The IDEA offers a further definition of child with a disability for children aged three to nine, which may be used at the discretion of the State and local educational agency.³² This definition includes a child experiencing developmental delays, as defined by the State and as measured by appropriate diagnostic instruments and procedures in one or more of the following areas: physical development; cognitive development; communication development; social or emotional development; or adaptive development, and who due to this impairment, needs special education and related services.³³

In South Carolina, the definition is for children ages three, four, and five.³⁴ S.C. Code Ann. § 59-36-10 defines “[p]reschool children with disabilities” as “children ages three, four, and five whose developmental progress is delayed to the extent that a program of special education is required to ensure their adequate preparation for school-age experiences.”³⁵ Eligibility must be noncategorical and must provide for children who are experiencing developmental delays in one or more of the following areas: cognitive ability, social ability, emotional ability, perceptual ability, visual ability, hearing ability, motor ability, speech-language ability, and other health impairments.³⁶ The requirement that eligibility for children ages three to five be noncategorical aims to prevent the premature labeling of children and to provide flexibility in service delivery.³⁷ This requirement also allows a child to access services without a specific diagnosis. This is important because it enables a pediatrician or other health evaluator to refer a child to services before an official diagnosis is made.

²⁷ *Id.* at §§ 1411-1419.

²⁸ *Id.* at §§ 1431-1444 (2019).

²⁹ *Id.* at §§ 1450-1482 (2019).

³⁰ Houtrow, Valliere & Byers, *supra* note 12.

³¹ 20 U.S.C. § 1401 (2019).

³² *Id.*

³³ *Id.*

³⁴ S.C. Code Ann. § 59-36-10(1).

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Report Summarizing Services Provided Under the Individuals with Disabilities Education Act (IDEA) to Preschool Children with Disabilities 2015-16 School Year 34*, STATE OF S.C. DEP’T OF EDUC. (2017).

Comparing Section 504 to the IDEA		
	Section 504	IDEA
Purpose	Prevent discrimination	Direct assessment, planning, educational provisions/services
Funding	No funding attached	State funding attached
Ages Served	Lifetime	Birth through 21 or upon completion of high school diploma
Population	All federally funded programs	Schools
Procedural Regulations	Not strictly regulated	Specific rules and requirements

Source: Skalski & Stanek (2010), National Assoc. of School Psychologists³⁸

IDEA Part B – Child Find

Much like the requirement under Section 504 for schools to timely evaluate children who may have a disability, the IDEA has a mandate called Child Find. Child Find legally requires that schools find all children, from birth through age 21, who have disabilities and may be entitled to special education services.³⁹ Under Child Find, school districts must have a plan for identifying and evaluating children who may need special services. These requirements also apply to children who are being homeschooled or are enrolled in private school.⁴⁰

³⁸ Adapted from Anastasia Kalamaros Skalski & John Stanek, *Section 504: A Guide for Parents and Educators*, NAT'L ASSOC. OF SCHOOL PSYCHOLOGISTS, 1-5 (2010), https://www.nasponline.org/Documents/Research%20and%20Policy/Advocacy%20Resources/35-1_S8-35_section_504.pdf (last visited Jan. 29, 2020).

³⁹ 20 C.F.R. § 300.111 (2012).

⁴⁰ *Id.*

Mandated Child Find Agencies & Programs	
Agency	Program
Early Intervention Service Providers	
SC Children's Trust	<ul style="list-style-type: none"> • Maternal, Infant, and Early Childhood Home visitation program • Family Violence Prevention and Services
SC Department of Disabilities and Special Needs (DDSN)	<ul style="list-style-type: none"> • County Boards of Disabilities and Special Needs • Private Qualified Providers of IDEA/Part C Services
SC Department of Education	<ul style="list-style-type: none"> • Office of Special Education Services • McKinney-Vento District Liaisons • Maternal and Child Health
SC Department of Health and Environmental Control (DHEC)	<ul style="list-style-type: none"> • Early Hearings and Detection • Birth Defects Registry • County Health Departments
SC Department of Health and Human Services (HHS)	<ul style="list-style-type: none"> • Early Periodic Screening, Diagnosis, and Treatment • Supplemental Security Income • Children's Health Insurance • Federally Qualified Health Centers
SC Department of Mental Health (DMH)	<ul style="list-style-type: none"> • Community Mental Health Centers
SC Department of Social Services	<ul style="list-style-type: none"> • Head Start Programs • Early Care and Education • Child Protective Services • Foster Care Services
SC School for the Deaf and Blind	
SC School Districts (LEAS)	

Source: SC Department of Health and Human Services⁴¹

IDEA Part B – Individualized Education Program

The IDEA Part B requires states to conduct a complete, individual initial evaluation before a child may begin receiving special education services.⁴² It also requires an Individualized Education Program be developed.⁴³ An Individualized Education Program (IEP) is a written statement for each child with a disability under the IDEA that is developed, reviewed, and revised in accordance with the statute.⁴⁴

⁴¹ *Child Find Activities: Pre-Referral*, S.C. DEP'T OF HEALTH AND HUMAN SERV. (2019), <https://mssp.scdhhs.gov/babynet/sites/default/files/%282019-12-13%29%20IDEA%20Part%20C%20Procedures%20for%20Child%20Find%20Activities.pdf> (last visited Feb. 3, 2020).

⁴² 20 C.F.R. § 1411 (2019).

⁴³ *Id.*

⁴⁴ 20 C.F.R. § 1414 (2019).

The IDEA lays out specific requirements for IEPs and the process through which they are developed in Section 1414 of Part B. These requirements include things such as: how the child's disability affects the child's involvement and progress in the general education curriculum; a statement of measurable annual goals, including academic and functional goals; a description of how the child's progress toward meeting the annual goals will be measured; and a statement of the special education services, modifications, and supplementary aids and services to be provided to the child, or on behalf of the child.⁴⁵

The IEP is developed by an IEP team, which should include: the child's parents; the child's regular education teacher; a special education teacher; and a representative of the district who is knowledgeable about the general education curriculum and the resources available to the district, and who is qualified to provide specially designed instruction to meet the needs of children with disabilities.⁴⁶ The IDEA also calls for an individual who can interpret the instructional implications of evaluation results and any other individual who has the knowledge or special expertise regarding the child.⁴⁷ These individuals may be members of the IEP team in another capacity as well.⁴⁸ The child may also participate whenever appropriate.⁴⁹

IDEA Part C– BabyNet

South Carolina's IDEA Part C program is called BabyNet and is available to children from birth to age three.⁵⁰ An infant or toddler is determined eligible for Part C if the child is experiencing either a diagnosis known to result in lifelong disability, or significant delays in development.⁵¹ Significant delays in development are considered a delay of at least 40% in one area of development, or delays of at least 25% in two areas.⁵² The areas of development are cognitive development, physical development (including vision and hearing), communication development, social or emotional development and adaptive development.⁵³ A child can also be determined eligible for Part C if the child has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.⁵⁴ Anyone can make a referral to BabyNet for very young children or to the public school for determination of eligibility for special education for older children if they feel a child might need extra help. This includes school personnel (including

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *What is BabyNet?*, S.C. DEP'T OF HEALTH AND HUMAN SERV. (2020), <https://msp.scdhhs.gov/babynet/> (last visited Feb. 5, 2020).

⁵¹ *Id.*

⁵² *Healthy Connections – Policy: Intake, Screening, and Initial Eligibility Evaluation*, S.C. DEP'T OF HEALTH AND HUMAN SERV. (2019), <https://msp.scdhhs.gov/babynet/sites/default/files/SCDHHS%20IDEA%20Part%20C%20Policy%20for%20Intake%20Screening%20and%20Initial%20Eligibility%20Evaluation.pdf> (last visited Feb. 5, 2020).

⁵³ *Determination of Initial Eligibility*, S.C. DEP'T OF HEALTH AND HUMAN SERV. <https://msp.scdhhs.gov/babynet/sites/default/files/BabyNet%20Procedures%20for%20Determination%20of%20Initial%20Eligibility.pdf> (last visited Feb. 5, 2020).

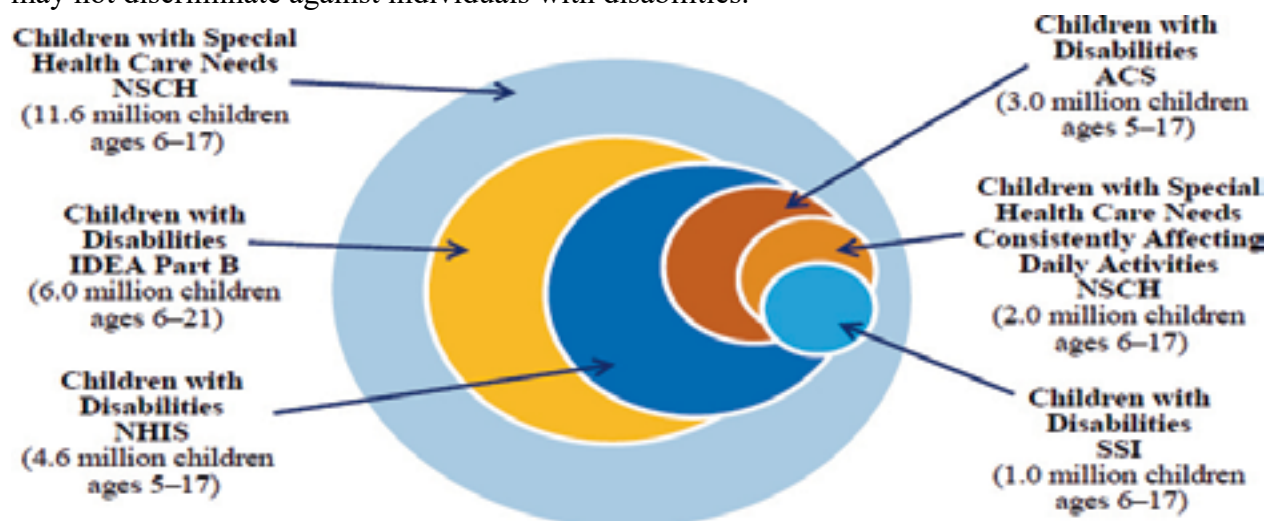
⁵⁴ *Id.* Conditions with a high probability of resulting delay include conditions such as chromosomal abnormalities; genetic or congenital disorders; sensory impairments; inborn errors of metabolism; disorders reflecting disturbance of the development of the nervous system; congenital infections; severe attachment disorders; complications of prematurity; and disorders secondary to exposure to toxic substances, including fetal alcohol syndrome.

general education teachers, special education teachers, counselors, administrators, etc.), child's parent(s) or legal guardian(s), and any other person involved in the education or care of the child.

The Americans with Disabilities Act (ADA)

The Americans with Disabilities Act (ADA) is a federal civil rights law that protects individuals of all ages from disability discrimination by the government, employers, schools, and anyone who offers goods and services to the public.⁵⁵ The ADA is intentionally broad and protects anyone with a physical or mental impairment, which substantially limits one or more life activities.⁵⁶ Life activities include things like eating, hearing, speaking, learning, reading, concentrating, and communicating. **If a child qualifies for protection under Section 504, they are also protected by the ADA.**

The ADA affords people with disabilities the right to reasonable accommodations so they can have equal access and opportunities to participate in society.⁵⁷ Accommodations can range from wheelchair access to large print informational sheets, but an accommodation is not required if it would cause an undue burden or a fundamental alteration to what a school, program, or business is offering.⁵⁸ Unlike Section 504 and the IDEA, the ADA does not make schools responsible for free and appropriate public education (FAPE). While the ADA affords less protection than other acts and regulations, it does apply whether or not a program is federally funded. This means programs like camps, sports leagues, and college admissions testing facilities may not discriminate against individuals with disabilities.



*Source: National Academies of Sciences, Engineering and Medicine*⁵⁹

South Carolina State Statute

⁵⁵ *Americans with Disabilities Act (ADA)*, U.S. DEP'T OF EDUC. (2020), <https://www2.ed.gov/about/offices/list/ocr/docs/hq9805.html> (last visited Feb. 5, 2020).

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ Houtrow, Valliere & Byers, *supra* note 12.

S.C. Code Ann. § 43-33-340 defines “developmental disability” as “a severe, chronic disability of a person which: is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the person attains age twenty-two; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; reflects the person’s need for a combination and sequence of special, interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.”

In S.C. Code Ann. § 2-7-35 a “person with a disability” or “handicapped person” is defined as “a person who has a physical or mental impairment which substantially limits one or more major life activities including, but not limited to caring for himself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working;” and “a person who meets any other definition prescribed by federal law or regulation for use by agencies of state government which serve handicapped persons.”

Statistics and Trends

It is challenging to state with great precision how many children with special needs live in the Palmetto State. Eligibility for services from agencies is one way to identify this population, but there are additional groups of children with special healthcare needs that may not fall into any of those existing eligibility categories. Independent of state and federal agency calculations, there are some statistics collected on specific conditions, yet even these data may not fully reflect the population due to data collection issues such as varying definitions of disability, bias, and use of different data collection instruments. Another ongoing barrier to fully capturing accurate numbers is that many children who have a limiting condition or illness are able to thrive with mitigations such as medication and therapies. However, it is important to quantify those disability-causing illnesses and conditions because many other children in our state do not have full access to those same supports. Decisionmakers can also consider potential prevention strategies for some of these conditions.

Children with Special Needs: A Potentially Underrepresented Population

By some measures, **upwards of 42% of our children have significant healthcare needs which could rise to the level of a disabling condition that impacts how they develop or learn.** In South Carolina, 24.2% or 265,712 children ages 0 - 17 have one current or lifelong health condition and another 18.1% or 198,875 children ages 0 - 17 have two or more current or lifelong health conditions.⁶⁰ Nearly 21% or 228,278 of our children have special healthcare needs, generally defined as having a chronic condition and needing access to healthcare systems as a result.⁶¹ At another, higher level of need, 14.7% or 160,930 have one functional difficulty and another 10.4% or 113,956 have two or more functional difficulties.⁶²

Over recent years, there has been an overall increase in children identified as needing developmental and educational supports and services, and along with it, a corresponding increase in the development of technology, interventions, and identification processes that makes determining trends much more complicated.⁶³ With that increase, some disabling conditions have emerged as more prevalent. Some of those disabilities may have been categorized differently just

⁶⁰ *The Child and Adolescent Health Measurement Initiative; 2017-2018 National Survey of Children's Health (NSCH) Data Query*, DATA RES. CTR. FOR CHILD AND ADOLESCENT (2018), www.childhealthdata.org (last visited Jan. 10, 2020). For the 27 conditions included in this measure see, <https://www.childhealthdata.org/browse/survey?s=2&y=28&r=1>.

⁶¹ See *id.* The National Survey of Children's Health uses the Children with Special Health Care Needs Screener to identify children with special health care needs. The Screener is a five item, parent-reported tool designed to reflect the federal Maternal and Child Health Bureau's consequences-based definition of children with special health care needs. It identifies children across the range and diversity of childhood chronic conditions and special needs, allowing a more comprehensive and robust assessment of children's needs and health care system performance than is attainable by focusing on a single diagnosis or type of special need.

⁶² See *id.* For a list of functional disabilities used in the measure. See also, <https://www.childhealthdata.org/browse/survey?s=2&y=28&r=1>.

⁶³ Neal Halfon et al., *The Changing Landscape of Childhood Disability*, 22(1) THE FUTURE OF CHILDREN (2012), https://futureofchildren.princeton.edu/sites/futureofchildren/files/media/children_with_disabilities_22_01_fulljournal.pdf (last accessed Jan. 14, 2020). Research raises concerns there may be an underrepresentation of children of color within special education populations. See generally, Paul Morgan et al., *Replicated Evidence of Racial and Ethnic Disparities in Disability Identification in U.S. Schools*, 46(6) EDUC. RESEARCHER (2017).

a few years ago. For example, some students who previously would have been classified as having a specific learning disability may now be classified as having autism or “other health impairment.”

In the United States, approximately 13%, or 7 million students ages 3-21, are served under the Individuals with Disabilities Education Act (IDEA).⁶⁴

Similarly, in South Carolina, 13.5% of our students are served by IDEA.⁶⁵

Among our youngest children in South Carolina, 2.5% of the population 0-3 is served by IDEA Part C⁶⁶ and 41.6% of those children continue in IDEA Part B services once they reach age 3.⁶⁷

**Children with Disabilities, Early Childhood (Ages 3-5), South Carolina
By Primary Disability and Age (as of the Child Count Date)**

Reported Primary Disability	Age					
	Age 3		Age 4		Age 5	
	Count	Column Percent	Count	Column Percent	Count	Column Percent
Autism spectrum disorder	322	15.9%	410	13.5%	694	10.6%
Deaf and Hard of Hearing	33	1.6%	31	1.0%	45	1.0%
Deaf-Blindness	-	-	-	-	-	-
Developmental Delay	655	44.0%	1274	41.2%	1545	33.0%
Emotional Disability	-	-	-	-	-	-
Hearing Impairment	-	-	-	-	-	-
Intellectual Disability	-	-	-	-	25	0.5%
Multiple Disabilities	20	1.4%	17	0.6%	29	0.6%
Orthopedic Impairment	12	0.6%	19	0.6%	24	0.6%
Other Health Impairment	49	2.4%	50	1.6%	90	2.0%
Specific Learning Disability	-	-	-	-	-	-
Speech or Language Impairment	655	33.1%	1260	40.7%	2375	50.8%
Traumatic Brain Injury	-	-	-	-	-	-
Visual Impairment	12	0.6%	12	0.4%	20	0.5%
	2019	100.0%	3095	100.0%	4575	100.0%

Source: South Carolina Department of Education⁶⁸

There has been a significant shift in the overall type of disabling conditions in children. Now, developmental, emotional, and behavioral conditions make up the majority of identifications rather than physical conditions. For each of the categories, it is important to remember that a number of factors contribute to changes and increases in rates of disability including the change in identification methods, a lessening of the resistance once present to identification, increased

⁶⁴ *Children 3 to 21 Years Old Served Under Individuals with Disabilities Education Act (IDEA), Part B, by Type of Disability: Selected Years, 1976-77 through 2017-18*, NAT'L CTR. FOR EDUC. STATISTICS (2018), https://nces.ed.gov/programs/digest/d18/tables/dt18_204.30.asp (last visited Jan. 9, 2020).

⁶⁵ Maya Riser-Kositsky, *Special Education: Definition, Statistics, and Trends*, EDUC. WEEK (2019), <http://www.edweek.org/ew/issues/special-populations/> (last visited Jan. 2, 2020).

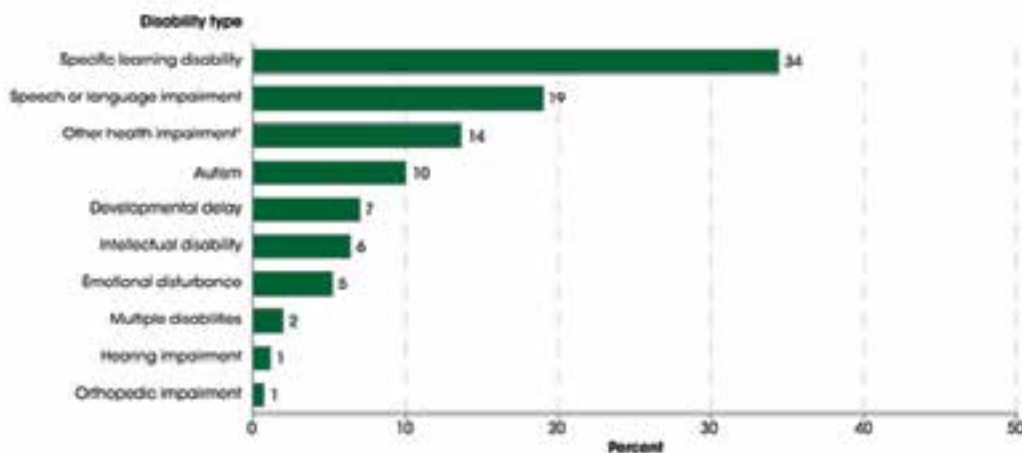
⁶⁶ *40th Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2018*, U.S. DEP'T OF EDUC. (2018), <https://www2.ed.gov/about/reports/annual/osep/2018/parts-b-c/40th-arc-for-idea.pdf> (last visited Jan. 2, 2020).

⁶⁷ *Id.*

⁶⁸ *Children with Disabilities, Early Childhood (Ages 3-5), South Carolina By Primary Disability and Age (as of the Child Count Date)*, STATE OF S.C. DEP'T OF EDUC. (2018), <https://ed.sc.gov/districts-schools/special-education-services/data-and-technology-d-t/data-collection-and-reporting/sc-data-collection-history/idea-child-count-data/2018-2019-child-count-data/sc-2018-2019-age-3-to-5-state-summary-and-tables-pdf/> (last visited Jan. 2, 2020).

exposure, and changes in access to services.⁶⁹ In South Carolina, 23.1% of children ages 3 - 17 have a mental, emotional, developmental, or behavioral problem.⁷⁰

Percentage distribution of students ages 3–21 in the U.S. served under the Individuals with Disabilities Education Act (IDEA), by disability type (school year 2017–18)



Source: National Center for Education Statistics⁷¹

Although these statistics provide a snapshot of information regarding children with disabilities, the possibility remains that children with special needs may still be an underrepresented population. Varying definitions of disabilities, changing categorizations, and differing data collection methodologies make identification of children with disabilities more complex. Fortunately, acknowledging these challenges and collaborating for viable solutions may help ease the burdens families face, improve service provision, and contribute to more accurate data.

⁶⁹ Halfon, *supra* note 63.

⁷⁰ DATA RES. CTR. FOR CHILD AND ADOLESCENT, *supra* note 60. To qualify as having a mental, emotional, developmental or behavioral problem, the child must have any of 10 conditions currently and/or qualify on the CSHCN Screener ongoing emotional, developmental or behavioral conditions criteria.

⁷¹ *Children and Youth with Disabilities*, NAT'L CTR. FOR EDUC. STATISTICS (2019), https://nces.ed.gov/programs/coe/indicator_cgg.asp (last visited on Jan. 30, 2020).

State Agency Services and Programs for Children with Disabilities and their Families

The State of South Carolina is fortunate to have many agencies that offer support to children with special needs and their families. While discussing a comprehensive list of agencies, programs, and services is beyond the scope of this report, here we highlight some of the programs and services for South Carolina's young people. Please note, each agency maintains publicly available details online and in published form.

Agency	Programs and Services for Children
South Carolina Department of Health and Human Services	<ul style="list-style-type: none"> • BabyNet/Early intervention services for children aged 0 – 3, which may include physical therapy, occupational therapy, speech therapy or assistive technology, among others
South Carolina Department of Disabilities and Special Needs	<ul style="list-style-type: none"> • Diagnostic Evaluations • Case coordination • Early intervention services for children aged 3 to 5 • Coordination of Respite Services
Greenwood Genetic Center	<ul style="list-style-type: none"> • Genetic evaluations, counseling, and diagnostic testing for DDSN clients
South Carolina Department of Social Services	<ul style="list-style-type: none"> • SC Special Needs childcare vouchers for income-eligible families of children from birth to 19 with a documented disability or special need
Continuum of Care	<p>High Fidelity Wraparound Services for children:</p> <ul style="list-style-type: none"> • with severe emotional or behavioral health diagnosis and treatment needs which are not currently being met, and • currently residing in or on the waitlist for a psychiatric residential treatment facility, or • with a court order admission to a psychiatric residential treatment facility, or • with a discharge from an acute hospitalization.
Vocational Rehabilitation	<ul style="list-style-type: none"> • Pre-Employment Transition Services for students aged 13-21 with 504 Plans or IEPs • Group Transition Services for youth with disabilities aged 14-24 • Individualized Transition Services for youth eligible for VR services and who have an Individualized Plan for Employment • Project SEARCH internships, Disability Mentoring Day, and Jobs for America's Graduates dropout recovery program • Summer camps and activities for students with barriers to education or employment

Agency	Programs and Services for Children
South Carolina Department of Health and Environmental Control	<p>For Children in Income-Eligible Families:</p> <ul style="list-style-type: none"> • Children’s Rehabilitative Services: case assessment and care plans, referrals, coordination, and financial assistance for medical services, supplies, equipment and prescriptions for covered conditions • Hearing aids, supplies, information and referrals • Special Formula Program • Sickle Cell Program • Hemophilia Assistance Plan • Orthodontic services <p>Camp Burnt Gin: summer camp experience for children and young adults with disabilities and special healthcare needs</p>
South Carolina Department of Mental Health	<ul style="list-style-type: none"> • Clinic based outpatient services including individual, family, and group therapy • School Mental Health Services (available in the majority of public schools) • Wrap or Intensive Services: in-home, behaviorally-oriented services for youth and families • Parent Child Interaction Therapy (available in some SCDMH Community Mental Health Centers for children 2 ½ - 7 and their parents) <p>William S. Hall Psychiatric Institute (Hall Institute): specialized children’s psychiatric hospital; includes treatment for substance use disorders</p>
South Carolina School for the Deaf and Blind	<ul style="list-style-type: none"> • Statewide early intervention services, coordination, and family training for children ages birth through 5, who are deaf, blind, or sensory multi-disabled • Kelly’s Kids Center: services for children aged 6 weeks to 3 years • Specialized day and residential education for students PK3 – 12th grade who are deaf or blind on the main campus in Spartanburg • Cedar Spring Academy: programming for students ages 3 – 21 who have a vision or hearing disability and at least one other physical or intellectual disability • Statewide Deaf and Hard-of-Hearing Education Program, and ASL/Interpreting Services; Blind and Visually Impaired Education; Deaf-Blind Project; and Instructional Materials Center
South Carolina Commission for the Blind- Children’s Services Program	<ul style="list-style-type: none"> • Assessments and assistance with development of IFSPs and IEPs and participation in related meetings • Parent counseling, family workshops and support groups • Summer camping and independent living skills • Consultation and coordination with community resources • Services through Low Vision Clinics for periodic evaluations, • Low-vision devices and instruction on use

Healthcare, In Brief

Medicaid

The South Carolina Department of Health and Human Services (DHHS) is the state agency that administers the Medicaid program under the name Healthy Connections.⁷² Healthy Connections provides health insurance for low income families and some higher income children with disabilities through a waiver program named “Katie Beckett.” Also referred to as a TEFRA waiver, this coverage is designed to help children receive Medicaid-covered, institutional level care at home if they meet the Supplemental Security Income (SSI) definition of disability and meet the level of care requirements. Additional special services may be available under other home and community waivers described below.

Under the Children with Special Health Care Needs provision of the Social Security Act, states provide healthcare services for qualifying children.⁷³ Sometimes, these programs are available for children who do not qualify for SSI as well.⁷⁴ For children meeting the Social Security Administration’s definition of disability, two types of benefits are available. First, SSI provides monthly cash payments. In South Carolina, a child who is receiving SSI benefits is also eligible for Medicaid coverage. The amount of SSI benefits a child receives is determined by several factors centered on income and resources available to the child and their family. South Carolina is one of 19 states that do not supplement the federal benefit for children. The second benefit is the Social Security Disability Insurance (SSDI) program. This program provides benefits to adults who have a disability that began before they turned 22 years old.

Developmental Disabilities

DDSN operates the three home and community waiver programs on behalf of DHHS. The Medicaid programs for children with intellectual and developmental disabilities are Home and Community-Based and Intermediate Care Facilities.⁷⁵ The Home and Community-Based Programs are the Community Supports Waiver, ID/RD Waiver, and the Head and Spinal Cord Injury Waiver. The waivers allow children to access services that would otherwise not be covered under the Medicaid Program.⁷⁶ There are various services under each waiver including private vehicle and environmental modifications that allows adaptations to the home and vehicle for safety, and behavior supports.

DDSN also offers four types of covered residential service supports if needed.⁷⁷ The Supported and Supervised Living Program Models is for adults who need supervision and support to live in apartments or other housing. The next level of care is Community Training Home Models that consist of caregivers who provide care in their own homes or provider employees who care

⁷² *Disabled Children: “Katie Beckett” TEFRA Children*, S.C. HEALTHY CONNECTIONS MEDICAID, <https://www.scdhhs.gov/eligibility-groups/disabled-children> (last visited Feb. 5, 2020).

⁷³ *Benefits for Children with Disabilities*, SOCIAL SECURITY ADMIN. 1,13 (2019), <https://www.ssa.gov/pubs/EN-05-10026.pdf> (last visited Feb. 5, 2020).

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Medicaid Home and Community Based Waiver Services*, S.C. DEP’T OF DISABILITIES AND SPECIAL NEEDS (2020), <https://ddsn.sc.gov/services/medicaid-home-and-community-based-waiver-services> (last visited Feb. 5, 2020).

⁷⁷ *Id.*

for adult individuals in a home operated by a provider agency. DDSN has very few positions available for children. For individuals needing maximum support, ID/DD Community and Regional Center Intermediate Care Facilities both provide 24-hour care, supervision, and treatment. This type of facility is only recommended when appropriate community services are not available. Other covered residential service options available to children via other agencies include Psychiatric Residential Treatment Facilities (PRTFs), Intensive Group Homes, and Therapeutic Foster Care.

There are a range of at-home services that allow children to remain in their own home.⁷⁸ As noted in the chart, DHHS administers the Early Intervention program and BabyNet for children from birth to their third birthday; and DDSN offers Early Intervention services for children ages three until their sixth birthday. This program helps families better understand their child's development and gives training to address specific areas of delay. In addition, there are supports that target adults such as support for independent living that includes paying bills, shopping for groceries, adult day services, and assistance with expenses incurred due to disability and accessing medical care. Employment services are available to obtain and sustain employment. Vocational Rehabilitation is also used to obtain employment. There are very limited state funds available for those who cannot qualify for a Medicaid Waiver.

Mental Health

The South Carolina Department of Mental Health (DMH) is the State of South Carolina's public mental health authority. DMH is one of only a few integrated public mental health systems in the 50 states and 8 U.S. territories, meaning that in addition to its three State hospitals, the agency also directly operates the State's community mental health centers. DMH is consequently one of the very few State mental health agencies that directly provides community mental health services to its State's citizens. DMH operates 16 community mental health centers, with a combined total of 63 outpatient treatment sites covering all 46 counties in South Carolina. The mental health centers now offer an around-the-clock mobile crisis program and are equipped to use telemedicine, expanding access particularly to psychiatrists to patients in rural areas of the state.

DMH school mental health services continue to expand through its community mental health centers. As of 2020, DMH now has clinical counselors providing mental health services in over 750 public schools in South Carolina, approximately 60% of all public schools. In 2019, of the more than 90,000 patients treated by DMH mental health centers, over 30,000 were children, adolescents, and their families, and over half of the children and adolescents treated received some of their mental health services in their school.

As the State's public mental health authority and its largest provider of mental health services to children, adolescents, and their families, DMH's goal is to create a sustainable

⁷⁸ *Overview of DDSN Services*, S.C. DEP'T OF DISABILITIES AND SPECIAL NEEDS (2020), <https://ddsn.sc.gov/services/overview-ddsn-services> (last visited Feb. 5, 2020).

infrastructure and further develop and expand the system of mental health care available in South Carolina for children and adolescents with serious emotional disturbances and their families.

Education Coordination and Collaboration

Childcare and Preschool

The South Carolina Child Care Inclusion Collaborative provides training and coaching for childcare providers to support the inclusion of children with disabilities or developmental delays in their programs.⁷⁹ It is important to remember that the Americans with Disabilities Act applies to most childcare facilities, via either Title II if they are provided by government agencies, or Title III if they are privately funded.

One childcare option specifically charged with serving children with disabilities is Head Start. Head Start is a federal program that promotes school readiness in children from birth to age five, from low-income families.⁸⁰ Head Start programs aim to enhance cognitive, social, and emotional development in preparing children for school.⁸¹ Early Head Start provides services for infants, toddlers, and pregnant women and their families.⁸² Head Start programs must ensure that all enrolled children with disabilities, whether or not they are eligible for services under the IDEA, and their families receive all applicable program services in the least restrictive environment possible and full participation in program activities.⁸³ Programs must provide any necessary modifications to the environment and instruction, and offer individualized accommodations and supports as necessary to enable full participation.⁸⁴

South Carolina Department of Education

While the responsibility to adhere to many federal and state regulations relating to students with disabilities falls to local education agencies (LEAs) - usually school districts, the South Carolina Department of Education (SDE), via their South Carolina Policies and Procedures, and the Standards for Evaluation and Eligibility Determination (SEED), offers many forms of support, supervision, and guidance for these groups. These supports are provided by the Office of Special Education Services' various teams.⁸⁵ The SDE provides assistance to LEAs in developing high quality IEPs for students through the SC Enrich program,⁸⁶ and its Oversight and Assistance team is responsible for supervising and guiding LEAs to meet federal and state legal mandates.⁸⁷ SDE

⁷⁹ *Special Needs/Different Abilities and Needs*, S.C. CHILD CARE (2020), <https://www.sccildcare.org/providers/become-an-abc-provider/special-needs.aspx> (last visited Jan. 14, 2020).

⁸⁰ *South Carolina Head Start*, BENEFITS.GOV (2020), <https://www.benefits.gov/benefit/1938> (last visited Jan. 14, 2020).

⁸¹ *Id.*

⁸² *Id.*

⁸³ 45 C.F.R. § 1302.60.

⁸⁴ 45 C.F.R. § 1302.61.

⁸⁵ *Special Education Services*, STATE OF S.C. DEP'T OF EDUC. (2020), <https://ed.sc.gov/districts-schools/special-education-services/> (last visited Jan. 14, 2020).

⁸⁶ *South Carolina Enrich IEP System*, STATE OF S.C. DEP'T OF EDUC. (2020), <https://ed.sc.gov/districts-schools/special-education-services/oversight-and-assistance-o-a/south-carolina-enrich-iep-system/> (last visited Jan. 14, 2020).

⁸⁷ *Oversight and Assistance (O&A)*, STATE OF S.C. DEP'T OF EDUC. (2020), <https://ed.sc.gov/districts-schools/special-education-services/oversight-and-assistance-o-a/> (last visited Jan. 14, 2020).

also provides training and technical assistance to help meet students' needs, working with districts around the state in areas including preschool, curriculum and instruction, post-secondary transition, assistive technology, behavioral supports, deaf and hard of hearing, visually impaired, group homes, and residential treatment facilities.⁸⁸ While the Office of Special Education Services has been highlighted here, the South Carolina Department of Education offers many more services, programs, and supports for school personnel as well as students and families regarding students with disabilities.

Trauma-Informed Practices

Since 2013, this Committee has maintained an initiative to promote trauma-informed practices within child-serving agencies to encourage the detection and treatment of childhood trauma. Trauma-informed services are those influenced by an understanding of the impact that trauma, violence, toxic stress, and adverse childhood experiences (ACEs) have on a child's development and life.⁸⁹ A number of promising programs exist to address ACEs in South Carolina, and within the context of the focus in this year's report on services for children with disabilities and special health care needs, the Committee renews its recommendation for agencies to coordinate, collaborate, and promote activities to develop evidence-based services that address the impact of trauma on the children they serve.

⁸⁸ *Id.*

⁸⁹ Denise E. Elliott et al., *Trauma-informed or Trauma-denied: Principals and Implementation of Trauma-informed Services for Women*, 33(4) J. OF COMMUNITY PSYCHOLOGY 461-477 (2005).

Challenges for System-Involved Children with Special Needs

Child Welfare Policies and Practices for Children with Disabilities

Rate of Maltreatment for Children with Disabilities

Children with disabilities have a higher risk of maltreatment in the form of abuse or neglect than peers without disabilities.⁹⁰ **Research indicates that on average, children with disabilities were 3.4 times more likely to be maltreated than their peers without disabilities.**⁹¹ Alarming, some studies found incidences of maltreatment were up to 5.29 times more likely to occur.⁹² This increase of maltreatment of children with disabilities could be due in part to societal stigma and discrimination, negative traditional beliefs and ignorance within communities,⁹³ lack of social support for caregivers,⁹⁴ communication difficulties, and heightened vulnerability of the population as a result of the need for increased care, including medical attention.⁹⁵

The types of maltreatment that children with disabilities are most likely to experience include neglect,⁹⁶ physical neglect, and medical neglect.⁹⁷ Children with disabilities are significantly more likely to live in families experiencing poverty than their peers without disabilities, an exposure which can potentially lead to adverse outcomes for this population.⁹⁸ In 2019, 14 children in South Carolina entered foster care solely based on the child's disability, and 99 children entered the system because of a child's behavior problem.⁹⁹ Furthermore, children in foster care are frequently under-identified in having a disability because of placement and school changes.¹⁰⁰

⁹⁰ Melissa Jonson-Reid et al., *A Prospective Analysis of the Relationship Between Reported Child Maltreatment and Special Education Eligibility Among Poor Children*, *Child Maltreatment*, 9(4) CHILD MALTREATMENT 382-394 (2004).

⁹¹ Patricia M. Sullivan & John F. Knutson, *Maltreatment and Disabilities: A Population-Based Epidemiological Study*, 24 *CHILD ABUSE & NEGLECT*, 1257-1273 (2000). See also Scott B. Crosse et al., *A Report on the Maltreatment of Children with Disabilities*, NAT'L CTR. OF CHILD ABUSE AND NEGLECT (1992).

⁹² Lisa Jones et al., *Prevalence and Risk of Violence Against Children with Disabilities: A Systematic Review and Meta-analysis of Observational Studies*, 380(9845) *THE LANCET*, 899-907 (2012). See Table 3: Random-effects pooled odds ratios for risk of violence.

⁹³ Nora Ellen Groce & Corrie Paeglow, *Summary Report: Violence against Disabled Children – UN Secretary General's Report on Violence Against Children*, UNICEF (2005), https://www.unicef.org/videoaudio/PDFs/UNICEF_Violence_Against_Disabled_Children_Report_Distributed_Version.pdf (last visited Feb 6, 2020).

⁹⁴ Robert T. Ammerman et al., *Maltreatment in Psychiatrically Hospitalized Children and Adolescents with Developmental Disabilities: Prevalence and Correlates*, 33 *J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY* 567-76 (1994).

⁹⁵ Robert T. Ammerman, Martin J. Lubetsky, & Karen F. Stubenbort, *Maltreatment of Children with Disabilities*, *CASE STUDIES IN FAMILY VIOLENCE* 231-258 (2000).

⁹⁶ *Id.*

⁹⁷ Sullivan & Knutson, *supra* note 91.

⁹⁸ *Id.*

⁹⁹ *Reasons Youth <18 Years Old Entered Foster Care during SFY 2019*, S.C. DEP'T OF SOCIAL SERV. (2019), <https://dss.sc.gov/media/2135/reasons-that-children-entered-foster-care.pdf> (last visited on Feb. 9, 2020).

¹⁰⁰ Andrea Zetlin, *The Experiences of Foster Children and Youth in Special Education*, 31(3) *J. OF INTELLECTUAL AND DEVELOPMENTAL DISABILITY*, 161-165 (2006).

Prevalence of Youth with Disabilities in the Child Welfare System

Children with some types of disabilities are more likely to experience maltreatment and subsequently become involved in the child welfare system leading to a disproportional overrepresentation of children with disabilities. The overrepresentation of child welfare-involved children with disabilities ranges from 14% to 47% of the population.¹⁰¹ As of 2012, youth with disabilities constituted 31.8% of the entire foster care population represented in the Adoption and Foster Care Analysis and Reporting System (AFCARS).¹⁰² In South Carolina, as of May 2018, 1,329 children in the foster care system had a type of psychiatric diagnosis such as ADHD, anxiety, depression, bipolar disorder, personality disorder, or schizophrenia and 117 children in foster care were hospitalized for psychiatric conditions.¹⁰³ Additionally, 197 foster children were diagnosed with asthma, diabetes, or sickle cell; and 1,137 foster children were taken to the emergency room.¹⁰⁴ According to the South Carolina Department of Social Services, 3,823 or 82.4% of children received an initial physical health screening, while 252 children or 17.6%, did not have a physical health screening documented in SCDSS' data system, CAPSS.¹⁰⁵ For children in foster care, 3,379 children or 92.3% received an initial behavioral health screening, and 732 children or 7.7% did not have a behavioral health screening documented in CAPSS.¹⁰⁶ Through partnerships with SCDHHS and Select Health, SCDSS receives monthly Medicaid claims data to determine which children in care have follow-up health care needs. The agency also has a team of registered nurses dedicated to improving health care coordination and documentation, and who assist in following up on health care needs for children in foster care. This additional documentation will provide needed information about potential health and behavior challenges for a sizeable number of children in care.

Outcomes for Children with Disabilities in the Child Welfare System

Policies within the child welfare system mandate that when first entering care, children and youth should be placed in the least restrictive, most family-like placement such as with kin or nonrelative caregivers.¹⁰⁷ More restrictive levels of care are intended to be a last resort to serve those children with increased behavioral and/or emotional needs who cannot be safely placed with kin or in nonrelative foster homes.¹⁰⁸ Studies have shown that youth who reside in congregate care settings, such as group homes, have worse outcomes as young adults compared to children in traditional family setting foster care placements.¹⁰⁹

¹⁰¹ Elspeth Slayter, *Youth with Disabilities in the United States Child Welfare System*, 64 CHILDREN AND YOUTH SERV. REVIEW, 155-165 (2016).

¹⁰² *Id.*

¹⁰³ South Carolina Department of Social Services *Child Health Fact Sheet*, S.C. DEP'T OF SOCIAL SERV. (2018), <https://dss.sc.gov/media/1983/appendix-dss-child-health-fact-sheet.pdf>.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ MaryLee Allen & Mary Bissell, *Safety and Stability for Foster Children: The Policy Context*, 14(1) THE FUTURE OF CHILDREN 48-73 (2004).

¹⁰⁸ Richard P. Barth, *Child Welfare and Race: Models of Disproportionality*, RACE MATTERS IN CHILD WELFARE: THE OVERREPRESENTATION OF AFRICAN AMERICAN CHILDREN IN THE SYSTEM 25-46 (2005).

¹⁰⁹ Thomas P. MacDonald et al., *Assessing the Long-Term Effects of Foster Care: A Research Synthesis*, INST. FOR RESEARCH ON POVERTY, 1-182 (1993).

National data show that children in out-of-home care who experience a disability, specifically those with significant emotional, behavioral, or developmental needs, appear to be placed in restrictive or intensive settings more frequently.¹¹⁰ **In other words, children with disabilities are more likely to be placed in specialized settings rather than in kinship care or non-relative foster placements.**¹¹¹ Specifically, 15.3% of youth in special education were placed in kinship care (versus 25.4% of youth without disabilities), 38.7% were in non-relative placements (versus 60.2% of youth without disabilities), and 46% of youth in special education resided in specialized care settings (versus 14.4% of youth without disabilities).¹¹² With respect to congregate care settings, youth with disabilities were 2.47 times more likely to live in an institution and were 2.22 times more likely to live in community-based group homes, which raises questions about whether goals of community inclusion for youth with disabilities are highlighted as important in the child welfare system.¹¹³ Furthermore, children with disabilities are less likely to achieve family reunification as an outcome to their case.¹¹⁴

Barriers to Service

There are several barriers that child welfare professionals face when serving children with disabilities. These barriers often include lack of resources and training, large caseloads, and inadequate policies and procedures. One of the main frustrations reported by child welfare workers is multiple bureaucratic barriers.¹¹⁵ Few state child protective systems identify and report the prevalence of disabilities.¹¹⁶ Moreover, identification and assessment of children with disabilities can be problematic as many child welfare workers have not received the adequate information necessary to identify this population of children,¹¹⁷ assess their unmet needs as they enter the child welfare system,¹¹⁸ or properly communicate with them.¹¹⁹

Another critical barrier child welfare workers face is inadequate educational and occupational training to serve this population of children. Training on serving children with disabilities is not often a significant part of child welfare education within schools of social work

¹¹⁰ Sigrid James, John Landsverk, & Donald J. Slymen, *Placement Movement in Out-of-Home Care: Patterns and Predictors*, 26(2) CHILDREN AND YOUTH SERV. REVIEW 185-206 (2004). See also Sigrid James et al., *Children in Out-of-Home Care: Entry into Intensive or Restrictive Mental Health and Residential Care Placements*, 14(4) J. OF EMOTIONAL AND BEHAVIORAL DISORDERS 196-208 (2006).

¹¹¹ Slayter, *supra* note 101.

¹¹² Jessica Schmidt et al., *Assessing Restrictiveness: A Closer Look at the Foster Care Placements and Perceptions of Youth With and Without Disabilities Aging Out of Care*, 7(5) J. OF PUBLIC CHILD WELFARE 586-609 (2013).

¹¹³ Sullivan & Knutson, *supra* note 91. Please note the adjusted odds ratios of this study stated youth with disabilities were 1.41 times more likely to live in an institution and 1.28 times more likely to live in community-based group homes respectively.

¹¹⁴ Becci A. Akin, *Predictors of Foster Care Exists to Permanency: A Competing Risks Analysis of Reunification, Guardianship and Adoption*, 33(6) CHILDREN AND YOUTH SERV. REVIEW 999-1011 (2011).

¹¹⁵ Patrick Shannon & Christine Tappan, *Identification and Assessment of Children with Developmental Disabilities in Child Welfare*, 56(4) SOCIAL WORK 297-305 (2011).

¹¹⁶ *Id.*

¹¹⁷ Jeanette E. Manders, & Zolinda Stoneman, *Children with Disabilities in the Child Protective Services System: An Analog Study of Investigation and Case Management*, 33(4) CHILD ABUSE AND NEGLECT 229-237 (2009).

¹¹⁸ Shannon & Tappan, *supra* note 115.

¹¹⁹ *Id.*

or in pre-service or in-service training with child welfare agencies.¹²⁰ And while there are some evidence-based programs for training child welfare workers on disability issues that could be used by both child welfare agencies and higher education programs, agencies are not required to utilize these tools to fortify employee knowledge.¹²¹

Building and supporting this knowledge base within our child welfare workforce can have positive impacts beyond improved outcomes that will lead to permanency more quickly; the educational success of children in care is also at stake. For all children in state custody as a result of abuse, neglect, or exploitation, the attendant trauma has the potential to negatively affect how well they do in school. We also know that children in foster care often experience frequent school changes that negatively affect their educational outcomes. But for children with special needs, these problems can be exacerbated when the services and supports they receive in school are interrupted by removal from the home and subsequent placement. There may also be undiagnosed or unidentified special needs that require services that need to be implemented right away. Having an accurate picture of the special needs of a child in care can ease the transition not only to a new placement but also to a new school.

Distinct State Child Welfare Policies and Procedures

Child welfare agencies do not utilize a standard definition or procedure to identify children with disabilities. In fact, many children are not required to be screened for certain disabilities.¹²² Under Part C of the Individuals with Disabilities Education Act (IDEA) and Child Abuse Prevention and Treatment Act (CAPTA), upon entering the child welfare system, only children under the age of three are required to undergo a comprehensive assessment to determine if early intervention services are required. But under this federal policy, all children under age three who are involved in a substantiated case of abuse or neglect must be referred to a state's early intervention services that are funded under Part C of IDEA. While the referral is mandatory, the assessment and intervention provided by Part C services are optional and parental consent is required. Some studies have shown that 35.2 percent of children under the age of three entering foster care had developmental delays significant enough to make them eligible for Individuals with Disabilities Education Act (IDEA) Part C early intervention services, while only 12.7 percent of these children actually received Part C services.¹²³ Early intervention programs are required to complete timely, comprehensive, and multidisciplinary evaluations on children; to develop Individual Family Services Plans (IFSPs); and to provide appropriate services.¹²⁴ There is no similar type of referral required for children over age three, and procedures vary by state or local child welfare agency.¹²⁵

¹²⁰ *Serving Children with Disabilities: A Video Series for Child Welfare Workers*, GEORGETOWN UNIV. CHILD DEV. CTR. (2001), https://gucchd.georgetown.edu/products/SCWD_2FCD.pdf (last visited on Feb. 9, 2020).

¹²¹ *Id.*

¹²² Shannon & Tappan, *supra* note 115.

¹²³ *Id.*

¹²⁴ *Id.*

¹²⁵ Elizabeth Lightfoot, *Children and Youth with Disabilities in the Child Welfare System: An Overview*, 93(2) CHILD WELFARE 23-45 (2014).

Some agencies have developed special disability units within their child protection agency that respond when the child and/or the parent has a disability.¹²⁶ Other agencies have specific workers that are cross-trained in disability issues and are responsible for cases that involve these issues.¹²⁷ Child protection agencies more frequently use collaborative approaches.¹²⁸ This might involve dual case assignment, in which a family would have both a child protection worker and some type of disability worker, such as a social worker from developmental disabilities or a public health worker.¹²⁹ Alternatively, child welfare agencies might make use of a variety of forms of teaming to help with assessment, interventions, placement, or disability modifications.¹³⁰ As of February 1, 2020, SCDSS established Regional Well-Being Teams that function as teams with front line case managers and provide expertise and follow-up to improve health, behavioral health, and dental access to care. SCDSS Well-Being Teams are comprised of nurses, behavioral health clinicians, community liaisons (serving as juvenile justice and education specialists), therapeutic service coordinators, individual contract service specialists, and assessment and planning coordinators who review and advise staff on the Child and Adolescent Needs and Strengths (CANS) assessment tool.

Collaboration can lead to provision of more appropriate and holistic services to families affected by a disability.¹³¹ The SCDSS policy and procedure manual addresses children with disabilities. For determining whether a child has a disability, that manual states, “[a]t the time of entry into foster care, the worker shall inquire with the biological parent(s) or foster child about whether the child attends or has ever received special education services” and “[t]he worker shall approve an evaluation of the child if the screening suggests that the child may have a disability. An evaluation must assess all areas related to the disability including, if appropriate, his or her health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities.”¹³² Training for SCDSS case managers includes a webinar on providing quality case management services for both parents and children with disabilities developed in collaboration with Able South Carolina, a disability advocacy organization.

Interventions

There are several interventions that are relevant for child welfare professionals when working with families that have a child with a disability. These interventions include promotion of family preservation (specifically respite care), parenting training, and family-centered

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ Jenny Ziviani et al., *Children with Disabilities in Out-of-Home Care: Perspectives on Organizational Collaborations*, 35(5) CHILD AND YOUTH SERV. REVIEW 797-805 (2013).

¹³² *South Carolina Department of Social Services Human Services Policy and Procedure Manual, Chapter 7: Child Protective and Preventive Services*, S.C. DEP'T OF SOCIAL SERV. (2010), https://dss.sc.gov/media/1897/cpps_2019-01-15.pdf (last visited on Feb. 9, 2020).

approaches.¹³³ One of the most important interventions to help family functioning is respite care.¹³⁴ Respite care is essentially the provision of short-term, temporary breaks from caregiving, and is an important intervention for anyone with ongoing caregiving responsibilities.¹³⁵ While respite care is something that most parents have in the form of grandparents watching grandchildren or paid babysitters, parents who are caring for children that have complex physical or behavioral needs might not be able to rely on these informal forms of care.¹³⁶ Formal respite care, which can be provided both in the home and out of the home, has been repeatedly found to reduce parental stress among parents who have a child with a developmental disability.¹³⁷

Interventions can be utilized to improve the outcomes of children with disabilities in transitioning out of the foster care system. One study identifies self-determination enhancement as an effective practice in secondary and transition special education.¹³⁸ Self-determination means having the power to make decisions, to direct one's actions, to dream and take risks, and to exercise rights and responsibilities.¹³⁹ Studies have shown that there is a positive correlation between high levels of self-determination, employment, and independent living among students with learning and cognitive disabilities at one and three years after high school.¹⁴⁰ Some programs such as the "Take Charge" intervention developed in Oregon, have shown increases in self-determination, quality of life, high school completion, and employment.¹⁴¹

Improved Outcomes: Federal Guidance and Strategies

A series of federal legislative efforts have addressed youth with disabilities who are either at risk of child welfare involvement or who are living in foster care.¹⁴² The passage of the Children's Justice and Assistance Act of 1986 had ramifications for youth with disabilities.¹⁴³ In general, this act was focused on addressing the handling of child abuse cases so as to limit additional trauma to the child victim and the investigation and prosecution of child abuse cases.¹⁴⁴ For states to qualify for financial assistance under this act, they needed to establish an interdisciplinary task force on children's justice and adopt the recommendations of that task force in three programmatic areas, one of which led to supports for youth with disabilities.¹⁴⁵ Specifically, they needed to consider recommendations related to experimental, model, and demonstration programs for testing innovative approaches and techniques for enhancing the

¹³³ Richard P. Hastings & Alexandra Beck, *Practitioner Review: Stress Intervention for Parents of Children with Intellectual Disabilities*, 45(8) J. OF CHILD PSYCHOLOGY AND PSYCHIATRY 1338-1349 (2008).

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ Laurie E. Powers et al., *Life Effects of a Longitudinal Randomized Study of Self-determination Enhancement on the Transition Outcomes of Youth in Foster Care and Special Education*, 34(11) CHILD AND YOUTH SERV. REVIEW 2179-2187 (2012).

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² Slayter, *supra* note 101.

¹⁴³ *Id.*

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

effectiveness of judicial or administrative action in child abuse cases.¹⁴⁶ South Carolina's Children's Justice Act Task Force follows this model, developing recommendations and implementing improvements in the collaborative work of protecting children from abuse and neglect.

In 1988, the passage of the Child Abuse Prevention, Adoption and Family Services Act of 1988 focused attention on foster youth with special needs.¹⁴⁷ In this act, "special needs" is defined in the context of situations where it is reasonable to conclude that a youth could be placed with adoptive parents without financial assistance in the form of adoption subsidies and/or medical assistance.¹⁴⁸ Specifically, special needs could include ethnic background, age, and membership in a sibling group.¹⁴⁹ Additionally, the term could also apply to a youth with a medical condition or a physical, mental or emotional disability.¹⁵⁰ While this act is not specific to youth with disabilities, it does include the provision for services that could support this specific population of foster youth.¹⁵¹

One essential strategy for improving child welfare services to children with disabling conditions is to provide specialized training to the caseworkers and supervisors who serve them, namely a comprehensive, competency-based training model.¹⁵² There is also a need for cross-training of early childhood professionals and child protection workers on how to encourage parents to access early childhood intervention services.¹⁵³ Once trained, child welfare professionals can help parents take the next step by filling out the early intervention (EI) applications, ensure that each child gets a developmental screening, and provide families with the resources and support they need. Follow-up and collaboration with early interventionist program staff can also support successful EI enrollment and service provision.

Courts could use the "power of the courts" to mandate that developmental screenings take place, and that children who are referred for EI follow through with recommendations. State statutes can be enacted to mandate standardized disability screenings for all children entering the foster care system and parental follow through. Innovative projects around the country include Safe Baby Court Teams (Zero to Three) or Arizona's Best for Babies. The Safe Babies Court Team program was started in 2004 through the National Center for Infants and Toddlers (also called ZERO TO THREE) to address the needs of families and young children involved in the child welfare system.¹⁵⁴ The Safe Babies Court Team program incorporates a developmental approach into child welfare cases by having multidisciplinary professionals and community stakeholder

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² Cindy Toppin, *Early Intervention for Young Children with Disabilities in the Child Welfare System*, CW 360: A COMPREHENSIVE LOOK AT A PREVALENT CHILD WELFARE ISSUE – THE INTERSECTION OF CHILD WELFARE AND DISABILITY: FOCUS ON CHILDREN (2013), https://cascw.umn.edu/wp-content/uploads/2013/12/Spring2013_360_web-FINAL.pdf (last visited on Feb. 9, 2020).

¹⁵³ *Id.*

¹⁵⁴ *Safe Babies Court Teams, ZERO TO THREE* (2020), <https://www.zerotothree.org/our-work/safe-babies-court-team> (last visited on Feb. 9, 2020).

members who are actively involved in each phase of reunification and permanency planning.¹⁵⁵ Families are informed of case plans, encouraged to participate actively, and connected to needed treatment services for their mental health or substance abuse issues.¹⁵⁶ Monthly meetings with all service providers help address any systemic concerns.¹⁵⁷

Child welfare professionals need to focus on child well-being, not just safety and permanency. Historically, social workers in child welfare have focused primarily on keeping children safe from abuse and neglect, and helping them return home safely or find new adoptive homes.¹⁵⁸ The Adoption and Safe Families Act (ASFA) of 1997 mandated three goals for public child welfare agencies—safety, permanency, and well-being for children and families.¹⁵⁹ This marked the first time that well-being was made a specific goal. Well-being necessarily implicates the involvement of other systems, particularly education. A different approach by schools to engaging these families on front-end services can have a preventative effect.¹⁶⁰ However, more discrete steps, such as collaborating with DSS staff to ensure educational records are transferred timely and enrollment is not delayed, are also needed to work toward increased well-being of this vulnerable population.¹⁶¹ Overall, a coordinated approach to information sharing, support, and training for foster families, child welfare workers, and educators will serve to enhance the supports provided and the quality of life for all involved.

Children with Special Needs in the Juvenile Justice System

Links to Delinquent Behavior

Children with disabilities are being incarcerated at higher rates than their peers. **Nationally, it is estimated that nearly 60-75% of youth involved in the juvenile justice system have a disability.** This rate is three times higher than that compared to youth without a disability.¹⁶² The South Carolina Children's Code states that no youth may be committed to the Department of Juvenile Justice who is seriously mentally ill or intellectually disabled.¹⁶³ However,

¹⁵⁵ See *The Core Components of the Safe Babies Court Team Approach*, ZERO TO THREE (2020), <https://www.zerotothree.org/resources/1655-the-core-components-of-the-safe-babies-court-team-approach> (last visited on Feb. 9, 2020).

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ Dana J. Sullivan & Michiel A. Van Zyl, *The Well-being of Children in Foster Care: Exploring Physical and Mental Health Needs*, 30(7) CHILD AND YOUTH SERV. REVIEW 774-786 (2008).

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ S.C. Code Ann. § 59-38-10; South Carolina Education Bill of Rights for Children in Foster Care requires immediate enrollment and expedited school record transfer.

¹⁶² *Justice-Involved Youth with Intellectual and Developmental Disabilities*, THE ARC (2015), http://thearc.org/wp-content/uploads/2019/07/15-037-Juvenile-Justice-White-Paper_2016.pdf. (last visited on Feb. 9, 2020); *Students with Disabilities and the Juvenile Justice System: What Parents Need to Know*, PACER CTR. (2013), <https://www.pacer.org/jj/pdf/jj-8.pdf> (last visited on Feb. 9, 2020).

¹⁶³ S.C. Code Ann. § 63-19-1450 (2018). Note: Many people confuse mental illnesses with intellectual disabilities, but they are distinct. Mental illnesses are medical conditions that can disrupt a child's thinking, mood, daily functioning, or ability to relate to others. Intellectual disabilities are a type of developmental disability characterized by significant limitations in both intellectual functioning (e.g., a person's IQ or intellectual quotient) and adaptive behavior (social and practical skills). Individuals who have an intellectual disability are more susceptible to developing a mental illness. See generally, Kerim M. Munir, *The Co-occurrence of Mental Disorders in Children and Adolescents with Intellectual Disability/Intellectual Developmental Disorder*, 29(2)

the disabilities experienced by youth involved in the juvenile justice system expand beyond these two categories. According to the South Carolina Department of Education Special Education Child Count Data, there were 230 children ages 6-21 with a documented disability placed in correctional facilities in the 2018-2019 school year. The majority of these children were male, approximately 87%, with the primary disabilities ranging from 17% with an emotional disability, 36.5% with a specific learning disability, and 33.5% with other health impairments.¹⁶⁴ This number is likely to be higher given the underidentification of children with disabilities. Youth at the Department of Juvenile Justice also experience disorders such as depression, generalized anxiety, and attention deficit hyperactivity disorder.

Risk Factors

Research suggests that youth with intellectual and developmental disabilities commit more serious offenses, are at a higher risk of second and third time offending, and enter the juvenile justice system at a younger age.¹⁶⁵ Low IQ is not a predictor of delinquent behavior, rather youth with lower IQs exhibit behavior that makes them more likely to be labeled as delinquent.¹⁶⁶ For example, children with disabilities, especially learning disabilities, have characteristics of a short attention span, hyperactivity, and impulsivity. Furthermore, children with disabilities express impulsive behaviors, low social skills, and difficulty reading social cues, which can often lead to susceptibility to delinquent behavior.¹⁶⁷ Children with disabilities can become easily frustrated and have difficulty “unlearning” inappropriate behaviors.¹⁶⁸

Disabilities can prevent youth from advocating appropriately for themselves when arrested and throughout the juvenile justice process.¹⁶⁹ Youth with disabilities are more likely to confess to a crime they did not commit or may not even be able to express what exactly happened during the incident. A youth may be unable to explain their perspective regarding the incident or may be named by another youth in an attempt to deflect responsibility.¹⁷⁰ All of these scenarios increase the likelihood that a youth with a disability will be involved with the juvenile justice system, and statistics bear these tendencies out.¹⁷¹

CURRENT OPINION IN PSYCHIATRY 95-102 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4814928/> (last visited on Feb. 9, 2020).

¹⁶⁴ 2018-2019 Child Count Data, STATE OF S.C. DEP'T OF EDUC. (2018), <https://ed.sc.gov/districts-schools/special-education-services/data-and-technology-d-t/data-collection-and-reporting/sc-data-collection-history/idea-child-count-data/2018-2019-child-count-data/sc-2018-2019-age-6-to-21-state-summary-and-tables-pdf/> (last visited on Feb. 9, 2020). This data point is reflective of students with disabilities, ages 6-21, special education and related services through Individualized Education Programs under the coverage of the Individuals with Disabilities Act, 2004. These counts would not include children with disabilities who do not have IEPs.

¹⁶⁵ *Youth with Intellectual and Developmental Disabilities in the Juvenile Justice System*, OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION (2017), <https://www.ojjdp.gov/mpg/litreviews/Intellectual-Developmental-Disabilities.pdf> (last visited on Feb. 9, 2020).

¹⁶⁶ *Id.* at 5.

¹⁶⁷ *Id.* at 6.

¹⁶⁸ THE ARC, *supra* note 164 at 7.

¹⁶⁹ *Probation Referral: A Model for Diversion of Children and Youth with Disabilities from the Juvenile Justice System*, NAT'L DISABILITY RIGHTS NETWORK (2019), https://www.ndrn.org/wp-content/uploads/2019/10/Probation_Referral_Report_FINAL_w_Appendices.pdf (last visited on Feb. 9, 2020).

¹⁷⁰ *Id.* at 11.

¹⁷¹ In 2016, the most recent year such data was reported, students with disabilities served by IDEA constituted 12% of the overall student population and 28% of students arrested or referred to law enforcement. 2015-2016 Civil Rights Data Collection: School

School to Prison Pipeline

For many students, especially those with disabilities, education has moved from a protective factor to a risk factor. Students who are excluded from school are more likely to enter the juvenile justice system.¹⁷² Zero tolerance policies act as a mechanism to push out students most in need of school support.¹⁷³ Low achieving youth are often redirected to alternative platforms and the juvenile justice system has become the default for youth who perform poorly in school.¹⁷⁴

Students with disabilities constitute 13% of students nationally, but represent 19% of in-school suspensions, 20% of out-of-school suspensions, 25% of multiple out-of-school suspensions, and 19% of expulsions.¹⁷⁵ The statistics are even higher for minority students with 25% of students of color with disabilities receiving at least one suspension.¹⁷⁶ Moreover, African American students with disabilities constitute 18.7% of the special education student population but represent 49.9% of special education students in correctional facilities.¹⁷⁷

In addition, national data indicates special education students have a much higher occurrence of health conditions.¹⁷⁸ Chronic health conditions are three times more common among youth with an Individualized Education Plan than those without.¹⁷⁹ These students may experience chronic absenteeism due to their health-related disability. Furthermore, youth with an IEP are overall more likely to have poorer health, chronic conditions, and behavioral issues that require medical care and medication.¹⁸⁰ The status offense of truancy and the harsh penalties that coincide overlooks the impact of health reasons on absences. The criminalization of truancy also overlooks the possibility that a child may be unable to attend school because the appropriate accommodations have not been made so the child can function and learn.

Special Education in Juvenile Correctional Facilities

Absent a specific exception, all IDEA protections apply to students with disabilities in juvenile correctional facilities and their parents.¹⁸¹ However, according to national reports, only about one-third of students in juvenile correctional facilities qualifying for special education

Climate and Safety, U.S. DEP'T OF EDUC. (2018), <https://www2.ed.gov/about/offices/list/ocr/docs/school-climate-and-safety.pdf> (last visited on Feb. 9, 2020).

¹⁷² NAT'L DISABILITY RIGHTS NETWORK, *supra* note 171 at 9.

¹⁷³ THE ARC, *supra* note 164 at 7.

¹⁷⁴ OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION *supra* note 167 at 6.

¹⁷⁵ THE ARC, *supra* note 164 at 13.

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ *Chronic Absenteeism and Students with Disabilities: Health Issues of Students with Disabilities: Impact on Attendance*, NAT'L CTR. ON EDUC. OUTCOMES (2018), <https://nceo.umn.edu/docs/OnlinePubs/ChronicAbsenteeismHealthIssuesSWD.pdf> (last visited on Feb. 9, 2020).

¹⁷⁹ *Id.* at 4.

¹⁸⁰ *Id.*

¹⁸¹ *Office of Special Education and Rehabilitative Services, OSEP Dear Colleague Letter on the Individuals with Disabilities Education Act for Students with Disabilities in Correctional Facilities*, U.S. DEP'T OF EDUC. (2014), <https://sites.ed.gov/idea/files/idea-letter.pdf>; 520 U.S.C. § 1412(a)(1).

services are receiving the services to which they are entitled.¹⁸² Furthermore, juvenile correctional facilities are responsible under the IDEA for identifying youth who need an IEP and creating one with the child and his or her parent/guardian(s).¹⁸³ However, juvenile correctional facilities often experience challenges in identifying youth with disabilities and providing special education and related services stemming from limited resources or lack of personnel with expertise in special education.¹⁸⁴ There can be a lack of school records or significant delays in receiving them as well as an overall shortage of information and time constraints that can delay the process of identification.¹⁸⁵ The shortage of information can make it difficult for educators to plan instruction for the youth and the educators have to prepare instruction for students with a range of abilities in the same classroom.¹⁸⁶ Youth with disabilities are further disadvantaged by instruction interruptions due to changes in their daily schedule or disruptions by other students.¹⁸⁷

Mental Health and DJJ

All youth entering a DJJ facility are screened for mental health concerns and receive a full assessment and extensive recommendations to aid in their rehabilitation.¹⁸⁸ **Currently, over half of the youth in DJJ facilities have diagnosable mental health disorders, and approximately 25% of DJJ youth meet criteria for a serious mental illness (SMI).**¹⁸⁹ DJJ has established a system of coordinators trained in disability issues who are responsible for the oversight of cases that involve these special needs issues, including meetings with other agencies and entities in order to establish collaborations for treatment of such youth in the least restrictive environment and/or through community-based services.¹⁹⁰ However, for children requiring a higher level of care in a Psychiatric Residential Treatment Facility, the collaborative efforts are not sufficient to overcome the lack of adequate psychiatric bed spaces in our state or the difficulty navigating the Managed Care Organization processes that delay treatment or ultimately force the substitution of incarceration for treatment.

Under the *Alexander S.* class action agreement, youth with serious mental illness (SMI) and/or an intellectual disability (ID) are to be transferred from DJJ to DMH or DDSN and placed in a therapeutic environment that best suits the child's needs.¹⁹¹ Interagency "staffings" (i.e., interagency meetings regarding a specific youth) are held for the purpose of discussing the needs of youth with disabilities and to decide services and placements; memoranda of agreement between

¹⁸² U.S. DEP'T OF EDUC., *supra* note 183 at 2.

¹⁸³ 20 U.S.C. § 1412(a)(3)(A); 34 C.F.R. § 300.111.

¹⁸⁴ *Youth with Disabilities in Juvenile Corrections (Part 1): A Training Module*, THE IRIS CTR. (2016), <https://iris.peabody.vanderbilt.edu/module/jj1/> (last visited on Feb. 9, 2020).

¹⁸⁵ *Id.*; THE ARC, *supra* note 164 at 24.

¹⁸⁶ THE ARC, *supra* note 164 at 24.

¹⁸⁷ *Id.*

¹⁸⁸ *Seriously Mentally Ill Youth in the South Carolina Department of Juvenile Justice* (Unpublished report), S.C. DEP'T OF JUVENILE JUSTICE (Aug. 2019).

¹⁸⁹ *Id.* Between 2015 and 2019, the South Carolina Protection and Advocacy organization opened 502 cases for youth with serious mental illness or an intellectual disability who were committed to DJJ. All the cases were closed with the youth receiving services or being released home. In addition, S.C. Protection and Advocacy was able to achieve diversion for 130 youth with other disabilities. See also NAT'L DISABILITY RIGHTS NETWORK, *supra* note 171 at 23.

¹⁹⁰ S.C. DEP'T OF JUVENILE JUSTICE, *supra* note 190.

¹⁹¹ NAT'L DISABILITY RIGHTS NETWORK, *supra* note 171 at 21; see generally *Alexander S. By and Through Bowers v. Boyd*, 929 F.Supp. 925 (D.S.C. 1995).

DJJ and DMH and DDSN stipulate removal of these youth from “behind the fence” within 90 days of identification and inclusion in this subclass of youth.”¹⁹²

Community-Based Services and Supports

Just as youth without disabilities, youth with disabilities involved in the juvenile justice system face disruption with education, family and peer relationships, and community ties when committed to a correctional facility. In order to prepare youth for re-entry and a successful transition back into the community, the planning process must begin when a youth enters the facility and must take into consideration the youth’s voice in the process.¹⁹³ For youth with disabilities, system involvement could be lifelong because the individual may require services and community supports to function in everyday life. It is important to engage the family with the youth to learn system navigation.¹⁹⁴ Juvenile justice staff should help youth to better understand the depths of the disability and what accommodations are necessary. For offenders with disabilities, employment can be a protective factor.¹⁹⁵ Employment can teach a youth self-efficacy and self-awareness skills. Furthermore, employment can teach youth how to apply accommodations for their disability in settings other than the school environment.¹⁹⁶ To reduce recidivism rates, reentry programs to assist released offenders with successful transitions must be in place for all youth with disabilities.¹⁹⁷

Another approach to avoiding school exclusion and subsequent juvenile justice system involvement is through the process of creating a school climate where problem behaviors are prevented by teaching desirable behaviors to all students and positively recognizing appropriate behaviors. This system of support is known as Positive Behavior Interventions and Supports (PBIS), and South Carolina was one of the original states that began to implement this approach.¹⁹⁸ PBIS offers levels of support that are connected to the needs of the student: universal supports where all students are taught appropriate behaviors; targeted supports for students who need additional help in achieving appropriate behavior; and intensive individual interventions where needed. Coupled with school-based mental health services and family involvement and collaboration, this approach, when implemented with fidelity, is a proven method of reducing system involvement.¹⁹⁹ Notably, the IDEA requires positive behavioral interventions in a child’s

¹⁹² NAT’L DISABILITY RIGHTS NETWORK, *supra* note 171 at 21.

¹⁹³ *Id.* at 28; *Youth with Disabilities in Juvenile Corrections (Part 2): A Training Module*, THE IRIS CTR. (2017), <https://iris.peabody.vanderbilt.edu/module/jj2/>; <https://www.ncld.org/wp-content/uploads/2014/11/2014-State-of-LD.pdf> (last visited on Feb. 9, 2020).

¹⁹⁴ NAT’L DISABILITY RIGHTS NETWORK, *supra* note 171 at 28.

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ One study found that youth with disabilities who had jobs or attended school during the first six months following release were 3.2 times less likely to experience recidivism and 2.5 times more likely to remain employed and/or enrolled in school one year after exiting correctional facilities. See Candace Cortiella & Sheldon H. Horowitz, *The State of Learning Disabilities: Facts, Trends and Emerging Issues*, NAT’L CTR. FOR LEARNING DISABILITIES 1, 40 (3rd ed. 2014), <https://www.ncld.org/wp-content/uploads/2014/11/2014-State-of-LD.pdf> (last visited on Feb. 9, 2020).

¹⁹⁸ See generally *Positive Behavioral Interventions & Supports*, <https://www.pbis.org/>

¹⁹⁹ See generally *GREAT Results: Implications for PBIS in Schools*, <http://criminology.fsu.edu/wp-content/uploads/volume-12-issue-3.pdf#page=55>; *Combining School and Family Interventions for the Prevention and Early Intervention of Disruptive Behavior Problems in Children: A Public Health Perspective*, https://www.researchgate.net/profile/Cheryl_Offutt/publication/227615850_Combining_school_and_family_interventions_for_th

IEP when their behavior impedes their learning or that of others.²⁰⁰ Assistance and support via structured intervention for behavioral challenges is also a regular request of the state's teaching force.

Issues for Ongoing Consideration

Improving the multisystem processes and community supports that impact children with special needs is a task that many in our state have undertaken, and the Committee commends those interdisciplinary efforts. To impact identified needs and to encourage an emphasis on more effective, less costly preventive services, the Committee on Children recommends continued focus of state efforts and resources in specific topical areas. Based upon the information presented to the Committee by numerous stakeholders and further research by staff, the Committee recommends action in the following focus areas: prevention, early identification and service provision, workforce development needs, access to quality services, and successful transition to independent living. It is important to note that within each of these areas, parents and families of our special needs children require specific supports to navigate a complex system of care successfully; we make note of those related recommendations in each section.

Prevention

Prevention of harm to children can start as early as prenatal care. Birth defects can occur during any stage of pregnancy. For most birth defects, the singular cause is unknown, but they most likely occur due to a mix of factors including genes, behaviors, and environment. However, instances of birth defects may be mitigated through limiting harmful behaviors. Smoking, alcohol consumption, substance misuse, uncontrolled diabetes, and certain prescription medications can increase the chances of having an infant with a birth defect.²⁰¹ Access to timely, quality, affordable health care before, during, and after pregnancy is among the highest influence on birth outcomes for mothers and infants.²⁰² However, one in four women living below the federal poverty level lack health insurance making access to primary care and rehabilitation services even harder.²⁰³ Preconceptional care and maintaining a healthy lifestyle before pregnancy can reduce the chances of complications.²⁰⁴ Providing family support services and community health programs such as the Nurse-Family Partnership can not only improve health outcomes for mothers and babies, but empower families and create opportunities for future success.

e_prevention_and_early_intervention_of_disruptive_behavior_problems_in_children_A_public_health_perspective/links/5aba50eda6fdcc0e3d9eb219/Combining-school-and-family-interventions-for-the-prevention-and-early-intervention-of-disruptive-behavior-problems-in-children-A-public-health-perspective.pdf.

²⁰⁰ 20 U.S.C. § 1414(d)(3)(B)(i).

²⁰¹ *What are Birth Defects?*, CTRS. FOR DISEASE CONTROL AND PREVENTION (2019), <https://www.cdc.gov/ncbddd/birthdefects/facts.html> (last visited on Feb. 9, 2020).

²⁰² *Opportunities to Optimize Access to Prenatal Care Through Health Transformation*, ASS'N OF MATERNAL AND CHILD HEALTH PROGRAMS (2016), http://www.amchp.org/Policy-Advocacy/health-reform/resources/Documents/Pregnancy%20Issue%20Brief_Final%202016.pdf (last visited on Feb. 9, 2020).

²⁰³ *Id.*

²⁰⁴ CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra* note 203.

Another preventative measure to support children's health is limiting exposure to lead. The removal of lead hazards from a child's environment is the most effective way to ensure children are safe from the effects of lead exposure.²⁰⁵ Sources of lead can be found in homes built before 1978, certain water pipes, toys and jewelry, and certain jobs that involve working with lead-based products. Exposure can lead to damage in the brain and nervous system, delayed growth and development, and learning and speech problems. Children under six years old and families living in poverty and older housing are at the greatest risk.²⁰⁶ The key to preventing lead poisoning in children is identification and elimination of the major sources of lead exposure.²⁰⁷ There is a direct link between the level of housing maintenance and the potential for lead exposure leaving enforcement of housing code standards as a mechanism for exposure reduction. The National Center for Healthy Housing recommends that during the course of routine enforcement in older properties, code officials should focus on deteriorating paint and potential lead dust hazards, and should address current health and safety standards such as moisture problems and water leaks that cause them.²⁰⁸ In addition, the Center recommends state and local governments take action to prohibit lead-based paint hazards in rental housing and prohibit the occupancy of homes that have poisoned children unless it has subsequently been declared lead-safe.²⁰⁹

In addition to the health risks of lead exposure, environmental hazards can increase a child's likelihood of developing various adverse health outcomes including cancer, asthma and other respiratory diseases that lead to pneumonia, and impairment of reproductive function and development.²¹⁰ Children can be exposed to hazards at home from oils, insect repellants and other chemicals, as well as carbon monoxide. Additionally, children are at increased risk of illness or injury at school from the use of harsh sanitizers and disinfectants. Hazards at home and school can be mitigated through the practice of safe storage habits and using "green" nontoxic products.²¹¹ A large number of environmental hazards, however, including air pollutants and industrial chemicals, are beyond control of individuals. These hazards require action at the state, national, and even international level to regulate and monitor the potential risks to human health.²¹²

Harm prevention for children also expands to daily activities. Children are particularly vulnerable to unintentional injury due to their size, inexperience, and curiosity.²¹³ Common causes

²⁰⁵ *Childhood Lead Poisoning Prevention*, CTRS. FOR DISEASE CONTROL AND PREVENTION (2019), <https://www.cdc.gov/nceh/lead/prevention/default.htm> (last visited on Feb. 9, 2020).

²⁰⁶ *Id.*

²⁰⁷ Bruce Perrin Lanphear et al., *Prevention of Childhood Lead Toxicity*, 138 PEDIATRICS 1 (2016), <https://pediatrics.aappublications.org/content/pediatrics/138/1/e20161493.full.pdf> (last visited on Feb. 9, 2020).

²⁰⁸ *Ten Effective Strategies for Preventing Childhood Lead Poisoning Through Code Enforcement*, NAT'L CTR. FOR HEALTHY HOUSING (2002), <http://portal.hud.gov/hudportal/documents/huddoc?id=codeenforcementstrategies.doc> (last visited on Feb. 9, 2020).

²⁰⁹ *Preventing Lead Exposure in US Children: A Blueprint for Action*, NAT'L CTR. FOR HEALTHY HOUSING (2014), http://nchh.org/resource-library/lead%20strategies_v8%20%2819%20October%202014%29.pdf (last visited on Feb. 9, 2020).

²¹⁰ *Children's Environmental Health*, WORLD HEALTH ORGANIZATION (2020), <https://www.who.int/ceh/risks/en/> (last visited on Feb. 9, 2020).

²¹¹ *In the Home*, AM. ASS'N OF POISON CONTROL CTRS. (2017), <https://aapcc.org/prevention/home> (last visited on Feb. 9, 2020).

²¹² WORLD HEALTH ORGANIZATION, *supra* note 212.

²¹³ *National Action Plan for Child Injury Prevention*, CTRS. FOR DISEASE CONTROL AND PREVENTION (2012), https://www.cdc.gov/safecild/pdf/National_Action_Plan_for_Child_Injury_Prevention.pdf (last visited on Feb. 9, 2020).

of injury include motor vehicle accidents, drowning, falls, and burns from fire.²¹⁴ Children whose families live in impoverished conditions have disproportionately higher rates of injury.²¹⁵ Injuries include traumatic brain injuries, physical impairment, and death. Prevention includes strategies such as preventing the event in the first place, minimizing injury after the event has occurred, and reducing long-term consequences of injury.²¹⁶ Motor vehicle safety can include teaching adolescents about the harms of drinking and driving, child safety seats, and seat belt regulations. Other preventative measures include the use of smoke alarms and the use of helmets during biking and sports. Furthermore, children should have access to high quality emergency medical services and rehabilitation supports.²¹⁷

Early Identification and Service Provision

One of the most important strategies to improve outcomes for children is early, intensive services and interventions based on the best available research, yet children with disabilities are not always identified for needs when they have them. Without proper identification of needs, the result is often school exclusion, school failure, and failure to progress.²¹⁸ Conversely, effective interventions can change the life trajectory for children with special needs and prevent secondary disabilities.²¹⁹ Early and high quality programs yield results, as does longer program participation.²²⁰ One longitudinal study recently found a 41% reduction in special education placement rates for preschool participants and a sevenfold return on investment due to earnings, reduced costs of criminal involvement, and savings on school remedial services.²²¹ Infants may receive a referral from a doctor based on conditions present at birth, or delays in regular development may emerge which cause a medical professional or parent to seek screening and services, a process governed by federal law and state implementation.²²² Early intervention can be triggered by the professionals at Early Head Start for children under age three and Head Start for children ages three and four. Early intervention (EI) providers develop an Individualized Family Service Plan (IFSP), which identifies the child's needs, developmental goals, and the services he or she will receive. By law, these services must be provided in children's "natural environments"—their homes, childcare programs, or communities—to the maximum extent

²¹⁴ *Id.* at 16.

²¹⁵ *Id.* at 23.

²¹⁶ *Id.* at 26.

²¹⁷ *Id.*

²¹⁸ Laudan Aron & Pamela Loprest, *Disability and the Education System*, 22(1) THE FUTURE OF CHILDREN, 97, 98 (2012).

²¹⁹ *Id.*

²²⁰ Jack P. Shonkoff & Deborah A. Phillips, *From Neurons to Neighborhoods: The Science of Early Childhood Development*, NAT'L RESEARCH COUNCIL AND INSTITUTE OF MEDICINE (2000), <https://www.ncbi.nlm.nih.gov/books/NBK225557/> (last visited on Feb. 10, 2020).

²²¹ See Arthur J. Reynolds & Judy A. Temple, *Extended Early Childhood Intervention and School Achievement: Age Thirteen Findings from the Chicago Longitudinal Study*, 69(1) CHILD DEV. 231-246 (1998). See also Arthur J. Reynolds, *The Chicago Longitudinal Study: A Study of Children in the Chicago Public Schools*, CHICAGO LONGITUDINAL STUDY (1999) available at <http://www.chicagolongitudinalstudy.net/documents/Clswweb.pdf> (last visited on Feb. 11, 2020).

²²² *Overview of Early Intervention*, CTR. FOR PARENT INFORMATION & RESOURCES (2017), <https://www.parentcenterhub.org/ei-overview/> (last visited on Feb. 10, 2020).

possible. Examples of EI services include special instruction, family training, occupational or physical therapy, psychological services, and speech language pathology services.

South Carolina data on the IDEA Part C Child Find mandate shows that generally, the state's numbers of very young children (0 – 3) with Individual Family Service Plans are similar to national rates – around 2.5% of children in that age range.²²³ But we know – at least from national research – that there are more children who need services than are identified.²²⁴ Study samples have indicated that possibly as many as 13% of all children may have developmental delays that would make them eligible for services.²²⁵ Given this potential gap, young children and their families seemingly face a number of barriers when needing care. Noteworthy, often-cited research has identified five common barriers, some of which could serve to inform decisionmakers in consideration of any state policy improvement efforts: communication problems between families and pediatricians, parents' belief that they are the experts on their child's development and will decide for themselves whether evaluation is needed; parents' belief that their child's delays will resolve on their own or with their help; practical difficulties related to contacting early intervention providers; and parents' concerns, as reported by early intervention staff, that evaluators arriving at their home are from child protective services.²²⁶

Another potential barrier to supports for children is the process of determining mental health needs at an early age. Young children from birth to age three who are not developing socially or emotionally may have an undiagnosed mental health condition that could be addressed with services during these early years to avoid future welfare or juvenile justice system involvement. The Infant and Early Childhood Mental Health model assesses how well a child under five years old experiences, manages, and expresses a full range of emotions, in addition to how the child forms close and secure adult and peer relationships and explores the environment. Supporting mental health of very young children is an investment that is more cost-effective than addressing these concerns later in a child's life.²²⁷

When children 'graduate' from IDEA Part C to Part B services, responsibility for services shifts to the public school district. This transition is often identified as another challenge for families because of the potential for service reductions and interruptions because the agencies administering the programs are different. The Office of Special Education Services and BabyNet

²²³ U.S. DEP'T OF EDUC., *supra* note 66.

²²⁴ Steven A. Rosenburg, Duan Zhang, & Cordelia C. Robinson, *Prevalence of Developmental Delays and Participation in Early Intervention Services for Young Children*, 121(6) PEDIATRICS 1503-1509 (2008).

²²⁵ *Id.*

²²⁶ Manuel E. Jimenez et al., *Barriers to Evaluation for Early Intervention Services: Parent and Early Intervention Employee Perspectives*, 12(6) ACAD. PEDIATRICS 551-557 (2012). During its annual public hearings in the fall of 2019, the JCLCC heard testimony from a number of EI providers having difficulty navigating the billing and invoicing processes of BabyNet, which had the potential for delaying or removing services for children altogether. DHHS has worked closely with these providers to address concerns, and JCLCC continues to monitor this progress.

²²⁷ See *Persistent Fear and Anxiety Can Affect Young Children's Learning and Development*, Working Paper No. 9, NAT'L SCIENTIFIC COUNCIL ON THE DEVELOPING CHILD (2010), <http://developingchild.harvard.edu/resources/persistent-fear-and-anxiety-can-affect-young-childrens-learning-and-development> (last visited on Feb. 10, 2020); Steve Aos et al., *Benefits and Costs of Prevention and Early Intervention Programs for Youth*, WASHINGTON STATE INST. OF PUBLIC POLICY (2004), www.wsipp.wa.gov/rptfiles/04-07-3901a.pdf (last visited on Feb. 10, 2020). The JCLCC also heard testimony about the need to build out and support infant and early childhood mental health competency in the healthcare workforce at its 2019 public hearings.

have been working together to help school districts meet the requirements of state and federal law which mandate that those children served in Part C who are referred to Part B and eligible have an IEP plan in place by their third birthday.²²⁸ This improvement in continuity between Early Intervention and preschool helps ensure important gains are not lost.

Another powerful tool to help with early identification and services of our youngest children is Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. EPSDT covers four health-related areas: medical, vision, hearing, and dental.²²⁹ At these appointments, sometimes called well-child or well-care visits, health care professionals identify medically necessary health care services. EPSDT mandates coverage for those services identified through the screenings. The purpose of these visits is to identify physical, mental, or developmental problems and risks as early as possible and to link children to needed diagnostic and treatment services. Many Medicaid-enrolled children do not receive some or all of the screenings or the follow-up treatment, but states are required to report participation rates and progress toward screening goals.²³⁰

Workforce Development Needs

The National Council on Disability submitted a report to President Obama in 2010 entitled *Workforce Infrastructure in Support of People with Disabilities: Matching Human Resources to Service Needs*.²³¹ This report predicted that the need for services for persons with disabilities was going to increase significantly in the coming decades as a result of factors including the increase of disability with age, improved child survival rates, and the availability of human service workers due to the baby boomer generation's retirement.²³² As predicted exactly a decade ago, the supply for disability workforce consisting of health, education, and social service programs is consistently growing.²³³ The Council made several recommendations including targeting and encouraging school- and college-age youth to enter critical occupations, increased salary and benefits, and increased collaboration between public vocational programs and private employers.²³⁴

²²⁸ *Report Summarizing Services Provided Under the Individuals with Disabilities Education Act (IDEA) to Preschool Children with Disabilities 2016-17 School Year*, STATE OF S.C. DEP'T OF EDUC. (2018).

²²⁹ Social Security Act, § 1905(r)(1)(B), 42 U.S.C. § 1396d(r)(B). Notably, the Committee has regularly received testimony that hearing loss in children is not being identified through appropriate screening, and thousands of children in our state who are hearing-impaired are not receiving needed services as a result.

²³⁰ Daniel R. Levinson, *Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services*, U.S. DEP'T OF HEALTH AND HUMAN SERV. (2010), <https://oig.hhs.gov/oei/reports/oei-05-08-00520.pdf> (last visited on Feb. 10, 2020). See also Suzanne Murrin, *Recommendation Followup Memorandum Report: CMS Needs to Do More to Improve Medicaid Children's Utilization of Preventive Screening Services*, U.S. DEP'T OF HEALTH AND HUMAN SERV. (2014), <https://oig.hhs.gov/oei/reports/oei-05-13-00690.pdf> (last visited on Feb. 10, 2020).

²³¹ *Workforce Infrastructure in Support of People with Disabilities: Matching Human Resources to Service Needs*, NAT'L COUNCIL ON DISABILITY (2010), https://ncd.gov/rawmedia_repository/f8546e79_643f_48c4_92ab_59cb2b454a3f.pdf (last visited on Feb. 10, 2020).

²³² *Id.* at 1.

²³³ *Id.*

²³⁴ *Id.* at 75-76.

Health Care Workforce

Traditionally, the health care workforce has been described as nurses and doctors in primary care and hospital settings.²³⁵ As a result, community-based providers such as direct-care workers, family caregivers and behavioral health workers have received less funding and support compared to other health care providers.²³⁶ However, the movement to keep children with disabilities, whether physical, cognitive, or emotional, at home with their families has increased the demand for high quality health care services accessible in the community. The workforce capacity needs for in-home services for children who are medically fragile/technology dependent or who have developmental or mental health disorders is particularly acute.²³⁷ Recognizing the need, the South Carolina Institute of Medicine and Public Health created the Workforce for Health Taskforce and released recommendations for workforce solutions in June 2019 to improve population health and service delivery across the state.²³⁸ The Taskforce recommended to the state legislature and other partners to remove cost as a barrier to the pursuit of a certification or degree in health and human services through the expansion of curriculum into all public high schools and the use of lottery funds to support education.²³⁹ To address the high demand for behavioral health workers, the Taskforce recommended better job marketing strategies and offering tuition reimbursement opportunities, loan repayment programs, and other incentives to students, as well as improving reimbursement for behavioral health services and more competitive pay for public sector behavioral health professionals.²⁴⁰

Education Workforce

High-quality educational experiences for all children depend on effective teachers. This remains especially true for children with disabilities. According to the U.S. Department of Education, Office of Postsecondary Education, South Carolina has experienced a teacher shortage in special education areas as far back as 1990 and still experiences a shortage today.²⁴¹ In the 2017-2018 school year, 21.14% of South Carolina special education teaching positions were available.²⁴² South Carolina is not unique. Approximately 98% of U.S. school districts report special education teacher shortages, and of current special education teachers, about 45,514 are

²³⁵ Brie Hunt, *The Evolving Workforce Redefining Health Care Delivery in South Carolina*, S.C. INST. OF MEDICINE & PUBLIC HEALTH (2019), <http://imph.org/wp-content/uploads/2019/06/2019-IMPHWorkforceReport-FINAL-revised6.18.19.pdf> (last visited on Feb. 10, 2020).

²³⁶ *Id.* at 7.

²³⁷ See generally Carolyn C. Foster, Rishi K. Agrawal, & Matthew M. Davis, *Home Health Care for Children with Medical Complexity: Workforce Gaps, Policy, And Future Directions*, 38(6) HEALTH AFFAIRS, 987-993 (2019), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05531> (last visited on Feb. 10, 2020).

²³⁸ Hunt, *supra* note 237 at 6.

²³⁹ *Id.* at 8.

²⁴⁰ *Id.* at 32.

²⁴¹ *Teacher Shortage Areas Nationwide Listing 1990-1991 through 2014-2015*, U.S. DEP'T OF EDUC. (2014), <https://specialedshortages.org/wp-content/uploads/2014/07/DeptEd-Teacher-Shortage-Nationwide-List-Report-2014.pdf> (last visited on Feb. 10, 2020).

²⁴² *Identification of Critical Need Subject Areas Loan Cancellation 2018-2019*, STATE OF S.C. DEP'T OF EDUC., <https://ed.sc.gov/educators/recruitment-and-recognition/critical-need-areas/crit-sub-18-19/> (last visited on Feb. 10, 2020).

not qualified for these positions.²⁴³ General education teachers specifically lack skills needed to effectively instruct students with disabilities.²⁴⁴ Because students with disabilities are to be instructed in the least restrictive environment, preferably the general education classroom, this is grave cause for concern. Teacher qualifications have a direct impact on student achievement.²⁴⁵

To address the shortage, the South Carolina Department of Education has developed programs to provide incentives to teach special education. For example, teachers who received a South Carolina Teachers Loan or SC PACE Loan are eligible for teacher loan forgiveness by teaching in critical geographic areas and subject areas like special education.²⁴⁶ There are also federal student loan forgiveness programs for teachers. To address qualifications, the Department created SC CREATE, a program that allows full-time employees in public and charter schools to receive cost-free coursework to complete add-on, alternative, or initial licensure in special education and related services.²⁴⁷ There are only 13 colleges and universities in the state participating in the program.²⁴⁸ As an additional incentive, the South Carolina State Housing Finance and Development Authority offers a special homebuyer program called “Palmetto Heroes” for teachers.²⁴⁹ However, there is still work to be done to improve workplace conditions including increased funding for school resources and education-related services, revised college curriculum that provides future teachers with evidence-based interventions, and increased collaboration between special and general education.²⁵⁰ Without addressing these needs, schools may be able to recruit teachers, but retention is unlikely due to burnout or job dissatisfaction.

Access to Quality Services

Beyond these workforce shortages, other discrete, systemic issues continue to limit access to services for children with special needs. Lack of capacity in children’s mental/behavioral health services has been addressed in the context of children involved with juvenile justice earlier in this report, and for children with dual mental/developmental diagnoses there is a particular shortage of alternatives to crisis or institutional care. This is not a new problem in the state; according to the 2016-2017 National Survey of Children’s Health, approximately 48.6% of parents reported some level of difficulty in getting mental health counseling or services for their children.²⁵¹ Issues around Psychiatric Residential Treatment Facilities (PRTFs) and Rehabilitative Behavioral Health

²⁴³ *Shortage of Special Education Expertise Among Teachers and Higher Education Faculty*, HIGHER EDUC. CONSORTIUM FOR SPECIAL EDUCATION, <https://specialedshortages.org/wp-content/uploads/2014/03/HECSE-Shortage-Special-Education-Expertise-Among-Teachers-Faculty.pdf> (last visited on Feb. 10, 2020).

²⁴⁴ *Id.* at 2.

²⁴⁵ *Id.* at 1.

²⁴⁶ *Critical Need Areas*, STATE OF S.C. DEP’T OF EDUC. (2020), <https://ed.sc.gov/educators/recruitment-and-recognition/critical-need-areas/#loan> (last visited on Feb. 10, 2020).

²⁴⁷ *SC CREATE*, STATE OF S.C. DEP’T OF EDUC. (2020), <https://ed.sc.gov/educators/recruitment-and-recognition/recruitment-initiatives/sc-create/> (last visited on Feb. 10, 2020).

²⁴⁸ *Id.*

²⁴⁹ *Teacher Housing Initiative*, STATE OF S.C. DEP’T OF EDUC. (2020), <https://ed.sc.gov/educators/recruitment-and-recognition/recruitment-initiatives/teacher-housing-initiative/> (last visited on Feb. 10, 2020).

²⁵⁰ *Policy Recommendations*, NAT’L COALITION ON PERSONNEL SHORTAGES IN SPECIAL EDUCATION AND RELATED SERVICES (2020), <https://specialedshortages.org/take-action/policy-recommendations/> (last visited on Feb. 10, 2020).

²⁵¹ *The Child and Adolescent Health Measurement Initiative; 2016-2017 National Survey of Children’s Health (NSCH) Data Query*, DATA RES. CTR. FOR CHILD AND ADOLESCENT (2018), www.childhealthdata.org (last visited Jan. 10, 2020).

Services (RBHS) delivery have been documented extensively by the Legislative Audit Council,²⁵² but in a comprehensive discussion of children with special needs, this access issue cannot be omitted. In brief, there are too few RBHS providers and too few beds in PRTFs, and there is a need to increase reimbursement rates for those providers who are delivering these much-needed services for children.²⁵³ These capacity problems can result in long waiting times for services and unnecessarily high use of emergency and high-end or hospital care. In our state, these problems also result in children with very high levels of need or who are not competent to stand trial remaining detained in a secure facility.²⁵⁴ The importance of robust community-based and school-based mental health diagnosis and treatment for children cannot be overstated. Effective mental health services impact the school environment for all children, the utilization of foster care, and the number of juveniles committed to the Department of Juvenile Justice.

Even in advance of system involvement, children may experience barriers to services when their disabling condition is not properly identified. Mental health challenges as discussed earlier may present even in infants and very young children and can be addressed at those early ages. Other types of disabilities can be hard to identify; one such eligibility category is emotional disability (ED). Requirements for identification of ED must include one or more of the following: an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems.²⁵⁵ These requirements have been characterized by researchers and experts as subjective and as a result, can act as a barrier to identification and appropriate services.²⁵⁶ The causes of emotional disturbance are not entirely known and often manifest as not only emotional, but sometimes behavioral or mental disorders in students. Some characteristics of students with emotional disturbance might include hyperactivity, aggression, withdrawal, immaturity, or learning difficulties.²⁵⁷ There may be bias related to a dually diagnosed youth with both a mental illness and a conduct disorder that causes incorrect conclusions that behaviors are voluntary when they actually stem from a mental impairment.²⁵⁸

Also, families of these children need respite care, peer support networks, and training; and most research shows that these are not readily available, or that other limitations keep parents and

²⁵² *A Review of Children's Behavioral Health Services*, S.C. Department of Health and Human Services, S.C. GENERAL ASSEMBLY LEGISLATIVE AUDIT COUNCIL (2019),

https://lac.sc.gov/sites/default/files/Documents/Legislative%20Audit%20Council/Reports/A-K/DHHS_Child_Health_Svc_2019.pdf (last visited on Feb. 10, 2020).

²⁵³ *Id.*

²⁵⁴ *Report on SMI/ID Youth within the DJJ System*, (Unpublished report), S.C. DEP'T OF JUVENILE JUSTICE (Nov. 2019).

²⁵⁵ 34 C.F.R. § 300.8 (c)(4).

²⁵⁶ Lucy W. Shum, *Educationally Related Mental Health Services for Children with Serious Emotional Disturbance: Addressing Barriers to Access Through the IDEA*, 5(1) J. HEALTH CARE L. & POLICY 233-258 (2002), <http://digitalcommons.law.umaryland.edu/jhelp/vol5/iss1/11> (last visited on Feb. 10, 2020).

²⁵⁷ *Emotional Disturbance: Disability Fact Sheet No. 5*, NAT'L DISSEMINATION CTR. FOR CHILDREN AND YOUTH WITH DISABILITIES (2010), https://www.parentcenterhub.org/wp-content/uploads/repo_items/fs5.pdf (last visited on Feb. 10, 2020).

²⁵⁸ Wendy F. Hensel, *Sharing the Short Bus: Eligibility and Identity Under the IDEA*, 58(1) HASTINGS L.J. 1147, 1165 (2007), https://repository.uchastings.edu/cgi/viewcontent.cgi?article=3664&context=hastings_law_journal (last visited on Feb. 10, 2020).

caregivers from accessing them. In one study that looked at families of children receiving SSI benefits due to a disability, only 8% reported using respite care despite three quarters of families having unmet respite needs.²⁵⁹ This need is exacerbated for kinship caregivers, who are about four times less likely to receive any form of parent training and seven times less likely to have peer support groups or respite care.²⁶⁰ Respite services are cost effective ways of preventing hospitalization and out-of-home care.²⁶¹ Parent support networks provide numerous benefits for parents including increased skills and a sense of belonging.²⁶²

Families also need assistance in advocating for appropriate services for their children. A recent federal report showed that there are disparities in accessing the dispute resolution procedures provided by special education law.²⁶³ The IDEA provides three mechanisms to solve disagreements between parents and school districts: mediation, due process complaints, and state complaints.²⁶⁴ Families do have access to assistance through each state's Parent Training and Information Center (PTI) and Protection and Advocacy for People With Disabilities, and some districts provide information about locally-available legal services. Further, state education agencies are required to monitor dispute resolution processes generally and to investigate and respond to state complaints.²⁶⁵ Despite these protections, all parents may not be able to challenge what they see as incorrect decisions by schools for their children. Data in the report showed that families of students with disabilities, those with lower incomes, and those who have children of color were less likely than their affluent and white counterparts to access their legal rights under the IDEA and that districts serving a higher percentage of students of color were the least likely to be involved in resolving disputes concerning how to meet a child's educational needs.²⁶⁶ According to the report, challenges parents face while leveraging the IDEA's dispute resolution options include a lack of adequate legal representation, the inability of parents to take time off from work, fear of retaliation by school districts against parents, language barriers, and

²⁵⁹ Kalman Rupp et al., *A Profile of Children with Disabilities Receiving SSI: Highlights from the National Survey of SSI Children and Families*, 66(2) SOCIAL SECURITY BULLETIN (2006), https://www.researchgate.net/profile/Howard_Iams/publication/6909048_A_profile_of_children_with_disabilities_receiving_SSI_Highlights_from_the_National_Survey_of_SSI_Children_and_Families/links/54ca92080cf2517b755ea083.pdf (last visited on Feb. 10, 2020).

²⁶⁰ Christina Sakai, Hua Lin, & Glenn Flores, *Health Outcomes and Family Services in Kinship Care: Analysis of a National Sample of Children in the Child Welfare System*, 165(2) ARCHIVES OF PEDIATRIC ADOLESCENT MEDICINE (2011) 159-165, <https://jamanetwork.com/journals/jamapediatrics/fullarticle/384260> (last visited on Feb. 10, 2020).

²⁶¹ See David S. Mandell, Ming Xie, & Knashawn H. Morales, *The Interplay of Outpatient Services and Psychiatric Hospitalization Among Medicaid-Enrolled Children With Autism Spectrum Disorders*, 166(1) ARCHIVES OF PEDIATRIC ADOLESCENT MEDICINE 68-73 (2012), <https://jamanetwork.com/journals/jamapediatrics/fullarticle/1107676> (last visited on Feb. 10, 2020). See also Susan Dougherty et al., *Planned and Crisis Respite for Families with Children: Results of a Collaborative Study*, CHILD WELFARE LEAGUE OF AM. AND ARCH NAT'L RESPITE NETWORK AND RESOURCE CTR. (2002), <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.115.344&rep=rep1&type=pdf> (last visited on Feb. 10, 2020).

²⁶² Mary Law et al., *The Perceived Effects of Parent-Led Support Groups for Parents of Children with Disabilities*, 21(2-3) PHYSICAL & OCCUPATIONAL THERAPY IN PEDIATRICS 29-48 (2002).

²⁶³ *Report to Congressional Requesters: Special Education IDEA Dispute Resolution Activity in Selected States Varied Based on School Districts' Characteristics*, U.S. GOV'T ACCOUNTABILITY OFFICE (2019), <https://www.gao.gov/assets/710/702514.pdf> (last visited on Feb. 10, 2020).

²⁶⁴ See 20 U.S.C. § 1415(e); 20 U.S.C. § 1415(f); 34 C.F.R. §§ 300.660-300.662.

²⁶⁵ 2220 U.S.C. § 1416(a)(1)(C).

²⁶⁶ U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 265 at 18.

inconsistent access to information about students' rights.²⁶⁷ Parents also perceived an imbalance of power, and in small and rural communities, may opt not to engage in dispute resolution due to privacy concerns and a lack of educational options.²⁶⁸

Successful Independent Adult Living

Thinking and planning for a productive and satisfying future can promote success for older youth. All students with disabilities served under IDEA are entitled to a formalized process designed to proactively prepare them for adult living. A transition plan for students with disabilities must be developed and include services designed to help students meet their individual goals and prepare for a successful transition from student life to adult life.²⁶⁹ While high school graduation rates for students with special needs are improving, post-secondary education and employment for these students are still areas of concern.

Currently, students with disabilities are served in this transition by local schools, DDSN, and Vocational Rehabilitation (VR). While in high school, the bulk of the responsibility falls to schools and VR to prepare students with disabilities for employment. DDSN employs three Post-Secondary Transition coordinators who work with local school districts and VR to push evidence-based transition practices such as Project Search, local interagency transition teams, and an overall awareness of the need for employment for students with disabilities.

While the students are being served by the schools and VR, Medicaid waivers and state funded employment supports through DDSN cannot be used to assist students in transition by law.²⁷⁰ This increases the need for the schools, VR, and DDSN to work collaboratively to enhance employment opportunities and training for students while they are in school so that Medicaid funded job coaching and state funded follow along programs can be most effective. There is a real need to develop secondary as well as post-secondary technical school-based training programs for these youths.

Employment Opportunities for Youth with Disabilities

Generally, most students served under the IDEA are able to earn a high school diploma, but some are unable to complete all required coursework due to their disability.²⁷¹ The SC High School Credential is an alternative option for these students and allows them another means of demonstrating their ability to transition into the work community.²⁷² Even with these options, youth with disabilities are less likely to find employment and may earn less than youth without

²⁶⁷ *Id.* at 22.

²⁶⁸ *Id.*

²⁶⁹ 34 C.F.R. § 300.320(b).

²⁷⁰ 29 U.S.C. § 701(110).

²⁷¹ *South Carolina High School Credential*, STATE OF S.C. DEP'T OF EDUC. (2020), <https://ed.sc.gov/districts-schools/special-education-services/programs-and-initiatives-p-i/sc-employability-credential/> (last visited on Feb. 10, 2020).

²⁷² *Id.*

disabilities.²⁷³ Employed individuals with disabilities often work fewer than average hours and consistently get placed in the same types of jobs.²⁷⁴ Educational credentials, employer attitudes, and assumptions about the capacities of individuals with disabilities, along with a youth's lack of guidance and understanding of their own abilities present challenges to finding meaningful employment.²⁷⁵ **In 2016, the rate of individuals with disabilities ages 18 to 24 who were neither in school nor working was 34.5% compared to 11.9% of their peers without disabilities, with a high school dropout rate of 12.4%.**²⁷⁶ This presents the question of why, in a time of historically low unemployment rates in the U.S., so many young people are being left behind.

It is critically important that everyone working in the transition space do all that they can to create and strengthen a culture of parent and student expectations for employment. Students who work while in school have much more success in finding employment after high school. Again, by using this time of transition, thinking non-traditionally, and expanding on the technical school track already in place, teachers, job coaches and parents can prepare these young people for future employment.

Employment First

To address employment gaps, the U.S. Department of Labor's Office of Disability Employment Policy has made *Employment First*, a national movement and framework for systems change that is centered on the premise that all citizens, including individuals with significant disabilities, are capable of full participation in integrated employment and community life, a top priority in the recent years.²⁷⁷ In 2018, the South Carolina General Assembly passed legislation creating the Employment First Study Committee to evaluate the need for an Employment First Initiative Act.²⁷⁸ The Committee released its report in May 2019 finding that

²⁷³ *Research in Focus: A Weekly Digest of New Research from the NIKILRR Community*, NAT'L REHABILITATION INFORMATION CTR., <https://naric.com/sites/default/files/For%20Youth%20with%20Disabilities%20Seeking%20Employment%2C%20Work%20Experience%20May%20Matter%20More%20Than%20School%20Factors.pdf> (last visited on Feb. 10, 2020).

²⁷⁴ *Id.* at 1.

²⁷⁵ Linda Toms Barker, *Career Pathways for Youth with Disabilities: Transition from School to Work and Lifelong Learning*, IMPAQ INT'L, <https://www.impaqint.com/sites/default/files/files/Career%20Pathways%20for%20Youth%20with%20Disabilities%20-%20Transition%20from%20School%20to%20Work%20and%20Lifelong%20Learning.pdf> (last visited on Feb. 10, 2020).

²⁷⁶ *Dialogue Report: Policies for Increasing Employment Among Opportunity Youth with Disabilities*, NAT'L COLLABORATIVE ON WORKFORCE AND DISABILITY (2019), http://www.ncwd-youth.info/wp-content/uploads/2019/07/Accessible_NCWD_IEL-Dialogue-Report_Increasing-Employment_052919.pdf (last visited on Feb. 10, 2020).

²⁷⁷ *Employment First*, U.S. DEP'T OF LABOR, <https://www.dol.gov/odep/topics/EmploymentFirst.htm> (last visited Jan. 9, 2020).

²⁷⁸ S.C. Code Ann. §§ 41-5-130, 41-5-140 (2018); *S.C. Employment First Study Committee Report*, S.C. GENERAL ASSEMBLY (2019), <https://scstatehouse.gov/CommitteeInfo/EmploymentFirstStudyCommittee/SC%20Employment%20First%20Study%20Committee%20Report.pdf> (last visited on Feb. 10, 2020).

South Carolina has the sixth highest unemployment rate for people with disabilities in the country.²⁷⁹

As of 2018, there were over 700,000 South Carolinians with disabilities, and only 32.6% were employed.²⁸⁰

Many of these individuals work for less than minimum wage based on the perceived impact the disability has on job performance.²⁸¹ The Committee recommended the state adopt legislation that establishes South Carolina as an Employment First state as well as a Commission for guidance.²⁸² In addition, the SC Disability Employment Coalition and Able SC have launched the Hire Me SC campaign to drive awareness of employment issues for those with disabilities and employers.²⁸³

Path to Meaningful Employment

On average, less than half of youth with disabilities enroll in college and as a result, a significant number of them are left without future plans when exiting high school.²⁸⁴ Some youth may find jobs in food service, retail, or janitorial services, but often these positions do not match the ambitions or earning potential youth with disabilities maintain.²⁸⁵ Youth with disabilities are often overlooked or regarded as a potential burden in the workplace. The consequences of a lack of meaningful employment are economic and societal.²⁸⁶ The path to meaningful employment for youth with disabilities begins with education, employment preparation, and individualized planning to successfully transition from school to work.²⁸⁷

In 2018, the state adopted a South Carolina Credential Program for students with IEPs who are not on a diploma track. This program provides an “alternative option for students with disabilities to demonstrate their ability to transition into the work community.”²⁸⁸ In this program, students must complete at least 360 hours of work-based learning/training.²⁸⁹ This program needs to be available to as many students with significant disabilities as possible.

The South Carolina Department of Education, Office of Career and Technical Education offers programs and certifications in school districts across the state ranging from construction to information technology to health science to prepare students for employment after graduation.

²⁷⁹ S.C. GENERAL ASSEMBLY, *supra* note 280 at 3.

²⁸⁰ *Id.* at 6.

²⁸¹ *Id.* at 7.

²⁸² *Id.* at 3.

²⁸³ For more information on the Hire Me SC program, see hiremesc.org.

²⁸⁴ Barker, *supra* note 277 at 1.

²⁸⁵ *Employment Snapshot 2017*, THE ARC, <http://thearc.org/wp-content/uploads/2019/07/18-048-Finds-Study-Employment-One-Pager-FINAL.pdf> (last visited on Feb. 10, 2020). See generally *Planning for a Future in the Workforce: Jobs, Skills, and Supports: A Webinar*, THE ARC (2015), <https://futureplanning.thearc.org/pages/learn/where-to-start/webinars/archived-webinars> (last visited on Feb. 10, 2020).

²⁸⁶ NAT’L COLLABORATIVE ON WORKFORCE AND DISABILITY, *supra* note 278 at 1.

²⁸⁷ *Id.* at 3; *Supporting Youth with Learning Disabilities: A Webinar*, NAT’L COLLABORATIVE ON WORKFORCE AND DISABILITY (2016), <http://www.ncwd-youth.info/webinars/> (last visited on Feb. 10, 2020).

²⁸⁸ *South Carolina High School Credential*, STATE OF S.C. DEP’T OF EDUC. (2020), <https://ed.sc.gov/districts-schools/special-education-services/programs-and-initiatives-p-i/sc-employability-credential/> (last visited Jan. 29, 2020).

²⁸⁹ S.C. Code Ann. Regs. 43-235 (Supp. 2019).

Although the Department publishes the percentage of students receiving instruction in a general education setting, little is known about the percentage of youth with disabilities who are encouraged or allowed to participate in the career programs. All students should have access to career programs. Accessing this training while still in high school can be a benefit to students with disabilities who have an IEP. Such programs provide much more hands-on training rather than desk learning and students can exit high school ready to enter the workforce.

Possible vocational pathways could include:

- **Mechanics**
- **Childcare/Education**
- **Carpentry**
- **Agriculture**
- **Cosmetology**
- **Drafting & Design**
- **Welding**
- **Food Preparation**
- **Healthcare**
- **Criminal Justice**
- **Construction**

In addition, the South Carolina Vocational Rehabilitation Department offers training programs in customer service, office support, and computer aided drafting.²⁹⁰

Just like their peers, youth with significant disabilities must be given the opportunity to explore and develop ideas about what potential career paths they would be interested in and what path would best meet their strengths and weaknesses.²⁹¹ School staff should keep in mind the particular interests expressed by the student with respect to career exploration and work experience.

Youth with disabilities should also be encouraged to do informational interviews with businesses, participate in internships and seek summer employment while still in high school.²⁹² These opportunities provide valuable experiences and networking connections for possible employment post-graduation. Additionally, through experience, youth with disabilities are better able to understand how their disability affects their job performance and what accommodations may be necessary to thrive in a particular workplace.²⁹³

²⁹⁰ *Job Seeker Education and Training Programs*, S.C. WORKS, <https://scworks.org/jobseeker/education-and-training> (last visited on Feb. 10, 2020).

²⁹¹ THE ARC, *supra* note 287.

²⁹² *Id.*

²⁹³ *Id.*

Supportive Housing Programs

All children and youth, especially those with disabilities, need a home with a family that provides an atmosphere of love, security, and safety. The recognition that children with disabilities belong at home in the community has led to a demand for community-based housing.²⁹⁴ However, affordable housing programs are underfunded and have long waiting lists, leaving transitioning youth at risk of unnecessary institutionalization or homelessness.²⁹⁵ State- and federally-funded programs like Individual and Family Support (through DDSN) and Early Intervention and Home and Community-based waivers (through Medicaid), offer services to support youth with disabilities in remaining with their families, which lessens the burden of care.²⁹⁶ While these programs do provide necessary support services, it is important to note that efforts must also be taken to ensure that youth are integrated in their communities.

As youth with disabilities transition to adulthood, supports to transition from the family home to a home of their own are often needed. Throughout the nation, Centers for Independent Living (CILs) located in each state provide services to support individuals with disabilities to live as independently as possible. South Carolina has four CILs including Able South Carolina located in Columbia and Greenville, AccessAbility in North Charleston, and Walton Options in North Augusta.²⁹⁷ Together, these offices only serve 31 out of 46 counties, leaving parts of the state without services.

In addition to availability issues, persons with disabilities experience higher rates of housing discrimination and make up the majority of discrimination complaints received by the Fair Housing Enforcement Office and other agencies.²⁹⁸ The U.S. Department of Housing and Urban Development has three programs that seek to increase affordable housing for people with disabilities. The Section 811 Supportive Housing for Persons with Disabilities Program is the only HUD program committed to creating affordable, accessible housing for non-elderly, low income persons with significant disabilities.²⁹⁹ States including California, Maryland, Georgia, and North Carolina have received funds through this program to provide housing for individuals with disabilities.³⁰⁰ Furthermore, the National Housing Trust Fund provides grants to states to build, preserve, and rehabilitate housing for low income citizens.³⁰¹

²⁹⁴ *Housing*, THE ARC (2020), <https://thearc.org/position-statements/housing/> (last visited on Feb. 10, 2020).

²⁹⁵ *Id.*

²⁹⁶ See generally characteristics described in 42 C.F.R. § 441.301(c)(4); *Home and Community-Based Services (HCBS) Statewide Transition Plan*, S.C. DEP'T OF HEALTH AND HUMAN SERV. (2019), <https://ddsn.sc.gov/sites/default/files/Documents/Recent%20News/SC%20Statewide%20Transition%20Plan%20Revised%20Aug%20202019.pdf> (last visited on Feb. 10, 2020).

²⁹⁷ *ILRU Directory of Centers for Independent Living (CILs) and Associations*, INDEP. LIVING RESEARCH UTILIZATION (2020), <https://www.ilru.org/projects/cil-net/cil-center-and-association-directory-results/SC> (last visited on Feb. 10, 2020).

²⁹⁸ *Making Every Neighborhood a Place of Opportunity*, NAT'L FAIR HOUSING ALLIANCE (2018), <https://nationalfairhousing.org/wp-content/uploads/2018/04/NFHA-2018-Fair-Housing-Trends-Report.pdf> (last visited on Feb. 10, 2020).

²⁹⁹ THE ARC, *supra* note 296.

³⁰⁰ *Section 811 Project Rental Assistance Bringing Permanent Supportive Housing to Scale Status Report to Congress*, U.S. DEP'T OF HOUSING AND URBAN DEV. (2014), <https://www.hudexchange.info/onecpd/assets/File/Section-811-PRA-Congressional-Report.pdf> (last visited on Feb. 10, 2020).

³⁰¹ THE ARC, *supra* note 296.

In Conclusion

The General Assembly enacted the Children's Policy for South Carolina to affirm that all laws and regulations to provide for children's services should strengthen and encourage family life, serve and protect all children. This Policy applies to all children including those who are mentally, socially, economically, physically, developmentally, culturally, educationally, or economically disadvantaged or disabled; those who are neglected or abused; and those who violate the laws of South Carolina and are in need of rehabilitation. Our Children's Policy charges us with cooperatively identifying strategies that maximize all available resources to protect children. The challenges faced by children with special needs vary widely, depending on the nature and severity of the disability, the child's age, family education and economic status, and other factors; but improving outcomes for all of these children is achievable through shared commitment to collaborative effort.

Acknowledgments

The 2020 Annual Report of the Joint Citizens and Legislative Committee on Children is the result of countless hours of hard work and the cooperation of many agencies and individuals. Much assistance was provided to the Committee with its data collection, analysis, research, policy review, and editing to ensure that issues affecting children in South Carolina are accurately and clearly presented.

The Committee thanks the many citizens who took time to attend the public hearings and present testimony to the Committee. The Committee relies heavily on the concerns and recommendations offered by citizens who address children's issues on a daily basis. Additionally, the Committee expresses its appreciation to the many stakeholders and agency staff whose work contributed indirectly to this 2020 Annual Report, as well as those agency staff who assisted in its preparation.

The Joint Citizens and Legislative Committee on Children extends its appreciation to the staff at the Children's Law Center, USC School of Law for compilation of the 2020 Annual Report. In particular, we thank Michelle Dhunjishah, Director; Carolyn S. Morris, Assistant Director; Amanda Adler, Senior Resource Attorney to the Committee; Macaulay Morrison, Legislative Resource Attorney for the Committee; Ashley Blas, Resource Attorney; Liyun Zhang, Data Scientist; Morgan Maxwell and Brooke Mosely, Law Clerks; and Blanche Richey, Publications Manager.



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