COMMITTEE *on* CHILDREN

2017 Annual Report

Joint Citizens and Legislative

Committee on Children

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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
JOINT CITIZENS AND LEGISLATIVE COMMITTEE ON CHILDREN

Governor Henry D. McMaster
President *Pro Tempore* Hugh K. Leatherman, Sr.
Speaker James H. Lucas
Members of the General Assembly:

The Joint Citizens and Legislative Committee on Children is pleased to present its 2017 Annual Report. 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.

The 2017 Annual Report includes topics of concern identified by Committee members, by stakeholder partners, and by constituents. Public hearings conducted by the Committee around the state have also been an important source of information and insight on the citizen concern regarding our state's children. In this year's report, the Committee outlines needed efforts to achieve four critical goals:

- to better provide children the support they need to thrive and lead healthy lives;
- to provide additional protection for children who have been abused or neglected;
- to guard the physical and mental well-being of our children; and,
- to support our older youth as they transition to adulthood.

As you will read, included are actionable, immediate steps and long-term actions in each area that can be taken to improve the lives of South Carolina's children. We are proud to work on their behalf as a Committee; these youngest citizens are most worthy of our time and attention. Thank you for your consideration of the research and recommendations contained in this report.

Shannon Erickson — Brad Hutto

Shannon A. Erickson — Brad Hutto

Chair — Vice Chair

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www.sccommitteeonchildren.org

Executive Summary

This 2017 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 which 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:

- **Child Hunger**
- **Children Experiencing Homelessness**
- **Children Living with Kinship Caregivers**
- **Foster Youth in Transition**
- **Child Passenger Safety**
- **Tobacco Products Marketed to Children**
- **Child Suicide and Mental Health Needs of Children**
- **Reform of the Disturbing Schools Law**
- **Placement of Children on the Sex Offender Registry**
- **Incarceration of Status Offenders**

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

- **Children's Safety in Afterschool Programs and Summer Camps**
- **Early Childhood Education Opportunities/First Steps**
- **Implementation of Local Child Fatality Review Teams**
- **Children's Right to Counsel**
- **Transition of John de la Howe School**
- **Children's Advocacy Centers**
- **Teen Dating Violence Prevention**
- **Child Abuse Investigation or Forensic Interviews of Children with Hearing Impairments**
- **Drivers' Licenses and Drivers' Insurance for Children in Foster Care**
- **Mandatory Reporting of Child Abuse**
- **Child Victims of Human Trafficking**

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 ensure children can meet their full potential. Please consider our recommendations, accompanying legislation and the Committee position on them as you act this legislative session.

Data Highlights

South Carolina was ranked 41st in the nation on overall child well-being by Annie E. Casey Foundation in its 2016 annual *KIDS COUNT Data Book*.[1] There are nearly 1.1 million children living in South Carolina, which is 22% of the total population.[2] The most recent available data show that:

- **58,135** children were born in South Carolina.[3] (2015)
- **686** children died in South Carolina.[4] (2015)
- **1,110** infants were born to females under 18 years old.[5] (2015)
- **101,804** children suffered non-fatal injuries requiring a hospital or emergency room visit, incurring a total cost of **$232,389,734**.[6] (2015)
- **260,646** children lived in poverty, which was **24.4%** of the child population.[7] (2015)
- **626,615** or **57%** of children in South Carolina were enrolled in Medicaid.[8] (2015)
- **30,519** children were the subject of a child abuse or neglect investigation.[9] (2015)
- **3,985** children lived in foster care for some period of time.[10] (2016)
- **15,429** juvenile delinquency cases were referred to the Department of Juvenile Justice.[11] (2016)
- **26,039** children received mental health treatment.[12] (2016)
- **12.2%** of children in public schools were identified as having a disabling condition.[13] (2016)
- **17.4%** of all students who started school did not graduate with their peers.[14] (2016)
- **4,763** children were in treatment for drug or alcohol abuse.[15] (2016)

[1] Annie E. Casey Foundation, 2016 Kids Count Data Book: State Trends in Child Well-Being, http://www.aecf.org/m/resourcedoc/aecf-the2016kidscountdatabook-2016.pdf (last visited Mar 22, 2017).
[2] South Carolina Department of Health and Environmental Control, SCAN Population Data, http://scangis.dhec.sc.gov/scan/bdp/tables/populationtable.aspx (last visited Mar 22, 2017).
[3] South Carolina Department of Health and Environmental Control, SCAN Birth Certificate Data, http://scangis.dhec.sc.gov/scan/bdp/tables/birthtable.aspx (last visited Mar 22, 2017).
[4] South Carolina Department of Health and Environmental Control, SCAN Death Certificate Data, http://scangis.dhec.sc.gov/scan/bdp/tables/death2table.aspx (last visited Mar 22, 2017).
[5] SCAN Birth Certificate Data, *supra* note 3.
[6] South Carolina Revenue and Fiscal Affairs Office, South Carolina Emergency Department Discharges Ages 0-17 years (2016), unpublished.
[7] United States Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/did/www/saipe/data/index.html (last visited Feb 23, 2017).
[8] SC HealthViz, South Carolina eHealth Medicaid Statistics, http://www.schealthviz.sc.edu/medicaid-enrollment (last visited Mar 22, 2017).
[9] Fostering Court Improvement, http://www.fosteringcourtimprovement.org/state_websites.php (last visited Feb 23, 2017).
[10] *Id.*
[11] South Carolina Department of Juvenile Justice, 2015-2016 Annual Statistical Reports, http://www.state.sc.us/djj/pdfs/2015-16%20Annual%20Statistical%20Report%20Final.pdf (last visited Mar 13, 2017).
[12] South Carolina Department of Mental Health, Community Mental Health Services 07/01/2015 through 06/30/2016 (2017).
[13] South Carolina Department of Education, 2016 District Data, http://ed.sc.gov/data/report-cards/state-report-cards/2016/data-files-for-researchers-2016/.
[14] *Id*.
[15] South Carolina Department of Alcohol and Other Drug Addiction Services, Children in Treatment for Alcohol and Drug Abuse (2017).

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 2016, the Committee on Children sponsored or endorsed the following bills that ultimately passed:

- **Safety for Children in Family Childcare Homes (Act 263 of 2016)** increases training for family childcare home operators, requires background checks for other older youth or adults who later move into the home, provides authority to the Department of Social Services (DSS) in the registration process, and makes changes to the notice requirements for registrants in various stages of the process.

- **Healthy Food in Schools (Act 258 of 2016)** requires that meals and competitive foods offered in public schools meet the standards of the United States Department of Agriculture (USDA) and that state standards are regularly updated with the USDA guidelines.

- **CPR Instruction for High School Students (Act 152 of 2016)** requires that hands-on CPR training and instruction on the use of AEDs be taught in public schools at least once during grades 9-12 and allows for the adoption of waiver polices by school districts.

Other 2016 Committee on Children legislation and initiatives received hearings and prompted important discussion, public debate, and study of key children's issues, including:

- **Child Passenger Safety**
- **Recreational Off-Road Vehicle Safety**
- **Reauthorization of First Steps**
- **Reform of the Disturbing Schools Law**
- **Transition of John de la Howe School**

Finally, the Committee convened informational sessions that included stakeholder presentations and discussions on issues of foster care licensing and kinship care.

Improving Child Well-Being in South Carolina

Although South Carolina's Kids Count ranking of 41st in the nation represents a slight improvement from its previous rank of 42nd, significant challenges still persist and must be addressed on behalf of our state's children. Almost a quarter of the more than one million children in South Carolina live in poverty.[17] When measuring by Medicaid eligibility, nearly two-thirds of the children in this state are living in poverty.[18] Children in South Carolina also face a range of significant and complex challenges including mental health needs, abuse and neglect, family instability, lack of healthcare, and educational problems.

This Committee continues to study and work to address these challenges through legislation and policy recommendations. Please refer to the Committee's website, **sccommitteeonchildren.org**, for additional research and recommendations from previous annual reports and data books that have addressed adverse childhood experiences (ACEs) and childhood trauma, childhood fatalities and injuries, childhood immunizations, family dynamics and status offenders, safe sleeping practices for infants, and school readiness.

Since its inception, the Committee on Children has led a number of successful efforts to improve outcomes for children in our state, including developing a data-driven model for annual evaluation of child well-being in the state, and important legislative and policy initiatives, including the elimination of shackling of juveniles, strengthening the Child Fatality Advisory Committee, and supporting trauma-informed care training for child-serving professionals to encourage the detection and treatment of childhood trauma.

The Committee has conducted statewide public hearings annually to seek citizen and stakeholder insight on how well our children are faring. During the fall of 2016, a number of speakers presented information to the Committee, and the members are grateful for having had this important opportunity to receive these insights. Testimony received at the hearings as well as written testimony raised many pressing issues including child homelessness, infant fatalities resulting from unsafe sleep, utilization of brain development research in early childhood education settings, kinship caregiver needs, and mental health and disability services for children, among others. These hearings have significantly informed the work the Committee has undertaken this year.

[17] United States Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/did/www/saipe/data/index.html (last visited Feb 23, 2017).
[18] SC HealthViz, South Carolina eHealth Medicaid Statistics, http://www.schealthviz.sc.edu/medicaid-enrollment (last visited Mar 22, 2017).

Supporting Children in Poverty

Over the past year, the Committee has received multidisciplinary input from citizens, stakeholders, policy experts, and others about the devastating impact of poverty on children in our state. The Committee has heard compelling testimony on how poverty impacts children and those working diligently to serve children in our state, whether addressing education reform, children in the care of the state, the needs of those with disabling conditions, or other topics.

Over 260,000 children in South Carolina—24% of all of our children—live in families with incomes below the federal poverty threshold.[19] Poverty impedes children's ability to learn and contributes to social, emotional, and behavioral problems.[20] Poverty also contributes to poor physical and mental health.[21] Research clearly shows us that poverty is the single greatest threat to our children's well-being.[22] Continuing high levels of poverty in South Carolina are inextricably linked with hunger and homelessness of our smallest citizens. The Committee believes that children should know when their next meal will be and where they will sleep at night. Supporting effective policies to achieve these goals is a priority for the Committee and is reflected in its attention to **Child Hunger** and **Child Homelessness.**

Child Food Insecurity and Hunger

Food is a basic need for human survival. However, every day, thousands of children in our state do not have enough food to eat. Food insecurity and hunger impact children in every region of South Carolina. "Food Insecurity" is defined as limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.[23] "Hunger" is defined as the uneasy or painful sensation caused by a lack of food or the recurrent and involuntary lack of access to food.[24] On the national level, 42 million people, including 13 million children, struggle to have access to enough food.[25] Children are particularly vulnerable to economic hardship faced by families.[26] It is estimated that one in six children in the United States worries about when they'll have their next meal.[27]

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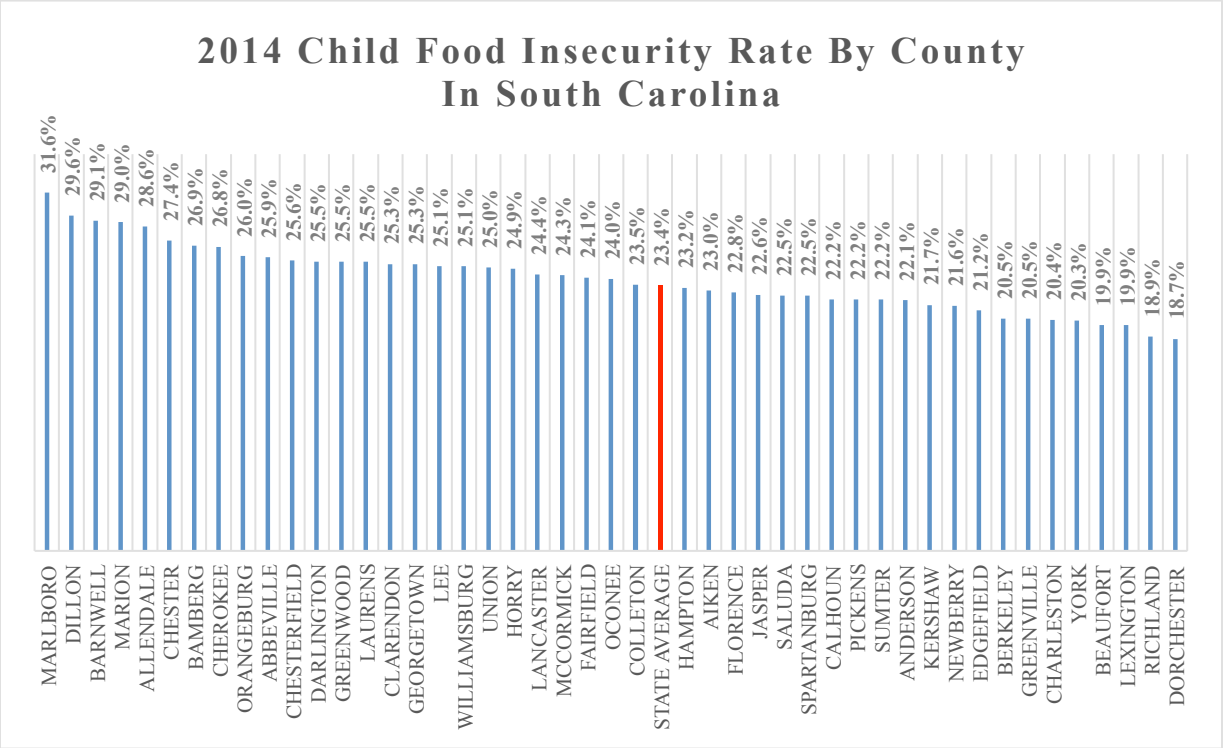
[19] Annie E. Casey Foundation, Kids Count Data Book, Children in Poverty in South Carolina.
[20] Eric Jensen, *Chapter 2: How Poverty Affects Behavior and Academic Performance*, *in* Teaching with Poverty in Mind (1st ed.), http://www.ascd.org/publications/books/109074/chapters/How-Poverty-Affects-Behavior-and-Academic-Performance.aspx (last visited Mar 22, 2017).
[21] Rita Paul-Sen Gupta, Margaret L. de Wit & David McKeown, *The Impact of Poverty on the Current and Future Health Status of Children*, 12 Pediatrics and Child Health 667–672 (2007).
[22] *See* The World Health Organization, The World Health Report 1995--Bridging the Gaps, http://www.who.int/whr/1995/media_centre/executive_summary1/en/ (last visited Mar 22, 2017). *See also* American Academy of Pediatrics, Poverty Threatens Health of U.S. Children (2013), https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/Poverty-Threatens-Health-of-US-Children.aspx (last visited Mar 21, 2017). *See also* Child Poverty, National Center for Children in Poverty, http://www.nccp.org/topics/childpoverty.html (last visited Mar 21, 2017).
[23] John Cook & Karen Jeng, Child Food Insecurity: The Economic Impact on our Nation – A report on research on the impact of food insecurity and hunger on child health, growth and development, https://www.nokidhungry.org/sites/default/files/child-economy-study.pdf (last visited Mar 21, 2017).
[24] *Id*.
[25] Feeding America, Child Food Insecurity – Executive Summary (2014), http://www.feedingamerica.org/hunger-in-america/our-research/map-the-meal-gap/2014/map-the-meal-gap-2014-exec-summ.pdf (last visited Mar 22, 2017).
[26] *Id.*
[27] Feeding America, Child Hunger in America, http://www.feedingamerica.org/hunger-in-america/impact-of-hunger/child-hunger/ (last visited Mar 22, 2017).

Child Food Insecurity in South Carolina

In our state, an estimated 23.4% of the child population, or 253,340 children, suffer from food insecurity.[28] In 2014, the counties that had the highest child food insecurity rates in the state were Marlboro County (31.6%), Dillon County (29.6%), Barnwell County (29.1%), Marion County (29.0%), and Allendale County (28.6%).[29]



Data Source: Gundersen, C., A. Dewey, A. Crumbaugh, M. Kato & E. Engelhard. Map the Meal Gap 2016: Food Insecurity and Child Food Insecurity Estimates at the County Level. Feeding America, 2016.

The Impact of Child Hunger

Research findings confirm that food insecurity and hunger are extremely harmful to children's growth and development.[30]

Early Childhood

Food insecurity in families can reduce the ability of parents to focus on other important needs of their very young children. Parents in food-insecure households are less likely to provide sufficient developmental stimulation, appropriate parent-child interaction, and attachment that are needed in early childhood.[31] Food insecurity is also related to low birth weight, which has been associated with poor long-term outcomes for children, such as lower IQ,

[28] C. Gunderson et al., Map the Meal Gap 2016: Child Food Insecurity in South Carolina by County in 2014, http://www.feedingamerica.org/hunger-in-america/our-research/map-the-meal-gap/2014/SC_AllCounties_CDs_CFI_2014.pdf (last visited Mar 22, 2017).
[29] *Id.*
[30] John Cook & Karen Jeng, *supra* note 23.
[31] The Science of Early Childhood Development (InBrief), (2007), http://developingchild.harvard.edu/resources/inbrief-science-of-ecd/.

lower educational attainment, and lower adult earnings.[32] Food insecurity and hunger are especially harmful to children in the first three years of life, when brain development is particularly sensitive to experiences in the environment[33,34] Food insecurity and hunger are also associated with iron deficiency in early life, which has been linked to persistent deficits in cognition, attention, and behavior even after treatment.[35] Food-insecure young children are more likely to be hospitalized than food-secure children.[36]

Obesity

While it seems counterintuitive, food insecurity is linked to obesity. Because of economic constraints, "to maintain adequate energy intake, many families with limited resources select lower-quality diets, including high calorie-energy dense foods. These foods are traditionally the least expensive, are easy to over consume, have been shown to promote weight gain, and have been found to be more prevalent in low-income neighborhoods compared to healthier food options."[37] Food-insecure children are more likely to be overweight or obese than children in food-secure households beginning as early as preschool.[38] Obesity harms the emotional and cognitive well-being of children and is related to long-term health problems such as cardiovascular disease, hypertension, diabetes, and joint degeneration.[39] Obese children experience lower self-esteem and academic achievement, increased alcohol and drug use, and higher suicide rates than their non-obese peers.[40]

Educational Outcomes

Research also shows that food-insecure children learn at a slower rate than their peers.[41] When combined with their initial disparities, this places them even further behind their food-secure peers. Food-insecure children score significantly lower in mathematics and are more likely to repeat a grade than their food-secure peers.[42] Children suffering from hunger are at higher risk of hyperactivity, absenteeism, and generally poor behavioral and academic

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[32] S.E. Black, P.J. Devereux & K.G. Salvanes, *From the Cradle to the Labor Market? The Effect of Birth Weight on Adult Outcomes*, 122 The Quarterly Journal of Economics 409–439 (2007).
[33] Feeding America, Child Hunger in America, http://www.feedingamerica.org/hunger-in-america/impact-of-hunger/child-hunger/ (last visited Mar 22, 2017).
[34] The Science of Early Childhood Development (InBrief), *supra* note 31.
[35] A. Skalicky et al., *Child Food Insecurity and Iron Deficiency Anemia in Low-Income Infants and Toddlers in the United States*, 10 Maternal and Child Health Journal 177–185 (2006).
[36] Cook et al., *Child Food Insecurity Increases Risks Posed by Household Food Insecurity to Young Children's Health*, 136 Journal of Nutrition 1073–1076 (2006).
[37] Angela Odoms-Young, Understanding the food-insecurity and obesity paradox. Feeding America (2012), http://www.feedingamerica.org/hunger-in-america/news-and-updates/hunger-blog/understanding-the-food-insecurity-and-obesity-paradox-by-dr-angela-odoms-young.html?referrer=https://www.google.com/.
[38] P.H. Casey et al., *Child Health-Related Quality of Life and Household Food Security*, 159 Archives of Pediatrics and Adolescent Medicine 51–56 (2005).
[39] L. Dubois, *Family food insufficiency is related to overweight among preschoolers*, 63 Social Science and Medicine 1503–1516 (2006); M.I. Goran, *Obesity and risk of Type 2 diabetes and cardiovascular disease in children and adolescents*, 88 Journal of Clinical Endocrinology and Metabolism 1417–1427 (2003); Y. Dong, Chunky Adolescents' Cardiovascular Health is Headed in Wrong Direction, Experts Say. Science Daily (2007), https://www.sciencedaily.com/releases/2007/05/070510093356.htm (last visited Mar 22, 2017).
[40] K.C. Swallen, *Overweight, obesity, and health-related quality of life among adolescents: The National Longitudinal Study of Adolescent Health*, 115 Pediatrics 340–347 (2005); N.H. Falkner, *Social, Educational, and Psychological Correlates of Weight Status in Adolescents*, 9 Obesity Research 32–42 (2001).
[41] K. Alaimo, *Food insufficiency and American school-aged children's cognitive, academic, and psychosocial development*, 108 Pediatrics 44–53 (2001).
[42] *Id*.

functioning than their peers.[43] As food-insecure children grow older, they are twice as likely to require psychiatric treatment.[44] By adolescence, they have greater difficulty getting along with other children, are more likely to have been suspended from school, and are at a much greater risk of dropping out in high school.[45]

Preventing Child Food Insecurity and Hunger

Child food insecurity and hunger can be reduced and prevented through effective nutrition programs such as school breakfast and lunch programs.[46] The national school lunch program is a federally-funded program that provides low-cost and free breakfasts, lunches, and, on a limited basis, summer food to school-aged children. These meals meet recommended nutrition and dietary guidelines for children and youth.

Only 71% of children who experience hunger are likely income-eligible for federal nutrition assistance, meaning that 29% of the children who are hungry are likely not income-eligible for federal nutrition assistance.[47] For a child to be eligible for federal nutrition assistance, the child must live in a household with incomes at or below 185% of the federal poverty guidelines.[48]

Community eligibility programs allow high-poverty schools and districts to offer breakfast and lunch at no charge to all students. Schools that use community eligibility have seen increases in participation in school breakfast and school lunch and reduced administrative costs,[49] as community eligibility schools no longer have to collect school meals applications. Another strategy schools participating in school breakfast programs can utilize to increase participation by serving "breakfast after the bell," meaning students do not have to rely on special transportation to arrive at school early to receive breakfast, but can instead have a simple meal in the classroom.

Other effective strategies to fight child hunger include working to remove barriers to enrollment in the free meal programs, partnering with community health centers to identify hungry families, reducing the stigma of nutrition programs, streamlining the application process for free school meals, improving the nutritional quality of free school meals, adding meals for children at summer recreation sites and after-school programs, and conducting public education to promote the federal nutrition programs.[50]

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[43] J.M. Murphy et al., *Relationship Between Hunger and Psychosocial Functioning in Low-income American Children*, 37 Journal of the American Academy of Child & Adolescent Psychiatry 163–170 (1998).
[44] Alaimo, K., *supra* note 40, at p. 44-53.
[45] *Id.*
[46] No Kid Hungry, Developing Innovative Child Hunger Solutions, https://www.nokidhungry.org/programs (last visited Mar 22, 2017); S.M. Irving, R.S. Njai & P.Z. Siegel, *Food Insecurity and Self-Reported Hypertension Among Hispanic, Black, and White Adults in 12 States, Behavioral Risk Factor Surveillance System, 2009*, Preventing Chronic Disease, https://www.cdc.gov/pcd/issues/2014/14_0190.htm.
[47] Feeding America, *supra* note 27 (Map the Meal Gap's child food insecurity rates are determined using data from the 2001-2014 Current Population Survey on children under 18 years old in food-insecure households; data from the 2014 American Community Survey on median family incomes for households with children, child poverty rates, home ownership, and race and ethnic demographics among children; and 2014 data from the Bureau of Labor Statistics on unemployment rates).
[48] Gundersen, *supra* note 28.
[49] Christopher W. Logan et al., Community Eligibility Provision Evaluation 60 (2014), https://www.fns.usda.gov/sites/default/files/CEPEvaluation.pdf.
[50] Community Action Partnership of Orange County, Child Hunger Prevention http://www.capoc.org/awareness/pdf/childhungerprevention.pdf.

Recommendations

To reduce and prevent child food insecurity and hunger in South Carolina, the Joint Citizens and Legislative Committee on Children recommends amending Section 59-63-790 of the South Carolina Code, relating to school breakfast and school lunch programs, to provide that by school year 2018-2019, each school district shall implement in each school a nutritional well-balanced school breakfast and lunch program at no cost to students, as provided in S 180.

The Committee also recommends that the State Board of Education draft policies and support districts' implementation of those policies to provide that breakfast may be included in the instructional day as long as appropriate educational activity is taking place while students are eating. Breakfast after the bell programs are effective in reducing student hunger "by maximizing convenience and overcoming barriers to participation."[51] This will increase the number of students who participate in breakfast at school and improve student performance.[52]

The Committee further recommends that the state continue to support the economic services programs administered by DSS that can connect hungry children to the food they need, particularly those in the lowest-income families who are eligible for TANF and SNAP.

Child Homelessness

Defining and Calculating Homelessness

There are two main methods of defining and counting the homeless. One is a point-in-time ("PIT") count, a one-night count of sheltered and unsheltered homeless people. In South Carolina's 2016 PIT count, "a total of 384 families were identified as experiencing homelessness in 2016."[53] Using this method, unaccompanied children and youth are typically undercounted. They are "harder to count because they tend to not reside in the same areas as older adults experiencing homelessness, not self-identify as 'homeless,' stay on friends' couches, or try to blend in."[54]

Despite these limitations, in 2016, the PIT count reported that 759 children under 18 were homeless in June of 2016. This was 16% of the total homeless population. Of those children, 86 (11%) were unsheltered,[55] 356 (47%) were living in transitional housing, 317 (42%) were living in an emergency shelter,[56] and 19 were not accompanied by an adult.[57] In addition, 307 youth

[51] Food Research & Action Center and National Association of Secondary School Principals, School Breakfast After the Bell: Equipping Students for Academic Success (2015), http://frac.org/wp-content/uploads/secondary-principals-bic-report.pdf (last visited Feb 27, 2017).
[52] *Id*. at 2. ("Among the positive outcomes observed by principals were improved student attentiveness (46 percent), fewer visits to the school nurse (22 percent), fewer occurrences of absenteeism (21 percent), fewer disciplinary referrals (18 percent), improved reading (nine percent), and elevated math test scores (nine percent). These survey findings align with academic research, which indicates that students who have breakfast exhibit improved cognitive function and perform better on standardized tests").
[53] Robert Kahle, 2016 Point-in-Time Report 5 (2016), http://www.schomeless.org/wp-content/uploads/2015/12/PIT-Report-2016-1.pdf (last visited Dec 21, 2016).
[54] *Id*. at 11.
[55] For the purposes of the PIT count, unsheltered means "people who live in places not meant for human habitation, such as the streets, vehicles, or parks." *Id*. at 8.
[56] *Id*. at 14.

aged 18-24 were homeless, including 104 who were unsheltered.[58] Given that 28% of 19-year-old former foster youth report experiencing homelessness in the past two years,[59] it is likely that a number of the homeless aged 18-24 are former foster youth.

The other primary method of counting homeless children is school district data collected pursuant to the McKinney-Vento Homeless Assistance Act (42 U.S.C. § 11301 et seq.). The McKinney-Vento Act defines homeless as:

1. Lacking a fixed, regular, and adequate nighttime residence;
2. Using a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;
3. Living in a shelter;
4. Facing imminent loss of housing or leaving one of the above situations; or
5. Unaccompanied youth.[60]

Most notably, the McKinney-Vento Act considers students living in motels or living doubled-up to be homeless.[61]

The McKinney-Vento Act count provides a more comprehensive picture of child homelessness in South Carolina than the PIT count,[62] but it is still likely an undercount of homeless children attending public schools.[63] Despite this undercount, there has been an increase in homeless children both state-wide and nationally.[64]

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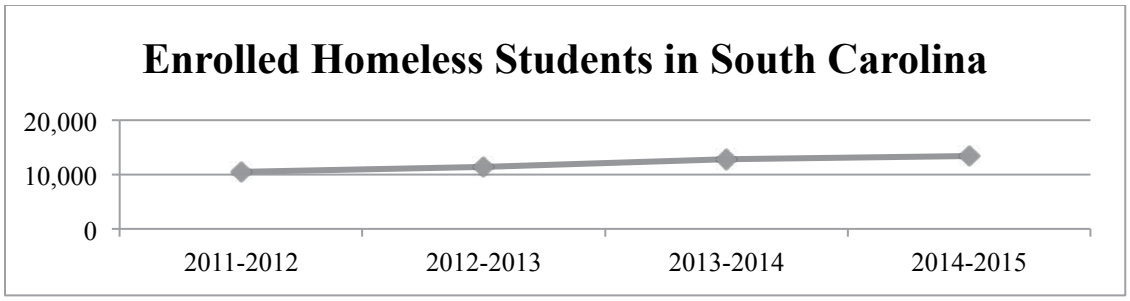
[57] *Id*. at 16.
[58] *Id*. at 14.
[59] South Carolina Department of Social Services & National Youth in Transition Database, Voices and Visions of SC Youth in Transition: A Report of the Survey of 21-Year-Old Youth Alumni of Foster Care (2014), http://www.nytdstayconnected.com/images/pdfs/voicesvisions.pdf (last visited Mar 22, 2017).
[60] The McKinney-Vento Education of Homeless Children and Youth Assistance Act, 42 U.S.C. § 11302(a)(1)-(6).
[61] *See* Federal Data Summary School Years 2012-13 to 2014-15: Education for Homeless Children and Youth, 14, http://nche.ed.gov/downloads/data-comp-1213-1415.pdf (last visited Dec 21, 2016). "Students living in hotels and motels are included when they lack alternative accommodations and their housing cannot be considered fixed, regular, and adequate. Students who are doubled-up are those who are sharing housing with others due to a loss of housing, economic hardship, or a similar reason. To be considered homeless, students sharing housing must also be determined to lack fixed, regular, and adequate nighttime residence. Common roommate situations do not qualify as homeless as they are considered fixed, regular, and adequate."
[62] Ellen L. Bassuk et al., America's Youngest Outcasts: A Report Card on Child Homelessness 14, http://www.air.org/sites/default/files/downloads/report/Americas-Youngest-Outcasts-Child-Homelessness-Nov2014.pdf (last visited Dec 21, 2016).
[63] *Id*. at 16. "Some families keep their homelessness a secret from friends and school officials to avoid the stigma and embarrassment of being homeless. Also, some school districts do not report a count, and some children do not attend school. What about younger homeless children who do not attend school? The age distribution of homeless children in the U.S. is estimated at 51% under age 6; 34% age 6 to 12; and 15% age 13 to 17 years (Samuels et al., 2010; HUD, 2009). Thus, about half of homeless children in America are not yet school age. A complete count of homeless children in America from 0 to 17 years is made by adding the number of homeless children under the age of 6 to the McKinney-Vento K-12 count."
[64] *Id*. at 14.



Data source: National Center for Homeless Education

South Carolina had the third highest risk in the United States for child homelessness in 2013.[65] Because McKinney-Vento only covers school-aged children, this data does not include children who are under the age of 6, who represent 51% of the child homeless population.[66]

Challenges Facing Homeless Children

Education

Homeless children have difficulty enrolling in and attending school. Enrollment may be difficult because homeless youth do not have access to documentation, cannot provide proof of residency, and may be unaccompanied and therefore lack documentation of legal guardianship.[67] Because homeless youth move frequently, getting to their school of origin may be difficult, and transportation arrangements must be adjusted frequently in collaboration with the school's McKinney-Vento liaison.[68] Ensuring continuity in educational progress is further complicated by varying curricula among districts and a lack of access to the child's records, which may result in the child missing out on necessary classes or services. Children who are homeless "have three times the rate of emotional and behavioral problems, are four times more likely to show delayed development, and have twice the rate of learning disabilities,"[69] and are thus more likely to qualify for special education services under the Individuals with Disabilities Education Act (IDEA).

Mental Health

Major psychiatric disorders and substance abuse are substantially more common among homeless children than their non-homeless peers.[70] Research has shown that "rates of having at least one psychiatric disorder among homeless youth can be as high as FOUR times the rate of youth in the general population."[71] Youth who are homeless are more likely to have histories of

[65] *Id*. at 20.
[66] The 2008 Annual Homeless Assessment Report to Congress, 32 (2009), http://www.huduser.gov/portal/publications/pdf/4thHomelessAssessmentReport.pdf (last visited Mar 22, 2017).
[67] Enrolling Children and Youth Experiencing Homelessness in School, (2014), http://nche.ed.gov/downloads/briefs/enrollment.pdf (last visited Mar 22, 2017).
[68] National Center for Homeless Education, Transporting Children and Youth Experiencing Homelessness (2015), http://nche.ed.gov/downloads/briefs/transportation.pdf.
[69] National Center for Homeless Education, Supporting Homeless Children and Youth With Disabilities--Legislative Provisions in the McKinney-Vento Act and the Individuals with Disabilities Education Act (2015), http://nche.ed.gov/downloads/briefs/idea.pdf.
[70] Behavioral Health Among Youth Experiencing Homelessness, 3 In Focus: A Quarterly Research Review of the National HCH Council (2015), https://www.nhchc.org/wp-content/uploads/2011/09/in-focus-behavioral-health-among-youth.pdf.
[71] *Id*.

physical or sexual abuse. They often "experience trauma prior to becoming homeless and are at increased risk of trauma after they become homeless."[72]

Recommendations

The Committee commits to further study of this issue to determine the best policy and practice solutions to benefit South Carolina's children. Committee staff will work to identify programs that have had been successful in reducing child homelessness within South Carolina and around the nation and will return to the Committee with additional recommendations for action.

Protecting Children from Abuse and Neglect

The most vulnerable children in South Carolina are those whom the State has removed from their homes due to maltreatment, and meeting their myriad needs is critical. Improving the multisystem processes and community supports that impact children in danger is a task that many in our state have undertaken, and the Committee commends those interdisciplinary efforts. The Children's Policy of South Carolina[73] charges the Committee with cooperatively identifying strategies that maximize all available resources to protect children. Providing support for children who have been abused or neglected has been a priority concern for the Committee since its formation and is the reason we continue focusing our attention on Kinship Care and undertake a new focus initiative on Youth in Transition.

Kinship Care

At the 2016 Public Hearings, the Committee again heard testimony from kinship caregivers and other stakeholders around the state. Witnesses identified the benefits of kinship care for South Carolina children and the struggles faced by kinship caregivers.

Definition and Background

Kinship care describes a setting in which a child is raised by someone that is familiar to that child who is not the child's parent. This includes grandparents, older siblings, or other relatives and "fictive kin," a term which encompasses people who are known to the child but are not related to the child by blood, marriage, or adoption. Kinship caregiving can be established pursuant to a DSS court case or investigation (public formal kinship care), by a private court case (private formal kinship care), or through an informal arrangement between parents and caregivers (private informal kinship care). Kinship care refers to cases where neither parent is living in the home with the child.[74]

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[72] Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States, (2011), https://www.samhsa.gov/sites/default/files/programs_campaigns/homelessness_programs_resources/hrc-factsheet-current-statistics-prevalence-characteristics-homelessness.pdf (last visited Mar 22, 2017).

[73] S.C. Code Ann. §63-1-20.

[74] *See* S.C. Code Ann. § 63-7-2320 (1976, as amended); S.C. Code Ann. § 63-7-1700(G) (1976, as amended).

The face of South Carolina families is changing: 5% of all South Carolina children (57,000 out of 1.1 million children) are living in kinship care.[75] Kinship care can be a very positive thing for South Carolina children, particularly those who are system-involved. Keeping children with family often allows those children to remain in the same school and community and provides consistency in relationships with caring adults, such as teachers, coaches, and members of the faith community. Public formal kinship care placements are more than two and a half times more stable than traditional foster placements.[76] Kinship care allows children to maintain ties to extended family and minimizes the trauma of removal.[77] Children are able to remain with people that they know and continue their cultural practices.[78] They are more likely to be placed with their siblings.[79] They are often able to have more contact with their parents than in traditional foster care,[80] and those contacts improve reunification rates.[81] Children in kinship care have better emotional and mental health; they are also less likely to suffer from depression than children in group homes or in traditional foster care.[82]

Problems Facing Kinship Caregivers

Kinship caregivers tend to be older, less educated, and poorer than their non-relative foster parent counterparts.[83] Because many kinship placements begin informally, it is difficult to anticipate financial and other needs of the children. Further, it is not uncommon for kinship care placements to have difficulty accessing much-needed services. Kinship caregivers face three significant challenges: lack of financial support, lack of services, and lack of legal documentation. They need access to benefits to support the children in their care. They need services to help them adjust to their new family structure and to help the children in their care process the trauma they have endured. Finally, they need training and support to understand their legal standing to facilitate medical care, school enrollment, and access to other services for the children in their care.

Recommendations

Becoming a licensed foster home allows kinship caregivers of children who are in DSS custody access to financial support[84] and other benefits. To facilitate the licensing process, the Preventing Sex Trafficking and Strengthening Families Act allows for waiver of non-safety

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[75] Annie E. Casey Foundation, Children in Kinship Care in South Carolina, http://datacenter.kidscount.org/data/tables/7172-children-in-kinship-care?loc=42&loct=2#detailed/2/42/false/1564,1491,1443,1218,1049/any/14207,14208 (last visited Nov 10, 2016).
[76] Joshua Gupta-Kagan, *The New Permanency*, 19 U.C. Davis Journal of Juvenile Law and Policy 81 (2015), citing 2013 D.C. CHILD AND FAMILY SERVS. AGENCY ANN. PUB. REP. 25 (2014). *See also* Sandra Bass, Margie K. Shield & Richard E. Behrman, *Children, Families, and Foster Care: Analysis and Recommendations*, 14 Future of Children 17 (2004).
[77] Sandra Bass, Margie K. Shield & Richard E. Behrman, *Children, Families, and Foster Care: Analysis and Recommendations*, 14 Future of Children 17 (2004).
[78] MaryLee Allen et al., Making it Work: Using the Guardianship Assistance Program (GAP) to Close the Permanency Gap for Children in Foster Care 8 (2012), http://www.childrensdefense.org/library/data/making-it-work-using-the.pdf.
[79] *Id*.
[80] Brea L. Perry, *Social Network Disruption: The Case of Youth in Foster Care*, 53 Social Problems 371–375 (2006).
[81] *Id*.
[82] *Id*. at 383.
[83] Bass, *supra* note 75, at 17.
[84] While states can extend foster care benefits to non-licensed foster homes, federal financial participation is not available for those homes. *See* 45 CFR 1355.20: "Anything less than full licensure or approval is insufficient for meeting title IV-E eligibility requirements." South Carolina has not extended foster care payments to non-licensed foster homes. *See* DSS Regulation 114-550.

requirements in foster care licensing of kinship caregivers,[85] and current DSS regulations also give the Department this discretion.[86] The Committee encourages DSS to utilize this discretion and to inform caregivers of their right to be licensed, the benefits of licensure, the process to become licensed, and any available waivers.

Subsidized guardianships allow for the use of federal funds to continue monetary support to kinship placements while achieving permanency for South Carolina children without necessitating the termination of parental rights. Implementing subsidized guardianship would better facilitate our state's ability to leverage federal funding to support children in kinship care.

Guardianships have been shown to decrease the time children spend in foster care without increasing maltreatment recurrence.[87] They are cost effective[88] and can lead to better outcomes for children than many other options for children in foster care.[89] The Committee has directed its staff to assist DSS in development of a state plan amendment and to assist in the related regulatory processes needed to obtain federal funding for a subsidized guardianship program. The Committee further supports amending S.C. Code § 62-5-106 to allow for the court to order automatic termination of these guardianships upon obtaining the age of majority unless good cause is shown.

Youth in Transition

Each year in South Carolina, roughly 200 young adults emancipate from or "age out" of foster care.[90] Youth emancipate from foster care if family reunification, termination, adoption or guardianship has not occurred by age 18. These young adults are at a critical juncture in development. They face unique challenges in their transition to adulthood, and South Carolina must take action to ensure that they are fully prepared for their next stage of life.

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[85] 42 USC 671§471(a)(10)(D): "a waiver of any standards established pursuant to subparagraph (A) may be made only on a case- by-case basis for nonsafety standards (as determined by the State) in relative foster family homes for specific children in care."

[86] DSS Regulation 114-550(L)(1): "Per federal policy, relatives being licensed must be licensed in accordance with the same requirements as non-relative applicants. SCDSS may waive, on a case by case basis, for relatives or non-relatives, non-safety elements as SCDSS deems appropriate. Safety elements such as history of child abuse/neglect, state and/or federal criminal history checks must not be waived. SCDSS must note on the standard license if there was a waiver of non-safety element and identify the element being waived."

[87] Synthesis of Findings: Subsidized Guardianship Child Welfare Waiver Demonstrations, 18–20 (2011), https://www.acf.hhs.gov/sites/default/files/cb/subsidized_0.pdf. *See also* M.F. Testa, Subsidized Guardianship: Testing the Effectiveness of an Idea Whose Time Has Finally Come 24 (2008): "Federally subsidized guardianship encourages a significant proportion of committed and caring foster parents who otherwise would stay in the foster care system to assume permanent legal responsibility of the children under their care."

[88] *Id*. at 24-25: "Discharging foster children to permanent guardianship is a cost effective alternative to retaining them in foster care because of the savings achieved from case closing and the discontinuation of agency administrative and judicial oversight." *See also* Cynthia Godsoe, *Parsing Parenthood*, 17 Lewis & Clark Law Review 113, 146 (2013): "Subsidized guardianship has been shown to have numerous positive outcomes for families involved with the child welfare system, including fewer children in foster care and shorter stays in care, and more children achieving permanent placements. It also brings significant fiscal savings for states because of decreased foster care caseloads. For instance, Massachusetts reported saving as much as $10,000 per year on each case moved from foster care to guardianship and Illinois reported total savings of over $54 million over five years."

[89] *See* MaryLee Allen, *supra* note 76, at p.8. *See also* Brea L. Perry, *supra* note 78, at p. 75.

[90] In 2011, this number peaked at 366, or 10% of children leaving foster care in South Carolina. In 2015, it had decreased to 184, or 6%. Kids Count Data Center for South Carolina. "Children Exiting Foster Care by Exit Reason," http://datacenter.kidscount.org/data/tables/6277-children-exiting-foster-care-by-exit-reason. (Last accessed February 27, 2017).

Challenges Facing Youth in Transition

The National Youth in Transition Database is a federally-funded program that tracks the outcomes of young adults who age out of foster care. The results of the survey reveal that this is a particularly vulnerable group of young adults in our state. In South Carolina, 212 youth who were formerly in foster care completed the federal and state questionnaires[91] with the following results:

- 44% of 21 year olds reported having engaged in high risk behavior in the past two years.
- 81% of 21 year olds reported having an adult with whom they could speak for emotional support (compared with 94% of 17 year olds).
- 28% of 21 year olds reported having experienced homelessness in the past two years.
- 31% of surveyed youth reported having parented a child in the last two years.
- 37% were receiving public food assistance when surveyed.[92]

Perhaps one of the most critical needs of these youth not as easily quantifiable is the challenge of dealing with the grief, trauma, and loss accompanying separation from their families. Youth who were asked to discuss an important loss experienced when entering foster care or while in foster care most often reported separation from siblings.[93] They also cited being alone without support, insufficient finances, fear of the unknown, unstable housing and homelessness, unemployment, incompletion of high school, loss of social support, and educational challenges – all complex and weighty concerns for the relatively very young.[94]

Youth in foster care also face difficulties in completing more typical teenage tasks, like completing driver's education, obtaining a driver's license, and applying for college. The John H. Chafee Foster Care Independence Program is a federal program that assists with some of these basic needs, such as educational support services, pre-college expenses, and transportation, but more needs to be done to support teenagers in foster care and young adults who have aged out of foster care.

Recommendations

First, youth in foster care need to be equipped with the tools and skills to become successful adults, just like their non-foster care counterparts. Teenagers in foster care need to be made aware of their rights and included in planning their futures. They need to be taught the same skills and given the same opportunities as their non-foster counterparts.

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[91] South Carolina Department of Social Services & National Youth in Transition Database, Voices and Visions of SC Youth in Transition: A Report of the Survey of 21-Year-Old Youth Alumni of Foster Care (2014), http://www.nytdstayconnected.com/images/pdfs/voicesvisions.pdf (last visited Mar 22, 2017).
[92] *Id.*
[93] Monique Mitchell & Tracey Beecken, Outcomes and Recommendations for South Carolina Youth in Transition (2017).
[94] *Id.*

The Committee has undertaken a survey of other states' approaches to tangible needs of former youth in foster care such as supervised transitional housing and will return with specific recommendations for our state. Another area of study for the Committee is implementation of mentoring programs that can help ensure that children and youth in foster care have mentors and/or meaningful connections that can be sustained after the young person leaves state care. Those exiting care need connections to an adult who can not only provide emotional and social support, but also help the youth continue educational pursuits, and meet other needs.[95]

Second, youth in foster care who are near or at transition age must be given the opportunity for active participation in designing their futures. Youth need to know and make their own choices about developmentally appropriate community options for education, housing, and other aspects of their post-care life. South Carolina must ensure that youth aged 14 and older are actively involved in their case planning while in foster care, in compliance with the Fostering Connections Act. Youth should be informed of their right to attend these court hearings and permanency planning conferences.

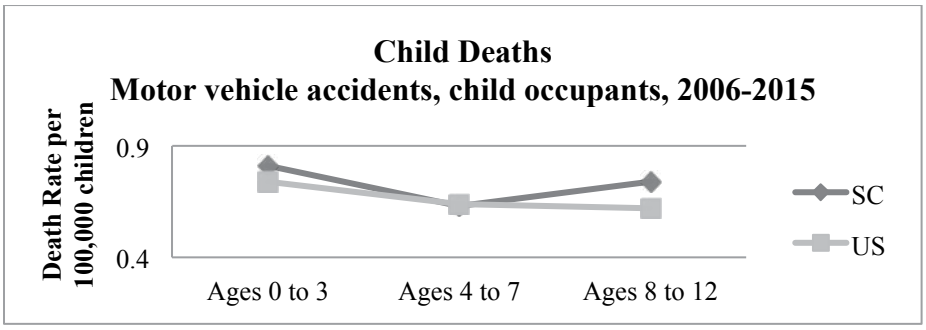
Third, youth in transition should have the opportunity to attain one of the most important skills needed for successful independent living: obtaining a drivers' license. The Committee supported legislation expanding the class of individuals allowed to sign a driver's license application for a youth in foster care, as provided in S 198 and was pleased to see this bill pass. We eagerly anticipate the Governor's signature. The Committee is also undertaking study and participating in stakeholder convenings to draft needed statutory changes and regulatory framework for drivers' insurance for older youth in care.

[95] Blueprint for Change: Education Success for Children in Foster Care, Second Edition, (2008), http://www.americanbar.org/content/dam/aba/publications/center_on_children_and_the_law/education/blueprint_second_edition_final.authcheckdam.pdf (last visited Mar 27, 2017).

Protecting Children's Physical and Mental Well-Being

Child Passenger Safety

The Committee continues to be deeply concerned about the dangers posed to our state's children by unsafe placement and restraint in motor vehicles. Motor vehicle accidents are the leading killer of children in South Carolina. In the past ten years, 230 children under 13 died from motor vehicle traffic accidents, with a death rate of 2.8 per 100,000 children, higher than the national rate of 2.1 per 100,000 children.[96,97] From 2006 to 2015, approximately 25% of the child motor vehicle traffic accident deaths in South Carolina involved child passengers. Among the child passenger deaths, 39% were children ages 8 to 12, 34% were children under 3, and 27% were ages 4 to 7. These child deaths could have been prevented if the child had been properly restrained in age- and size-appropriate car seats, booster seats, and seat belts.[98]



Research demonstrates that child safety seats reduce the risk of death by 71% for infants and by 54% for toddlers ages 1 to 4. Booster seats reduce the risk for serious injury by 45% for children ages 4 to 8.[99,100,101] Child safety seat laws are necessary and effective in increasing child safety seat use. Current South Carolina law **does not** meet the child safety seat guidelines recommended by the National Highway Traffic Safety Administration (NHTSA) and the American Academy of Pediatrics (AAP).

[96] Centers for Disease Control and Prevention, Injury Prevention & Control: Data & Statistics (WISQARSTM), https://www.cdc.gov/injury/wisqars/fatal_injury_reports.html.
[97] Insurance Institute for Highway Safety Highway Loss Data Institute, Child Safety (2016), http://www.iihs.org/iihs/topics/t/child-safety/fatalityfacts/child-safety (last visited Mar 22, 2017).
[98] Road Safety News of the Week, Together for Safer Roads (2016), http://www.togetherforsaferroads.org/road-safety-news-of-the-week-sept-26/ (last visited Mar 22, 2017).
[99] American Academy of Pediatrics, Child Passenger Safety (2016), https://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Documents/CPS.pdf.
[100] Insurance Institute for Highway Safety Highway Loss Data Institute, Child Safety (2016), http://www.iihs.org/iihs/topics/t/child-safety/fatalityfacts/child-safety (last visited Mar 22, 2017).
[101] D.R. Durbin et al., *Rear Seat Safety: Variation in Protection by Occupant, Crash, and Vehicle Characteristics*, 80 Accident Analysis and Prevention 185–192 (2015).

AAP Guidelines

The American Academy of Pediatrics (AAP) recommends[102] that:

- Infants and toddlers should ride facing the rear of the vehicle until they are at least 2 years old.
- Young children should ride in car safety seats with a harness until at least age 4, with guidance educating parents and caregivers about the benefits of riding in a seat with a 5-point harness up to the highest weight or height allowed by the manufacturer.
- School-aged children should ride in belt-positioning booster seats until at least age 8 or until the seat belt fits correctly, as described by the AAP and NHTSA.
- Children should ride in the back seat until 13 years old.
- Seat belt laws should apply to all vehicle occupants and should be subject to primary enforcement.

South Carolina's Child Passenger Restraint Law

As stated in the Committee's 2016 Annual Report, current South Carolina law requires that children between the ages of 1 and 6, from 40-80 pounds, ride in a booster seat. In contrast, NHTSA recommends that children up to age 8 who are less than 4'9" ride in a booster seat. Further, AAP recommends that children between the ages of 8 and 12 who are less than 4'9" ride in a booster seat. The purpose of a booster seat is to make the adult seatbelt fit a child properly. In addition to age and weight, height also determines where the seat belt will cross on the child. With the rise in child obesity, many children meet the age or weight requirements in South Carolina's current law while still being too short for the adult seatbelt to fit properly. Children's health professionals have also recommended that South Carolina's booster seat law be updated and changed from an age/weight-based measure to an age/height/weight-based measure.[103]

Child Passenger Restraint Laws in Other States

According to the American Academy of Pediatrics (AAP), as of December 2016, three states' laws (i.e., Washington, California, and Oklahoma) have included four of the five AAP recommended child passenger safety provisions, and seventeen states and DC laws have included three of the AAP recommended child passenger safety provisions. Other states, including South Carolina, have not yet complied with the major AAP evidence-based recommendations to strengthen child passenger safety protections.[104]

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[102] American Academy of Pediatrics, Child Passenger Safety (2016), https://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Documents/CPS.pdf.
[103] South Carolina Children's Hospital Collaborative, Issues and Advocacy, http://www.scchildrenshospitals.org/issues_advocacy/.
[104] American Academy of Pediatrics, Child Passenger Safety (2016), https://www.aap.org/en-us/advocacy-and-policy/state-advocacy/Documents/CPS.pdf.

Recommendations

The Joint Citizens and Legislative Committee on Children continues to recommend amending Sections 56-5-6410 and 56-5-6420 of the S.C. Code so as to revise the age, weight, and position of a child who must be secured in a child passenger restraint system as described in **S 478** and **H 3864.** These companion bills amend Sections 56-5-6410 and 56-5-6420 of South Carolina law to increase the age at which a child must be in a rear-facing seat from one to two years; to increase the age until which a child must be secured in forward-facing child seat; to add certain height requirements, and to make conforming changes. We are pleased to see the progress on this legislation this session and commend the body for their attention to this important and needed update to state law.

Tobacco Marketing To Youth

Tobacco use is prevalent among youth in South Carolina. In 2015, 29.1%, or 65,759 high school students in South Carolina reported that they used tobacco (cigarette, smokeless tobacco, cigar, or electronic vapor product use),[105] and almost half (i.e., 49.7%) did not try to quit smoking cigarettes.[106,107] Approximately 10% of high schoolers reported that they smoked a whole cigarette for the first time before age 13. This was statistically significantly higher than the national rate. Table 1 presents other tobacco use reports from high school students in South Carolina.[108]

According to the Office on Smoking and Health of the Centers for Disease Control and Prevention, nearly 9 out of 10 smokers start smoking by age 18 years, and 99% of smokers start by age 26.[109] Early smoking is particularly harmful to adolescents because they are more likely to become addicted to nicotine, become lifetime smokers, contract diseases caused by tobacco use, and die from a disease caused by tobacco use.[110] The main reasons young people start using tobacco include the susceptibility of youth, social norms, media and peer influences, youth-targeted marketing, immature decision making skills, and the risk-taking characteristics of an immature brain during adolescence.[111,112]

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[105] Laura Kann et al., *Youth Risk Behavior Surveillance--United States, 2015*, 65 Surveillance Summaries (2016), https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2015/ss6506_updated.pdf. 29.1% of high school students in South Carolina reported their tobacco use on at least 1 day during the 30 days before the survey.

[106] *Id*.

[107] The 2015 high school student enrollment was 225,975 in South Carolina. South Carolina Department of Education, State Report Card (2015), http://ed.sc.gov/data/report-cards/state-report-cards/2015/ (last visited Mar 22, 2017).

[108] Kann, *supra* note 100.

[109] *Id.*

[110] National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General, https://www.ncbi.nlm.nih.gov/books/NBK99237/.

[111] National Institute of Mental Health, The Teen Brain: Still Under Construction, https://www.nimh.nih.gov/health/publications/the-teen-brain-still-under-construction/index.shtml.

[112] Centers for Disease Control and Prevention, Youth and Tobacco Use, https://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/ (last visited Mar 5, 2017).

2015 Tobacco Use Survey Questions	South Carolina	United States
Ever tried cigarette smoking (even one or two puffs)	36.9%	32.3%
Ever used electronic vapor products[113]	42.9%	44.9%
Smoked a whole cigarette before age 13	10.0%	6.6%
Obtaining cigarettes		
Usually bought cigarettes at a store or gas station[114]	13.9%	12.6%
Usually bought cigarettes on the internet	2.4%	1.0%
Current tobacco use		
Currently smoked cigarettes[115]	9.6%	10.8%
Smoked more than 10 cigarettes per day[116]	8.5%	7.9%
Did not try to quit smoking cigarettes[117]	49.7%	54.6%
Currently smoked cigars [118]	11.2%	10.3%
Currently used electronic vapor products[119]	19.7%	24.1%
Currently smoked cigarettes or cigars[120]	16.4%	16.0%
Currently used cigarettes, cigars, or smokeless tobacco	19.7%	18.5%
Currently used smokeless tobacco	7.2%	7.3%
Currently used tobacco (current cigarette, smokeless tobacco, cigar, or electronic vapor product use)	29.1%	31.4%

Table 1 Tobacco use among high school students: 2015 South Carolina and national results[121]

Because many adults eventually quit smoking and half of long-term smokers die from tobacco-related diseases, tobacco companies view young smokers as "replacement smokers" to maintain profits.[122] Tobacco companies keep prices down, make products easy to buy, design products and packaging that appeal to children, and use the media to promote products. Children are especially responsive and vulnerable to those marketing strategies.[123]

Preventing Child Tobacco Use

Various strategies that have been proposed by researchers to decrease youth tobacco use include making tobacco products less affordable, restricting tobacco marketing, banning smoking in public places, and requiring tobacco companies to label tobacco packages with large, graphic

[113] Including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens.
[114] During the 30 days before the survey, among students who currently smoked cigarettes and who were aged <18 years.
[115] On at least 1 day during the 30 days before the survey.
[116] On the days they smoked during the 30 days before the survey, among students who currently smoked cigarettes.
[117] During the 12 months before the survey, among students who currently smoked cigarettes.
[118] Cigars, cigarillos, or little cigars on at least 1 day during the 30 days before the survey.
[119] Including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens on at least 1 day during the 30 days before the survey.
[120] On at least 1 day during the 30 days before the survey.
[121] Adolescent and School Health, YRBSS Results.
[122] *Id.*
[123] *Id.*

health warnings.[124] Among those, tax increases on tobacco products have been proven to be one of the most effective policies in reducing and preventing tobacco use among children.[125,126,127]

Tobacco Tax Increases

Tobacco tax increases can effectively reduce tobacco consumption among youth and thus reduce the health issues related to tobacco use. They increase revenue and save money by reducing tobacco-related health care costs. National and state polls consistently demonstrate that the majority of the public support tobacco tax increases.[128] Findings from numerous scientific studies regarding the effects of tax and prices increases also suggested that increases in cigarette prices lead to reductions in the prevalence of smoking and its intensity among youth, and adolescents are more responsive than adults to changes in cigarette prices.[129,130]

The South Carolina cigarette tax rate is $0.57 per pack, which was ranked the 45th lowest in the nation in cigarette tax rates. [131] Currently, 35 states, DC, Puerto Rico, the Northern Marianas, and Guam have cigarette tax rates of $1.00 per pack or higher. New York has the highest tax rate at $4.35 per pack. Nationally, the median tax rate is $1.60 per pack, and South Carolina's cigarette tax rate is far below that.[132]

Redefining Cigarettes

Currently, there is a loophole in the South Carolina tax code that allows tobacco product manufacturers to classify certain tobacco products as cigars simply because those tobacco products are wrapped in brown paper. Retailers and manufacturers have taken advantage of this loophole by classifying and selling cigarettes as cigars, avoiding restrictions and regulations that apply to cigarettes but not cigars, netting them significant profit. The resulting lower retail prices for cigars also contribute to the expansion of youth smoking because the products are significantly cheaper and easier to buy. Therefore, closing this definition loophole in the tax code could likely deter youth tobacco use.

[124] National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health. Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General, https://www.ncbi.nlm.nih.gov/books/NBK99237/.
[125] *Id.*
[126] Youth and Tobacco Use, *supra* note 107.
[127] U.S. State and Local Issues: State Tobacco Taxes, Campaign for Tobacco-Free Kids (2016), http://www.tobaccofreekids.org/what_we_do/state_local/taxes/.
[128] *Id.*
[129] Youth and Tobacco Use, *supra* note 107.
[130] Ann Boonn, Raising Cigarette Taxes Reduces Smoking, Especially Among Kids (And the Cigarette Companies Know It) (2017), https://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf.
[131] Ann Boonn, State Cigarette Excise Rates & Rankings (2017), http://www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf.
[132] *Id.*

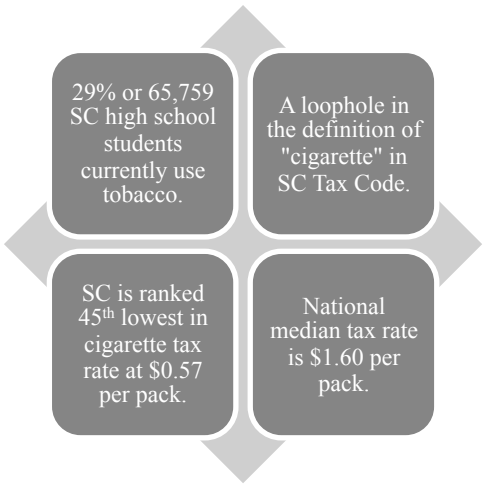


Figure: Overview of South Carolina Child Tobacco Use and Tax Code

Positive Programs

The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) offers the Palmetto Retailers Education Program (PREP). Available in all 46 counties, PREP is a course for retailers that "helps reduce underage access to alcohol and tobacco products in our communities, while also lowering the liability risks for businesses."[133] In Fiscal Year 2015, PREP served 2,180 merchants, up from 1,678 in Fiscal Year 2014.[134] Since April 2013, DAODAS has also provided inspections on youth buys for the FDA.[135] In Fiscal Year 2015, there were 1,063 tobacco checks under this system.[136] During that same period, 1,691 youth were served by DAODAS's Tobacco Education Program.[137]

Within the Department of Health and Environmental Control (DHEC), the Division of Tobacco Prevention and Control has four initiatives related to youth tobacco cessation. DHEC provides support to South Carolina's public school districts to implement comprehensive tobacco-free policies. DHEC has implemented a statewide youth prevention and cessation campaign, Backfire SC, to educate youth about the impact of tobacco use utilizing multiple media channels. DHEC is also one of the lead agencies in our state that, along with the State Department of Education, conducts the S.C. Youth Tobacco Survey. This survey collects data from students in grades 6 through 12 to measure knowledge and attitudes regarding tobacco use, exposure to media and advertising, and prevalence of tobacco use. Finally, DHEC provides key resources for CEASE (Clinical Effort Against Secondhand Smoke Exposure). CEASE is a clinical intervention for pediatric providers to screen for secondhand smoke exposure in patients,

[133] South Carolina Department of Alcohol and Other Drug Addiction Services, Palmetto Retailers Education Program, http://www.daodas.sc.gov/prevention/merchant-initiatives/prep/ (last visited Apr 7, 2017).
[134] Al Stein-Seroussi et al., Fiscal Year 2015 Prevention Outcomes Annual Report, http://ncweb.pire.org/scdocuments/documents/PrevOutcomesReport_15_FINAL%20MASTER_042616.pdf.
[135] South Carolina Department of Alcohol and Other Drug Addiction Services, FDA Tobacco Inspections, http://www.daodas.sc.gov/prevention/fda-tobacco-inspections/ (last visited Apr 7, 2017).
[136] Al Stein-Seroussi, *supra* note 134.
[137] *Id* at 33. "For tobacco, county agencies offer the Tobacco Education Program (TEP) for youth as a program they can complete when charged with underage tobacco possession in lieu of paying a fine. In FY '15, 1,691 youth participated in TEP, up considerably from FY '14. Fourteen counties delivered TEP in FY '15, with Fairfield (632), Chester (592), Charleston (287) serving the most youth."

and help parents quit by offering a referral to the SC Quitline. DHEC provides training for clinic staff and Quitline resources.

Recommendations

The Joint Citizens and Legislative Committee on Children supports **H 3664** and **S 575** which amend South Carolina Code Section 12-21-625, so as to revise the weight limitation on cigarettes from three pounds or less per one thousand cigarettes to four and one-half pounds or less per one thousand cigarettes, and to exempt those wrapped totally in tobacco leaf with no filter, and to define "cigarette" to include 0.325 ounces of tobacco likely intended to be purchased to roll your own cigarettes.

Child Suicide and Mental Health Services

Suicide is a serious public health problem that causes immeasurable pain and loss to individuals, families, and communities. Suicide is a leading cause of child death in South Carolina, particularly among adolescents. Suicide is the third leading cause of child deaths for children aged 10 to 17 in South Carolina. Between the years of 1999 and 2015, a total of 260 children under 18 died by suicide in South Carolina. Of these, 32% were children aged 10 to 14, and 68% were children aged 15 to 17. Approximately 52% of the suicide deaths were related to intentional discharge of firearms. The majority of the children who died by suicide were white males (61%), followed by white females (18%), black males (15%), black females (4%), and males of other races (2%).[138] More teens and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease, combined.[139]

In 2015, in the twelve months prior to being surveyed, 17.3% of South Carolina high school students had seriously considered attempting suicide, 14.7% had made a plan about how they would attempt suicide, 11% had attempted suicide one or more times, and 3.4% had attempted suicide that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse.[140] More female high school students than male high school students reported that they had thought about suicide and suicide attempts; however, more males, especially white males, died from suicide than females with the use of firearms.[141] Females were more likely to die by suicide by hanging or suffocation. Most child suicides occurred at home.

[138] South Carolina Department of Health and Environmental Control, SCAN Death Certificate Data, http://scangis.dhec.sc.gov/scan/bdp/tables/death2table.aspx (last visited Mar 22, 2017).
[139] The Jason Foundation, Youth Suicide Facts & Stats, http://jasonfoundation.com/youth-suicide/facts-stats/.
[140] Laura Kann et al., *Youth Risk Behavior Surveillance--United States, 2015*, 65 Surveillance Summaries (2016), https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2015/ss6506_updated.pdf.
[141] South Carolina Joint Citizens and Legislative Committee on Children, 2016 Data Reference Book 9, http://sccommitteeonchildren.org/doc/2016%20Data%20Reference%20Book.pdf.

Table: Suicide attempt and ideation among high school students: 2015 South Carolina and national results[142]

During the 12 months prior to the 2015 survey, high school students:	South Carolina	United States
Seriously considered attempting suicide	17.3%	17.7%
Made a plan about how they would attempt suicide	14.7%	14.6%
Attempted suicide one or more times	11%	8.6%
Attempted suicide that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse	3.4 %	2.8%

The main risk factors related to child suicide include relationship problems, especially intimate partner problems, and access to lethal means. Children's mental health problems are another major risk factor for child suicide.[143] Suicide may be linked to a clinical diagnosis such as depression, bipolar disorders, or substance abuse that has gone untreated or undertreated. Children who experience violence, drug or alcohol addiction, poverty, sexual, physical, or emotional abuse have a much higher risk for suicide. Many times suicides occur because the existing problem in a child's life is perceived to be insurmountable, without resolution, and one that will last forever.

The Importance of Protective Factors

An emphasis on the need for protective factors is important. Protective factors are the positive conditions, personal and social resources that promote resiliency and reduce the potential for suicide as well as other high-risk behaviors. Not everyone who is depressed thinks about or acts out suicidal behavior. The same is true for almost every psychiatric disorder. Most people who exhibit many of the risk factors for suicide do not engage in suicidal behavior. Conceptually, they, and most people, have positive conditions and personal and social resources that promote resiliency. These positive conditions and personal and social resources can be referred to as protective factors. Protective factors include family and community connections and support, clinical care, resilience, coping and life skills, frustration tolerance and emotion regulation, and cultural and religious beliefs or spirituality.[144]

Child Access to Mental Health Services

According to the 2011-2012 National Survey of Children's Health,[145] approximately

[142] Laura Kann et al., *Youth Risk Behavior Surveillance--United States, 2015*, 65 Surveillance Summaries (2016), https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2015/ss6506_updated.pdf.
[143] *Id.*
[144] U.S. Public Health Service. (2001). *National strategy for suicide prevention: Goals and objectives for action.* Rockville, MD: U.S. Department of Health and Human Services. Cha, C., Nock, M. (2009). Emotional intelligence is a protective factor for suicidal behavior. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(4), 422-430.
[145] Data Resource Center for Child & Adolescent Health, Nationwide vs. South Carolina: Received Needed Mental Health Care, Age 2-17 Years, http://www.childhealthdata.org/browse/survey/results?q=2504&r=1&r2=42.

49.9% of children with mental health problems in South Carolina did not receive mental health services. The rate of unmet mental health needs in South Carolina was 11% higher than the national average. South Carolina ranked the 4th highest in the nation for unmet mental health needs.[146] These needs span age groups and geographic areas of the state. During 2016 public hearings, the Committee also received testimony on the both mental health needs and on mental health service delivery in our state.

First, there is a significant need for therapeutic care for young children and for therapeutic interventions for their families in the state. Some children are denied mental health treatment by managed care organizations and left untreated. Without comprehensive early therapeutic interventions, the children may spiral to further disruptive behaviors that cause more problems, and this early involvement of mental health professionals may prevent suicide attempts.

Some school-aged children with mental health issues are well-served by school-based behavioral health programs. School-based programs are evidence-based programs that provide effective mental health services to children in the State. However, some counselors in the school-based services programs currently serve three to five schools, which does not meet the recommended counselor-school ratio of 1 to 1. Thus, the services have not been delivered evenly and fully. While the steady expansion of these services is positive, school-based services alone are not sufficient treatment for children with serious mental illnesses.

Recommendations

All children have the right to happy and healthy lives and deserve access to effective care to prevent or treat any mental health problems that they may develop. However, in South Carolina there are a tremendous number of unmet mental health needs among children. These unmet mental health needs contribute to the severity of child suicide in South Carolina.

The Joint Citizens and Legislative Committee on Children recommends that child suicide prevention should become a priority for the state. Early and effective detection, education, and support should be provided for high-risk suicide groups (e.g., white male children), and public education should be conducted to promote the awareness that child suicide is 100% preventable.

The Committee on Children also supports the following recommendations from testimony in its 2016 annual public hearings:

1) Expand funding for mental health services for young children, and to continue to seek comprehensive and innovative solutions with funding attached to address mental health needs of young children.

2) Continue to implement school-based services programs throughout South Carolina to

[146] *Id.*

bring services to students, and to increase the number of school-based services counselors and the distribution of services to meet the mandated 1 to 1 counselor to school ratio.

3) Study the state's children's mental health system and develop a plan to create an effective community-based system, with adequate institutional care available if necessary.

4) Encourage school districts to implement policies and procedures written around suicide prevention, intervention, and postvention, including increased clinical training around suicide care and implementation of a Zero Suicide approach.[147]

Protecting Youth and Supporting Responsible Decision-Making

Older adolescence and emerging adulthood is a pivotal period of development and brain growth. Teenagers are inherently different from adults; behavioral science tells us that their brain functions respond very differently to perceived risk and threats, often resulting in faulty judgment. Under current South Carolina laws, typical adolescent misbehavior and poor judgment can often result in detention and other life-altering negative outcomes. These harmful policies are inconsistent with research and evidence-based practices and are incompatible with children's well-being. The Committee supports the elimination of detention, incarceration, and other life-long consequences for youth except for those who pose a significant risk to safety.

Disturbing Schools

Current Disturbing Schools Law

S.C. Code § 16-17-420 is otherwise known as the Disturbing Schools law. The statute makes it a crime to "interfere with or to disturb in any way or in any place the students or teachers of any school or college in this State, to loiter about such school or college premises or to act in an obnoxious manner thereon."[148] Disturbing schools was the 8th most common charge resulting in juvenile detention in South Carolina in 2015-2016, and the 2nd most common juvenile charge referred to the solicitor's office, accounting for 9% of all such referrals during that time period.[149]

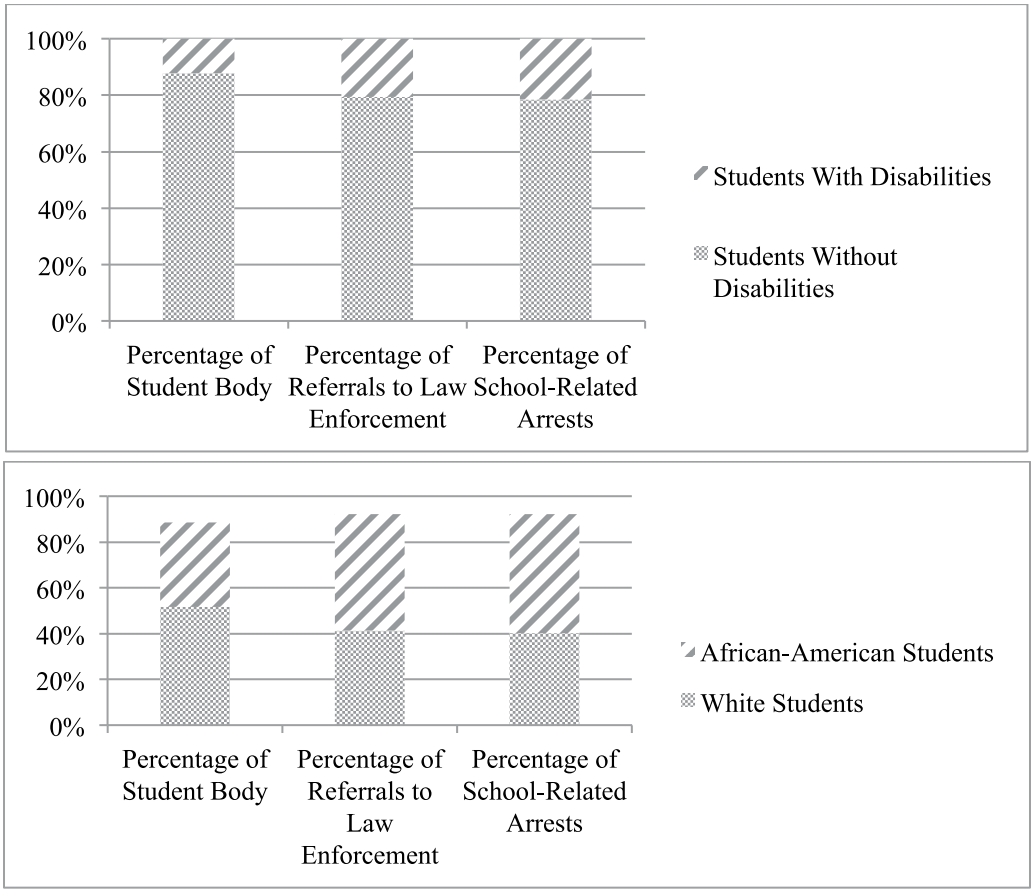
Problems with the Law

The South Carolina statute has been criticized nationally for its imprecision and application to enrolled students, with the former head of the Civil Rights Division of the United States Department of Justice noting, "the criminalization of everyday and ordinary childhood

[147] The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable, presenting both a bold goal and an aspirational challenge. Suicide Prevention Resource Center, *About Zero Suicide*, http://zerosuicide.sprc.org/about.
[148] S.C. Code Ann. §16-17-420(A)(1).
[149] South Carolina Department of Juvenile Justice, 2015-2016 Annual Statistical Report, http://www.state.sc.us/djj/pdfs/2015-16%20Annual%20Statistical%20Report%20Final.pdf (last visited Mar 13, 2017).

behavior under imprecise statutes can have disastrous and discriminatory consequences."[150] Richland County Sheriff Leon Lott further explained, "the ambiguity of the law has resulted in abuse and misuse that has resulted in criminal charges of students that are actually discipline and classroom management issues."[151] The law as written interferes with implementation of consistent student discipline practices in schools.

Arresting students for typical adolescent conduct "substantially reduces the odds that the student will graduate from high school, especially if that student appears in court, […]decreases the odds that a student will succeed academically and have future stable employment opportunities, […][and] increases the likelihood of that student's future involvement in the criminal justice system."[152] These arrests disproportionately affect minority students and students with disabilities, and we know that both of those groups of children are overrepresented in the population of youth in our state who are detained.



Department of Education Office of Civil Rights Survey Data, 2011-2012 (most recent)
South Carolina Department of Education 2015-2016 Active Student Headcount

[150] Department of Justice Office of Public Affairs, *Department of Justice Files Statement of Interest in South Carolina Statewide School-to-Prison Pipeline Case*, November 29, 2016, https://www.justice.gov/opa/pr/department-justice-files-statement-interest-south-carolina-statewide-school-prison-pipeline.
[151] Cynthia Roldán, *U.S. Justice Department Critical of SC's "Disturbing Schools" Law*, The State, December 1, 2016, http://www.thestate.com/news/local/crime/article118179603.html#storylink=cpy.
[152] Jason P. Nance, *Students, Police, and the School-to-Prison Pipeline*, 93 Washington University Law Review 919, 924 (2016).

According to the survey data from the United States Department of Education Office of Civil Rights, 2,182 students were arrested for school-related offenses in 2011-2012.[153] During that same period, the South Carolina Department of Juvenile Justice reports that 1,204 disturbing schools cases were referred to the solicitor's office. [154] Despite only being 37.1% of the South Carolina student population, African-American students received 51% of the referrals to law enforcement and 52% of the school-related arrests in South Carolina. Students with disabilities accounted for only 12.2% of the South Carolina student population but 20.6% of the referrals to law enforcements and 21.5% of the school-related arrests. These disproportionalities are not because certain groups are more prone to engage in disturbing or disruptive behavior, rather, they reflect disproportionalities in policing and discipline.[155]

Recommendations

The Committee supports reforming South Carolina's Disturbing Schools law as described in **S 131** and **H 3794** to keep schools safe without criminalizing typical adolescent conduct:

1) Amend the law to exclude currently enrolled students. The Disturbing Schools law was initially codified to protect students from outside agitators. Its scope has increased throughout its existence, and it now includes anyone on campus, including students. The Committee supports excluding students who are currently enrolled and allowed on campus from the application of disturbing schools. Students should be able to learn without disruption from outside agitators, but they should also be able to engage in typical adolescent behavior without fear of arrest.

2) Specifically list prohibited actions. The language in the current Disturbing Schools statute is vague with regards to what behaviors constitute "disturbing schools." This allows for a wide array of interpretations by teachers, law enforcement officers, and solicitors. In order for more predictability and consistency, the Committee supports specifically listing actions that are prohibited by the statute.

[153] United States Department of Education Office of Civil Rights, 2011-2012 Discipline Estimations by State, http://ocrdata.ed.gov/downloads/projections/2011-12/states/South%20Carolina.xlsx.
[154] South Carolina Department of Juvenile Justice, 2011-2012 Annual Statistical Report (2012), http://www.state.sc.us/djj/pdfs/2011-12%20Annual%20Statistical%20Report.pdf (last visited Mar 2, 2017).
[155] *See* Sarah E. Redfield & Jason P. Nance, *American Bar Association: Joint Task Force on Reversing the School-to-Prison Pipeline*, 47 University of Memphis Law Review 1, 9 (2016): "These negative disproportionalities might be understood if removals from school were in fact making schools safer or if confinement in juvenile detention or other facilities led to improved outcomes. This does not appear to be the case in practice or in theory. Nor can the disproportionate treatment of certain students and their overrepresentation in the negatives of our education and juvenile justice systems be explained away because certain groups are more likely to be engaged in bad or delinquent behavior."

Reforming Accountability for Juvenile Sex Offenders

Current Registry Requirements

Currently, juveniles are required to register as sex offenders under S.C. Code § 23-3-430 and have the same lifetime registration requirements as adults, even if they are not tried as adults. South Carolina law provides no minimum age for registration and does not require violence or threat of force as part of the offense causing registration. A child of any age may be placed on the sex offender registry where he or she will remain for life.

South Carolina law requires all persons convicted of sex offenses to be on the sex offender registry for the rest of their lives, regardless of their age, severity of offense, or likelihood to reoffend. This requirement does not differentiate between children and adults. While juvenile criminal records are private, the sex offender registry is public for most offenses. A 12-year-old child adjudicated for peeping could have the same lifetime sex offender registration requirements and associated stigma as a 30-year-old who commits a violent rape.[156] There are currently 250 people on South Carolina's sex offender registry who were juveniles when they were placed on the registry.[157] For the rest of their lives, registrants must provide their home, work, and school addresses; a current photograph; and other personal information to their local sheriff.[158] Sheriffs must notify schools and childcare facilities of registered offenders who live within one-half mile of the school or childcare facility.[159]

Offenses for which a child is currently required to be placed on the sex offender registry include:

- peeping[160]
- voluntary sexual contact between a 14 year-old and a 13 year-old [161]
- sexting (for example, a 17-year-old girl who sends her boyfriend a nude picture of herself, which under the law is child pornography,[162] can be required to register for life.[163] If her boyfriend either saves or forwards the picture,[164] he could be placed on the sex offender registry for life.[165])
- indecent exposure (for example, a child who "moons" his friends on a school bus[166] could be placed on the sex offender registry for life[167])

[156] S.C. Code Ann. § 23-3-430.
[157] Email from Belton Gardner, SLED Sex Offender Registry Coordinator, dated January 27, 2017.
[158] S.C. Code Ann. § 23-3-460.
[159] S.C. Code Ann. § 23-3-490(C).
[160] S.C. Code Ann. § 23-3-430(C)(12).
[161] S.C. Code Ann. § 23-3-430(C)(5).
[162] S.C. Code Ann. § 16-15-405.
[163] S.C. Code Ann. § 23-3-430(C)(13).
[164] S.C. Code Ann. § 16-15-410.
[165] S.C. Code Ann. § 23-3-430(C)(13).
[166] S.C. Code Ann. § 16-15-130.
[167] S.C. Code Ann. § 23-3-430(C)(13).

Distinguishing Juvenile and Adult Offenders

Juvenile offenders are different from adult offenders. Juvenile sex offenders rarely grow up to be adult rapists or pedophiles.[168] Child sexual behavior may sometimes be attributed to experimentation or to a lack of parental supervision, and juvenile sex offenders may not understand that their behavior is wrong. The part of the brain that functions to make decisions and control impulses is still developing during adolescence and does not reach full maturity until age 25.[169]

Brain plasticity is recognized and reflected by our juvenile justice system. Older, more violent offenders can be waived into adult court for trial and punishment,[170] but less serious offenders are kept in the family court system, which is designed to be rehabilitative.[171] This rehabilitation is particularly effective with sex offenses: during adolescent brain development, treatment and education are more likely to reduce the likelihood of the child later reoffending as an adult.[172] Juvenile brain development should be equally reflected in our sex offender registration process.

Registration Does Not Decrease Recidivism

Like their adult counterparts, juvenile sex offender registries were created to protect the public by helping law enforcement quickly identify potential suspects in the event of a sex crime and were premised on the concept that sex offenders have a high likelihood of reoffending.[173] However, research has shown that reconviction rates for juvenile sex offenders are actually much lower than other juvenile offenders: one study of juvenile sex offenders in South Carolina found the reconviction rate for another offense to be 3% after 9 years,[174] as compared to 15% after one year for juveniles adjudicated delinquent of non-sexual offenses.[175]

Further, research indicates that the threat of registration does not deter juveniles from engaging in sex offenses. One study of 14 to 17-year-old sex offenders in South Carolina found that the overall rate of sex offenses did not decrease subsequent to implementation of the sex

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[168] "Human Rights Watch, Raised on the Registry: The Irreparable Harm of Placing Children on Sex Offender Registries in the US (2013), https://www.hrw.org/sites/default/files/reports/us0513_ForUpload_1.pdf (last visited Mar 22, 2017).

[169] Jessie Breyer & Ken C. Winters, Adolescent Brain Development: Implications for Drug Use Prevention, http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.532.4720&rep=rep1&type=pdf.
"Advanced technologies in brain imaging have provided windows to the developing brain. Based on the pioneering work of Jay Giedd and colleagues at the National Institute of Mental Health in the United States, evidence is accumulating that the brain is not fully formed at puberty as earlier thought, but continues important maturation that is not complete until about age 24."

[170] S.C. Code Ann. § 63-19-1210.

[171] S.C. Code Ann. § 63-19-20(1).

[172] Justice Policy Institute, The Negative Impact of Registries on Youth: Why Are Youth Different From Adults?, http://www.justicepolicy.org/uploads/justicepolicy/documents/08-08_fac_sornakidsaredifferent_jj.pdf (last visited Mar 6, 2017).

[173] Human Rights Watch, Raised on the Registry: The Irreparable Harm of Placing Children on Sex Offender Registries in the US (2013), https://www.hrw.org/sites/default/files/reports/us0513_ForUpload_1.pdf (last visited Mar 22, 2017).

[174] E.J. Letourneau et al., *The Influence of Sex Offender Registration on Juvenile Sexual Recidivism*, 20 Criminal Justice Policy Review 136–153 (2009).

[175] South Carolina Department of Juvenile Justice, Report Card for 2014, http://www.state.sc.us/djj/pdfs/2014-report-card.pdf (last visited Mar 22, 2017).

offender registry law in 1995, nor did the rate of sex offenses decrease after the registry went online in 1999.[176]

Harms in Registration of Juvenile Sex Offenders

Mandatory registration means that children are not able to access the treatment they need. In cases with mandatory registration, for example, to avoid lifetime sex offender registration, the prosecutor may accept a plea to a lesser offense. In such a case, a juvenile who pleads to a lesser offense (such as assault and battery) may not be identified to receive appropriate treatment for his or her sexual offending behavior. An unintended consequence of the juvenile sex offender registry was a 40% reduction in the prosecution of juvenile sex crimes in South Carolina,[177] meaning that offenders are not getting the treatment that they need, and victims are not getting the justice that they deserve.

Sex offender registrants face a lifetime of stigma and collateral problems in addition to court-ordered punishment. Registered offenders have difficulty getting and keeping jobs,[178] locating a home in an approved area, and they experience depression and suicidal ideology more frequently due to the shame of being registered.[179] Registrants are harassed, physically assaulted, and even killed as a result of publication on the sex offender registry.[180]

Placing a child on the sex offender registry also adversely impacts his or her family. Restrictions severely limit where the juvenile and his or her family are allowed to live by prohibiting registrants from living within 1000 feet of a school, park, or playground.[181] Registered juveniles are prohibited from living in federally assisted housing,[182] forcing families to choose whether to forego federal housing assistance or to break up the family by requiring the juvenile registrant to live apart from the family.

Recommendations

The Committee on Children supports holding juvenile offenders appropriately accountable for their actions while preparing them for successful reentry into society, and makes the following recommendations, as described in **S 560** and **H 3948**:

Family court judges should have the discretion whether to require a juvenile aged 14 or older adjudicated delinquent for a sex offense in the family court to be placed on the sex offender registry, including the discretion to delay its decision until after court-ordered sentences, risk

[176] E.J. Letourneau et al., *Do Sex Offender Registration and Notification Requirements Deter Juvenile Sex Crimes?*, 37 Criminal Justice and Behavior 553–569 (2010).
[177] E.J. Letourneau, Affidavit of Elizabeth J. LeTourneau (2013), https://olis.leg.state.or.us/liz/201311/Downloads/CommitteeMeetingDocument/30208.
[178] J.S. Levenson & R. Tewskbury, *Collateral Damage: Family Members of Registered Sex Offenders*, 34 American Journal of Criminal Justice 54–68 (2009).
[179] Human Rights Watch, Raised on the Registry: The Irreparable Harm of Placing Children on Sex Offender Registries in the US (2013), https://www.hrw.org/sites/default/files/reports/us0513_ForUpload_1.pdf (last visited Mar 22, 2017).
[180] *Id*.
[181] S.C. Code Ann. § 23-3-535(B).
[182] 42 USC § 13663.

assessment, and treatment are completed. If the sentencing discretion of family court judges included whether to require sex offender registration on a case-by-case basis, prosecutors may be more willing to charge juvenile offenders with their actual offense, and judges would have the discretion to order more appropriate accountability and proper treatment and education about sex abuse and their behavior. Juveniles aged 13 and younger should not be subject to placement on the sex offender registry.

Second, upon reaching 21 years of age and completing any parole or probation requirements, a person previously adjudicated in the family court for a sex offense should be allowed to petition the family court for removal from the sex offender registry unless they pose a continuing risk to the community. If the court finds that the person has shown that they do not pose such a risk, their information should be removed from the registry. If the court finds that the person does pose a continuing risk, their information should remain on the registry.

Detention of Status Offenders

Current South Carolina Law

As discussed in our 2015 Annual report, under South Carolina law, a child charged with a status offense[183] may be locked up in a pre-trial detention center.[184] Pre-trial detention is limited to twenty four hours except for cases involving violation of a valid court order, where detention may be up to seventy two hours, excluding weekends and holidays.[185] If convicted of a status offense, a child may be committed to DJJ for a 45-day evaluation[186] and then may be committed to DJJ for up to 90 days.[187]

Of the 84 pre-trial detentions for status offenses from April 2013 to March 2014, the average length of pre-adjudicatory detention was 9 days.[188] Roughly half of these pre-trial detentions arose from a charge of running away from home. During the same year, there were 123 post-trial commitments to DJJ for conviction of status offenses of truancy, running away, or incorrigibility. Over half resulted from truancy cases where the student was a repeat truant in violation of a previous court order to attend school. Girls were incarcerated more often for status offenses than boys, and African-American girls were incarcerated disproportionately more often

[183] "'Status offense' means an offense which would not be a misdemeanor or felony if committed by an adult including, but not limited to, incorrigibility or beyond the control of parents, truancy, running away, playing or loitering in a billiard room, playing a pinball machine, or gaining admission to a theater by false identification." S.C. Code Ann. § 63-19-20(9).
[184] S.C. Code Ann. § 63-19-820.
[185] S.C. Code Ann. § 63-19-820(E).
[186] S.C. Code Ann. § 63-19-1440(C).
[187] S.C. Code Ann. § 63-19-1440(F).
[188] South Carolina Status Offense Task Force, Status Offense Cases in South Carolina: A Review and Recommendations, http://childlaw.sc.edu/frmPublications/SOTFReport2015.pdf.

than non-minority children.[189] Running away was the fourth most common reason for juvenile detention in South Carolina in 2016.[190]

The Harms of Incarcerating Status Offenders

Behaviors resulting in status offenses are often symptoms of underlying problems in a child's life, and those problems are not addressed by detention. For example, truant children report a wide range of reasons that contribute to their failure to attend school regularly, including problems with substance abuse, physical abuse, mental and physical illness, or poverty serious enough to impair a child's ability to attend school regularly.[191] Children who run away from home are often trying to escape family conflict or child abuse.[192] These children often struggle with mental health disorders, emotional distress, substance use, or physical and sexual abuse.[193] Parents who bring incorrigible petitions against their children sometimes lack appropriate parenting skills, which may be contributing to the volatile parent-child relationship. In some cases, an incorrigible child may be resisting the control of an abusive, intoxicated, or mentally ill parent.

Incarceration does not solve a child's emotional and family problems,[194] nor does it deter future status offending or criminal behavior.[195] In fact, "recidivism studies routinely show that 50 to 80 percent of youth released from juvenile correctional facilities are rearrested within 2 to 3 years—even those who were not serious offenders prior to their commitment."[196] This is especially true among less-serious youthful offenders, such as status offenders, for whom incarceration actually increases recidivism rates.[197] Incarceration worsens a juvenile's chances at successful transition to adulthood by subjecting him or her to institutional abuse,[198] worsening

[189] University of South Carolina Children's Law Center, Status Offense Project: South Carolina Statistics, 1. South Carolina Status Offense Task Force, Status Offense Cases in South Carolina: A Review and Recommendations, http://childlaw.sc.edu/frmPublications/SOTFReport2015.pdf.
[190] South Carolina Department of Juvenile Justice, 2015-2016 Annual Statistical Report, http://www.state.sc.us/djj/pdfs/2015-16%20Annual%20Statistical%20Report%20Final.pdf (last visited Mar 13, 2017).
[191] National Center for School Engagement, Reducing Truancy, http://schoolengagement.org/school-engagement-services/reducing-truancy. *See also* Strategies for Youth: Connecting Cops & Kids, How To...Understand Truancy, http://strategiesforyouth.org/for-police/how-to/how-to-truancy/. "Truant children may stay home from school to assist with family health problems, sibling care, or financial problems."
[192] Sydney McKinney, Runaway Youth: A Research Brief (2014), http://www.statusoffensereform.org/wp-content/uploads/2014/05/Running-Away_Final.pdf.
[193] *Id*.
[194] *See* Patricia J. Arthur & Regina Waugh, *Status Offenses and the Juvenile Justice and Delinquency Prevention Act: The Exception that Swallowed the Rule*, 7 Seattle Journal of Social Justice 555, 557–558 (2009): "Punitive programs that remove youth from their homes and their communities make it harder to address the problems that led to the out of-home placement in the first place."
[195] Annie E. Casey Foundation, A Road Map for Juvenile Justice Reform, http://www.campaignforyouthjustice.org/documents/AECNR_RoadMap.pdf.
[196] *Id*.
[197] Richard A. Mendel, No Place For Kids: The Case for Reducing Juvenile Incarceration (2011), http://www.aecf.org/m/resourcedoc/aecf-NoPlaceForKidsFullReport-2011.pdf.
[198] Richard A. Mendel, Maltreatment of Youth in U.S. Juvenile Corrections Facilities: An Update (2015), http://www.aecf.org/m/resourcedoc/aecf-maltreatmentyouthuscorrections-2015.pdf.

his or her educational[199] and employment[200] outcomes, and negatively impacting his or her mental health.[201]

Alternatives to Incarcerating Status Offenders

Programs in South Carolina and other states have successfully reduced the number of status offenders prosecuted and incarcerated by connecting children to appropriate services and providers that address family and mental health issues. Such programs achieve the desired outcomes of keeping children at home with their families, attending school, and reducing future offenses.

For example, the Waccamaw Center for Mental Health and the Horry County Department of Juvenile Justice, in cooperation with local law enforcement and the family court, provide crisis de-escalation services to juveniles and their families and connect them with community resources. The resulting incarcerations for status offenses and misdemeanors in Horry County following commencement of this program decreased by 72% from October 2010 to September 2012.[202]

The Solicitor's Office in York County, in cooperation with local school districts and the local DJJ office, provides a pre-trial diversion program for truant children. This program has proven to be an effective response to truancy cases. In the first year of the program, 69% of children referred to the solicitor for truancy began attending school again and there was no further involvement in the family court.[203]

The Clayton County Family Court in Georgia refers status offenders to a team of child-serving professionals that works with the family, evaluates each child, and develops a treatment plan tailored to meet the child's needs. The family court will not accept a status offense case for a hearing unless the child has first been referred to this program. After eight years, Clayton County has seen a 73% reduction in the number of children referred to juvenile court by schools, and its high school graduation rate has risen by 24%.[204]

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[199] *See, e.g.,* Randi Hjalmarsson, Criminal Justice Involvement and High School Completion, 63 Journal of Urban Economics 613, 619 (2008): "Being arrested at least once when 16 or younger decreases the likelihood of graduating by age 19 by 27 percent. Similarly, individuals who are incarcerated at least once when 16 or younger are 23 percent less likely to graduate by age 19, over and above the effects of arrest, charge, and conviction."

[200] Mendel, *supra* note 197, at 12. These impacts are long-lasting: "Even 15 years after release, those who had been incarcerated in their youth worked 10 percent fewer hours per year than similar individuals who had not been incarcerated."

[201] *Id* at 22: "Three of every 10 youth confined in correctional facilities had, on at least one occasion, attempted suicide. Seventy percent said that they had personally 'seen someone severely injured or killed,' and 72 percent said that they had 'had something very bad or terrible happen to you.'"

[202] Presentation: "Direction: a successful community based program addressing alternatives to juvenile justice detention," DMH/DJJ Horry County Detention Initiative, Advancing School Mental Health Conference. October 4, 2013. For more information, please contact Waccamaw Center for Mental Health, Conway, SC, Lori Chappelle, Director of Children's Services, and Eryn Bergeron, Children's Services Supervisor.

[203] Whitney Payne, York County Solicitor's Office, e-mail message, January 9, 2015.

[204] Status Offense Reform Center, Clayton County, Georgia (2014), http://www.modelsforchange.net/publications/677/Notes_from_the_Field_Clayton_County_GA.pdf.

Recommendations

The Committee on Children continues to support limiting the detention and incarceration of juveniles for status offenses and considering all possible alternatives before prosecuting status offenses. Accordingly, the Committee recommends the following reforms, as delineated in **S 580** and **H 3946**:

1) The Children's Code should be amended to reflect federal law, which prohibits the detention of status offenders unless they are in violation of a valid court order.

2) The Children's Code should require consideration of all possible alternatives before a status offense may be prosecuted in the family court.

3) State agencies should cooperate to develop a network of statewide placement services to be available to status offenders and their families including alternatives to incarceration, community-based evaluation services, runaway shelters, respite care homes, short-term alternative placements, and 24-hour crisis interventions.

4) A status offender should not be committed to a secure DJJ evaluation center for a 45-day evaluation. If an evaluation is needed, a status offender should remain in their home or community-based placement and receive the evaluation.

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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 deal with children's issues on a daily basis.

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