

STATE OF SOUTH CAROLINA



JOINT CITIZENS AND LEGISLATIVE COMMITTEE ON CHILDREN

ANNUAL REPORT
FEBRUARY 1, 2012

JOINT CITIZENS AND LEGISLATIVE COMMITTEE ON CHILDREN

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STATE OF SOUTH CAROLINA
JOINT CITIZENS AND LEGISLATIVE COMMITTEE ON CHILDREN

February 1, 2012

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As Chair and Vice-Chair of the Joint Citizens and Legislative Committee on Children, we are pleased to present the 2012 Annual Report of the Committee. The Committee offers a forum for citizens, legislators, and agency directors to identify and study the needs of children and to promote sound strategies for the development of children's policy.

In this Annual Report, the Committee offers a logic model to promote healthy child development, indicators of how well children are faring, and resource mapping to show our expenditures to serve children. This Annual Report provides sound data and informed guidance to identify the issues facing children and to address those issues.

The 2012 legislative session offers challenges to balance the needs of children with the realities of diminished resources. Clearly, it is desirable and more cost-effective to prevent or to resolve a problem early on, than to wait until the only option is a more costly treatment. Accordingly, the Committee has adopted four initiatives:

- **Safe sleeping practices for infants** to prevent infant fatalities
- **Immunizations** to prevent illness and avoid long term health care costs
- **"Trauma-informed practices"** within state child-serving agencies to mitigate trauma that will adversely affect healthy child development
- **Obesity** to promote healthy lifestyles and prevent chronic illness

On behalf of the Joint Citizens and Legislative Committee on Children, thank you for your consideration of this important Annual Report. To obtain copies of the full report and supplemental data workbook, please visit the Committee's website at www.sccommitteeonchildren.org.

Michael L. Fair
Chair

Joan B. Brady
Vice-Chair

2012 Annual Report of the Joint Citizens and Legislative Committee on Children Executive Summary

This 2012 Annual Report of the Committee on Children is intended to create awareness of the status of children in South Carolina, to stimulate informed discussion of children's issues, and to encourage sound public policy that promotes child well-being. To guide policy, the Committee on Children adopted three conceptual frameworks which identify the causal factors that influence child development, indicate how well children are faring, and report the allocation of state resources to provide public services for children. These three frameworks are:

- A **logic model** presenting a visual overview of child development outcomes, determinants, and services;
- **Indicators of “child well-being”** showing how children are faring; and,
- **Resource mapping** showing how state funds are allocated for services.

These three frameworks provide essential perspectives for devising prudent strategies to achieve substantial improvements in child well-being:

- Sound public policy that promotes healthy child well-being must address the child holistically, and it must consider the many diverse factors which influence how well a child develops emotionally and physically.
- The impacts of childhood trauma are pervasive. Undiagnosed child trauma affects physical health, academic achievement, teen pregnancy, and juvenile crime¹ and can have a profoundly negative effect on adulthood. Ultimately, these factors can contribute to long-term dependence on costly state services. Focused consideration on the identification and treatment of childhood trauma in state systems for education, child protection, health, courts, and juvenile justice should promote more positive outcomes and help direct resources toward early treatment rather than later, more intensive interventions.
- The state often delays action when a child's problem is in an initial stage. Thus, by failing to intervene early in the problem, the state ends up funding a more intensive and expensive intervention. Proven preventive interventions are generally less costly and more effective.
- State expenditures for the early childhood age group are only slightly higher than expenditures for middle childhood and adolescence age groups, despite research touting the benefits of early intervention.
- The indicators of child well-being and resource mapping in this report inform us that South Carolina expends some funds to mitigate the poor status quo of children which could be more wisely spent on preventive care and early intervention services.

¹ South Carolina Joint Citizens and Legislative Committee on Children, Summary of Testimony: 2011 Public Hearings. <http://www.sccommitteeonchildren.org/doc/PublicHearingFinalReport.pdf>. (last visited, February 22, 2012).

Recommendations of the Committee on Children

To impact identified needs and to encourage an emphasis to more effective, less costly preventive services, the Committee on Children recommends an initial focus of state efforts and resources to respond to specific topical areas. Based upon the three frameworks presented in this report, the Committee recommends immediate action in the following four focus areas.

Safe Sleeping for Infants

When an adult shares a bed with an infant, there is a risk of suffocation if during sleep, the adult rolls over on top of the baby. Good work is currently being done to educate and create public awareness of the risk of unsafe sleeping practices. These efforts have the potential to prevent infant deaths, and this work needs to be expanded. **The Committee on Children recommends that a comprehensive state and community-based initiative be undertaken to coordinate and mobilize the resources of state and private resources to prevent infants from dying from unsafe sleeping practices.**

Immunization

Children on Medicaid and those with comprehensive health insurance coverage receive immunizations; however, many children living just above poverty and in middle income families do not have adequate insurance that pays for recommended immunizations. Such non-immunized children are exposed to costly long term illnesses and place other children and adults at risk of contracting their illnesses. **The Committee on Children recommends that a comprehensive initiative be undertaken to secure the immunization of all children and prevent unnecessary childhood illness.**

“Trauma Informed” Practices

When a child experiences trauma in childhood that is not resolved, the long range effects of the trauma will hinder the child’s healthy development. The effects of childhood trauma caused by abuse, neglect, or family violence are often misdiagnosed as acting out or behavior issues. As a result of experiencing trauma, younger children may be irritable, aggressive, or distracted,² and older children may engage in self-destructive or reckless behaviors.³ When child trauma is properly diagnosed, a child can receive appropriate treatment for the underlying issue and avoid spiraling downward into an aftermath of preventable problems. Adoption of “trauma informed” practices by schools, child protection and treatment systems, courts, and juvenile justice will lead to more positive outcomes and save the state the cost of unnecessary and more intensive interventions. **The Committee on Children recommends that a comprehensive initiative be undertaken to promote “trauma informed” practices for state services which properly diagnose and treat childhood trauma as positive steps toward healthy child development.**

Childhood Obesity

Childhood obesity is reaching epidemic levels exposing many children to numerous and costly life-long effects. Improved nutrition and increased exercise among children will decrease the numbers of obese and overweight youth. Failure to address this problem will result in unnecessary and significant long term costs to the state for public support and health care as these children become adults. **The Committee on Children recommends that a comprehensive state and community-based initiative be undertaken to improve nutrition and to involve children in physical activities which promote healthy lifestyles.**

² National Child Traumatic Stress Network, The Effects of Trauma on Schools and Learning, <http://www.nctsn.org/resources/audiences/school-personnel/effects-of-trauma#q2> (last visited January 19, 2012).

³ Id.

2012 Annual Report of the Joint Citizens and Legislative Committee on Children

Introduction

This 2012 Annual Report of Joint Citizens and Legislative Committee on Children is intended to create awareness of the status of children in South Carolina, to stimulate informed discussion of children's issues, and to encourage sound public policy that promotes child well-being. The Committee on Children seeks resourceful, innovative ways to inform and engage all South Carolinians to encourage and support the well-being of children for a brighter future and a better State. The Committee on Children looks to draw upon research and data to guide policy and program development and to coordinate state services for children into a more seamless system of care.

A significant amount of data, research, and analysis is presented in this report. There are many opportunities for individuals to focus on specific areas of interest. Given the complexities of children's issues, it is also possible to get lost in the many details. **The revelation demonstrated by this report is that the state frequently reacts to children's needs far too late in life, far too beyond when the need arose, and with too few coordinated state and local resources.**

Because the Committee on Children is charged by statute to report to the Governor and General Assembly, the essence of this report is its focus specifically on services provided by public child-serving agencies. Most of the data in this report comes from the public agencies that serve children. The Committee on Children recognizes that families, communities, and private (non-state) professionals and organizations provide significant resources that improve the lives of children. However, data and resources spent for those private, non-state services are not easily obtained and are the focus of this report. Also, the data in this report does not measure the extent of children's needs in South Carolina; the report measures only those services actually rendered by state agencies.

The Committee on Children recognizes the myriad of non-governmental factors that impact a child's life and maturity into adulthood encourages public and private entities to think collectively and act cooperatively to pursue well-being of children in an intentional, systematic way.

To organize influences on children and analyze policy intervention, the Committee on Children adopted three conceptual frameworks. These three frameworks inform us what causal factors influence children into adulthood, how children are faring, and how public services are responding to their needs with the allocation of state resources. These three frameworks are:

- A **logic model** presenting a visual overview of child development outcomes, determinants, and services;
- **Indicators of "child well-being"** showing how children are faring; and,
- **Resource mapping** showing how state funds are allocated for services.

The **logic model** is a visual representation that depicts the causal factors, services, and outcomes in terms of child well-being. The logic model shows the relationship between the causal factors which influence child development into adulthood, the services offered by the state, and the desired outcomes. Thus, the logic model helps identify appropriate policies to guide decision making to enhance child well-being.

Indicators of child well-being are data which illustrate how children are faring in South Carolina. Data in this report primarily comes from **public** agencies. Indicators were chosen to identify child well-being at stages of child development divided into in five categories of interest. These five categories of interest represent the intent for children to be **safe, healthy, educated, responsible, and supported**. The data reflect whether children are:

- 1) **safe** from harm, such as child fatalities, non-fatal injuries, and child abuse;
- 2) **healthy**, including physical and behavioral health;⁴
- 3) **educated** for life as a working adult, such as participation in pre-kindergarten programs, testing scores, and graduation rates;
- 4) **responsible**, with measurements such as development of children's life skills (living, learning, and working skills), youth employment, rates of juvenile crime, and births to teens; and
- 5) **supported** and nurtured including children in poverty, births to teens, therapeutic foster care, and court ordered child support.

Resource mapping presents the expenditures by state agencies that are called upon to provide services when a family is not otherwise able to meet the essential needs of a child. All agencies offer a spectrum of services with increasing levels of involvement. Those at the top of the chart require less intensive intervention than those at the bottom. Agencies reported their array of service expenditures in six categories:

Service		Children Served	Example
Services to All Children		All Children	Public education
Prevention	Universal	All Children	Drug abuse awareness programs
	Targeted	At Risk Group	Prevention of disparities in minority health outcomes
Intervention	Initial	Identified Child	In-home visits for parents of pre-schoolers
	Moderate	Identified Child	School-based mental health
	Intensive	Identified Child	Removal of a child and placement in foster care

When considered together, these three frameworks of a logic model, indicators of well-being, and resource mapping offer a common language to design public policy and services through a more seamless system of care for children. Collectively, these three frameworks demonstrate that early diagnosis, effective intervention, and coordinated resources can dramatically improve the well-being and future of children in South Carolina.

⁴ Behavioral health includes both mental health and substance abuse treatment services.

I. Logic Model of Child Development

A. Methodology

The logic model presented in this report was constructed from a variety of sources, including testimony from the Committee on Children's statewide public hearings in September 2011 and an extensive review of research on child development.

B. Presentation

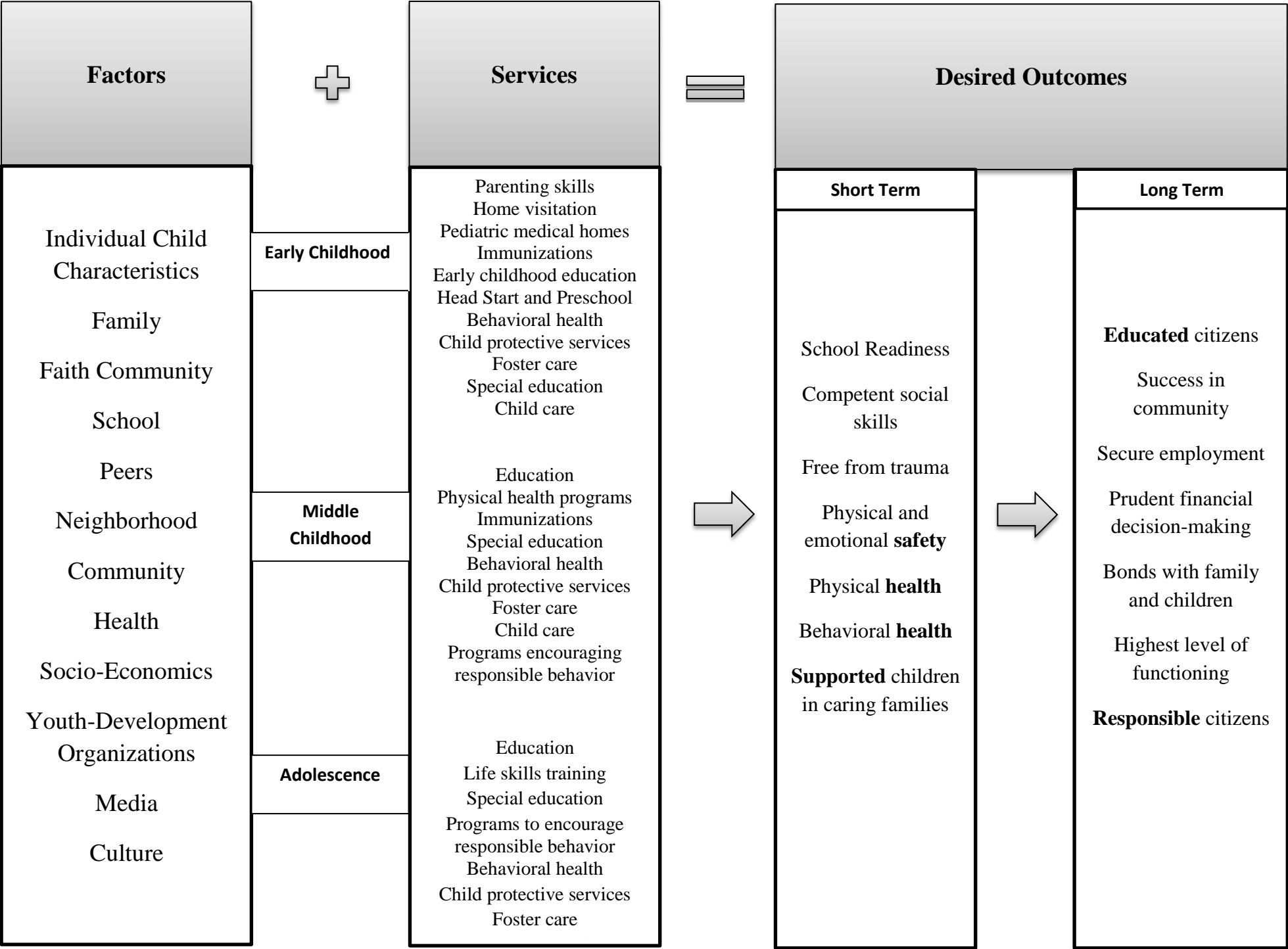
The logic model on the opposite page presents various causal factors that influence children as they mature into adulthood, children's services offered by state agencies, and desired short and long-term outcomes for healthy child development. Causal factors may be negative or positive influences and may commence even before birth. The factors that influence a child throughout life include:

- individual child characteristics
- family members
- faith community
- school
- peers
- neighborhood
- community
- health
- socio-economics
- youth-development organizations
- media
- culture

Child well-being requires favorable influence from these diverse and powerful arenas. Because these causal factors influence children in varying degrees at different ages, this logic model demonstrates three stages of child development: early childhood, middle childhood, and adolescence. Parents are clearly dominant in early childhood, while peers become a more powerful influence over adolescents.

When factors negatively influence children, well-designed services delivered effectively can mitigate those circumstances. The second column in the logic model represents services offered by child-serving agencies: State services are the focus of this report.

The third and fourth columns of the logic model represent short-term and long-term desired outcomes for children. Short-term outcomes include school readiness, competent social skills, physical and emotional **safety** from harm and trauma, good physical and behavioral **health**, and children and families **supported** to overcome challenges. Long-term outcomes are for children to become **responsible, educated** adults with appropriate life skills to maintain secure employment, be good citizens, make prudent financial decisions, and have healthy relationships with their families and neighbors.



I. Indicators of Child Well-being

A. Methodology

Indicators of child well-being were selected based on an extensive review of literature and discussion with child-serving agency leaders. The selected indicators reflect child well-being at all stages of child development in five areas of **safe, healthy, educated, responsible, and supported**. The data presented is for children under the age of eighteen for the past five fiscal years when available.

B. Presentation

Each indicator is defined and analyzed. If five consecutive years of statewide⁵ data were available, an arrow with the percentage of change from the first year to the fifth year is used to illustrate whether the number of children affected is increasing, decreasing, or unchanged. Changes greater than 5% from earliest to most recent year are indicated with an upward or downward arrow. A change between +4% and -4% is considered unchanged and is indicated with a horizontal arrow. If fewer than five years of historical data were available, interpretation of trends cannot be made with certainty.

Each section of child well-being data contains a summary table of indicators by heading. Certain indicators are analyzed in the body of the report. All other indicators are presented in the Data Workbook which may be accessed at <http://www.sccommitteeonchildren.org/>.

⁵ Information at the county level will be available in the future on the Committee on Children website, located at <http://www.sccommitteeonchildren.org/>.

C. Overview of Children in South Carolina

As noted, the data in this report pertains primarily to services to children provided by state agencies and the resources expended to pay for those services. To offer an overall perspective to numbers receiving services and to indicate levels of need without regard to the amount of services and resources that are available, the following statewide demographics are provided.

There are approximately 1,089,000 children living in South Carolina. Children represent 23% of the total state population.⁶ South Carolina data reflect that approximately:

- 511,000 children lived in some officially measured degree of poverty⁷
- 55% of school aged children received subsidized school meals⁸
- 94,000 students received special education services⁹
- 30,000 children were treated for behavioral health needs¹⁰
- 28,000 children were the subject of child abuse investigations¹¹
- 4,300 children lived in foster care on any given day¹²
- 18,000 cases of delinquency were referred to the family courts¹³
- 26% of children who enter 9th grade will not graduate¹⁴

⁶ U.S. Census Bureau, American Fact Finder, Age Groups and Sex in South Carolina: 2010, table generated January 13, 2012, http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_SF1_QTP1&prodType=table, 2010 census data are most recently available.

⁷ The National Center for Children in Poverty, South Carolina Children at 100% and 200% of the Federal Poverty Level. <http://nccp.org/topics/childpoverty.html> (last visited January 12, 2012).

⁸ S.C. Department of Education, Children Receiving Free and Reduced Lunch 2008-2011, generated December 2012 using e-rate data. <http://ed.sc.gov/data/erate/index.cfm> (last visited January 12, 2012), 2007 Children Receiving Free and Reduced Lunch, generated October 2011 using e-rate data. <http://ed.sc.gov/topics/researchandstats/reports/tech/erate/> (last visited October 2011).

⁹ S.C. Department of Education, unpublished report, Children Receiving Special Education Services, generated December 2012.

¹⁰ S.C. Department of Mental Health, Unpublished report generated December 2011, Mental Health Diagnoses in Children Served in Community Centers.

¹¹ S.C. Department of Social Services, CPS Referrals for Investigation.

<https://dss.sc.gov/content/library/statistics/cw/6CPSReferralsforInvestigation5-YrHistory.pdf> (last visited, January 20, 2012).

¹² S.C. Department of Social Services, unpublished report generated November 2011. Total Children in Foster Care on the Last Day of the SFY. In order to have consistent format, data from CAPSS on November 1, 2011, was used to compile the reports for SFY 06-07 through SFY 10-11.












¹³ S.C. Department of Juvenile Justice, 2010-2011 Annual Statistics Report. <http://www.state.sc.us/djj/pdfs/2010-11%20Annual%20Statistical%20Report.pdf> (last visited, January 20, 2012).

¹⁴ S.C. Department of Education, unpublished report, Four Year High School Graduation Rate generated December 2012.

D. Analysis of Indicators of Child Well-Being by Categories of Interest: Safe, Healthy, Educated, Responsible, and Supported

1. “Safe” Indicators of Child Well-Being

Keeping children safe from physical harm is essential to prevent traumatic experiences that can negatively impact a person’s childhood and adult life. Data in this report include information about child fatalities, child injuries, child abuse and neglect, and children in foster care. Data about children leaving foster care to live with a family, recurrence of abuse and neglect, and domestic violence is available in the Data Workbook which may be found at <http://www.sccommitteeonchildren.org/>.

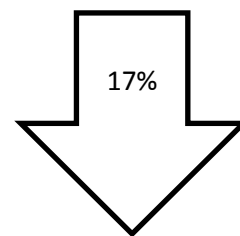
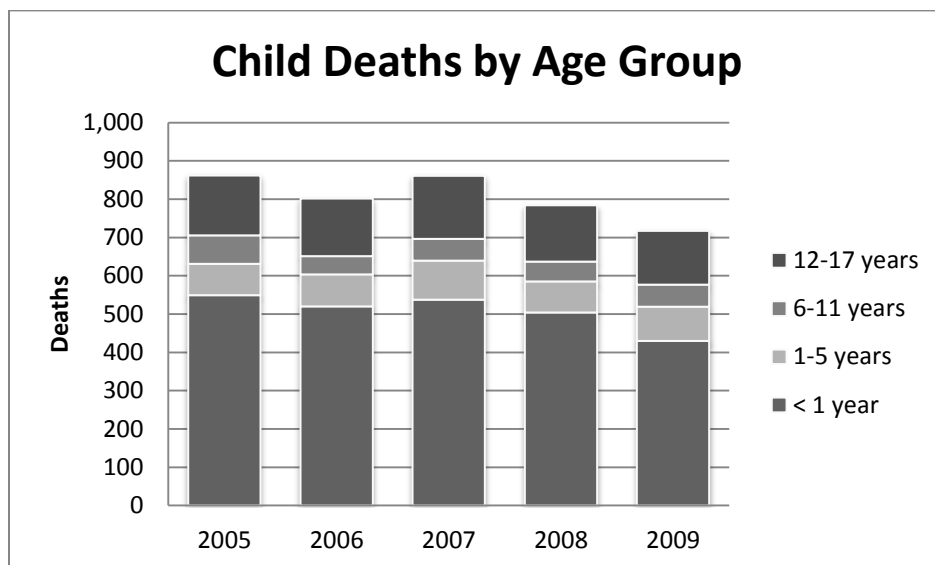
1. Index of Safety Indicators				
Indicator		Data from Earliest Year ¹⁵	Data from Latest Available Year	Percent Change from Earliest to Latest Available Year
1a. Total Child Deaths		862	717	-17% 
1b. Non-fatal Injuries		94,837	102,950	+9% 
1c. Children with Founded Maltreatment ¹⁶		12,358	11,802	n/a 
1d.Selected Founded Maltreatment Types ¹⁷	Physical Abuse	1,680	1,498	-11% 
	Neglect	8,127	5,381	-34% 
	Sexual Abuse	411	390	-5% 
1e. Total Children in Foster Care		5,150	3,797	-26% 
Rate of Children in Foster Care		5	3.5	n/a
1f. Children Leaving Foster Care to Live with a Family		3,067	3,356	+9% 
1g. Absence of Maltreatment Within 6 Months of Case Closure		5,051	5,569	10% 
Percent of Children Absent Maltreatment Within 6 Months of Case Closure		97.2%	96.8%	-.4% 
1h. Adult and Child Victims of Domestic Violence		52,001	52,023	+.04% 

¹⁵ Either four or five years of data is presented for each indicator. The earliest year of data collection is 2006 and the latest is 2011.

¹⁶ This indicator represents the number of children with founded maltreatment. “Maltreatment” includes abuse, neglect and other types of harm that children experience at the hands of a parent, guardian, or other person responsible for the child’s welfare. The Department of Social Services categorizes maltreatment into the following types of cases: abandonment, contributing to the delinquency of a minor, educational neglect, medical abuse, medical neglect, mental injury, neglect, other, physical abuse, sexual abuse, threat of harm abandonment, threat of harm contributing to the delinquency of a minor, threat of harm educational neglect, threat of harm medical neglect, threat of harm mental injury, threat of harm neglect, threat of harm physical abuse, threat of harm sexual abuse.

¹⁷ The number of physical abuse, physical neglect and sexual abuse maltreatments make up between 41% and 73% of all founded maltreatments for 2007-2011.

Child Deaths: Child fatalities are the number of children under the age of eighteen who died due to illness, accident, or maltreatment.¹⁸



Relevance: From 2005 to 2009, the total number of child fatalities decreased 17%. For all years, the infant death rate is higher than for children in middle childhood or adolescence. The most common causes of infant mortality for children under one include congenital deformities, disorders related to short gestation and low birth weight, and sudden infant death syndrome (SIDS).¹⁹ A decrease in infant mortality has the greatest potential to impact the overall number of child deaths. Programs designed to promote safe sleeping habits may further reduce the number of infant deaths. In 2009, 20 of these child fatalities occurred to children who were in custody of the state or in out-of-home treatment facilities.²⁰ This number includes child deaths that occur due to illness, maltreatment, homicide or suicide.

For children over age one, the most common causes of death are motor vehicle accidents, accidental drowning, exposure to fire or smoke, poisoning, and discharge of firearms. Motor vehicle accidents and discharge of firearms are particularly more prevalent in accidental deaths for older teens. Nationally, more than one-third of all teen deaths are the result of motor vehicle crashes.²¹ Interventions in the area of motor vehicle safety such as legislation to reduce distracted driving caused by texting are a means to reduce the number of teen deaths.

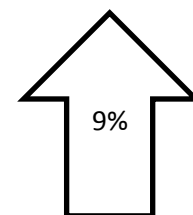
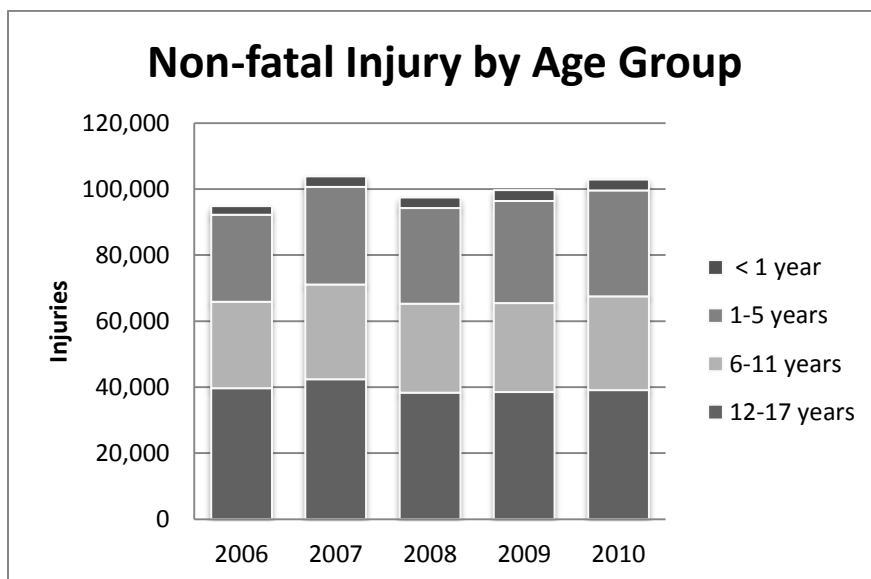
¹⁸ S.C. Department of Health and Environmental Control, unpublished report generated December 2011, Child Fatalities by Age Group.

¹⁹ S. C. Department of Health and Environmental Control, At a Glance: S.C. 2009 Infant Mortality Statistics, August 2011.

²⁰ Number compiled using data from published sources and all state agencies with residential facilities for children. U.S. Department of Health and Human Services Administration for Children and Families Administration on Children Youth and Families Children's Bureau, Child Maltreatment 2010. <http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf> (last visited, February 22, 2012).

²¹ Child Trends Data Bank, <http://www.childtrendsdatabank.org/?q=node/176> (last visited January 12, 2012).

Non-Fatal Child Injuries: Non-fatal injuries include accidental and intentional injuries that do not result in death.²² These injuries vary in severity and cause.



Relevance: From 2006 to 2010, the total number of injuries to children increased by 9%. Adolescents ages 12 through 17 are most likely to suffer injuries. A contributing factor to this phenomenon may be risk-seeking behavior by adolescents. Research demonstrates that in early adolescence, the frontal lobe of the brain that controls decision making skills such as attention, regulation of emotion, organization, and long-range planning is not fully developed.²³ For females this area of the brain matures around age 20 to 21, and for males it matures around age 23 to 25.²⁴ Underdeveloped decision-making skills place teens at a higher risk for injuries. Motor vehicle accidents are the leading cause of unintentional injury for children in South Carolina.²⁵

In 2011, the Committee on Children endorsed the adoption of Chandler’s Law, which established all-terrain vehicle (ATV) safety standards for children. Since the legislation became law on July 1, 2011, the Committee on Children continues to monitor the law’s effect on child injuries and deaths.

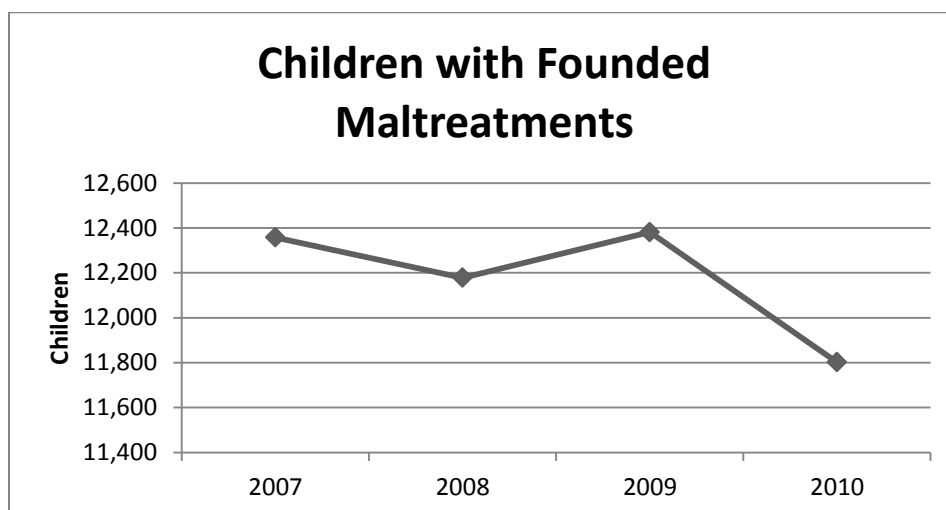
²² S.C. Department of Health and Environmental Control, unpublished report generated December 2011, Child Injuries by Age Group.

²³ Science Daily, “Risk-taking: Teenage Brains Really Art Different From Child or Adult Brains,” March 28, 2008, <http://www.sciencedaily.com/releases/2008/03/080328112127.htm> (last visited January 12, 2012).

²⁴ Morque, Georgetta, The Rye Record, “It Takes Brains: Michael Nerney on Adolescent Behavior,” <http://www.ryerecord.com/Rye%20Record%20Website%2012.14.07/html%20pages/schoolsheardinrye.htm> (last visited January 12, 2012).

²⁵ S.C. Department of Health and Environmental Control, Preventing Injuries, <https://www.scdhec.gov/health/mch/childcare/injuries.htm> (last visited January 11, 2012).

Children with Founded Maltreatment²⁶: When a report of child abuse or neglect is made to the Department of Social Services (DSS), an investigation determines whether the allegation is founded.²⁷ “Maltreatment” includes abuse, neglect, or other categories and refers to the unduplicated number of children.²⁸



Relevance: Founded maltreatment has remained consistent since 2007 in number of cases and the age of child. Younger children and those with special needs are more likely to be victims of abuse and neglect. From 2007 to 2010, there has been a -4% decrease in the number of children with founded maltreatments, which is a negligible change.

The effects of the trauma caused by child abuse and neglect have a significant impact on the demand for services by other agencies and non-profits. Testimony during the Committee’s public hearings cited the effect of undiagnosed trauma on physical health, academic achievement, teen pregnancy, and juvenile crime.²⁹ Younger children may be irritable, aggressive, or distracted,³⁰ and older children may engage in self-destructive or reckless behaviors.³¹

Child serving agencies often deal with the aftermath of early childhood traumatic events that occurred in unhealthy and violent family environments. When child trauma is properly diagnosed, children can receive treatment for the underlying issue. Trauma-informed practices for schools, courts, and juvenile justice will lead to more positive outcomes and save the state the cost of unneeded intensive interventions.

²⁶“Maltreatment” includes abuse, neglect and other types of harm that children experience at the hands of a parent, guardian, or other person responsible for the child’s welfare. The Department of Social Services categorizes maltreatment into the following types of cases: abandonment, contributing to the delinquency of a minor, educational neglect, medical neglect, mental injury, neglect, other, physical abuse, sexual abuse, threat of harm abandonment, threat of harm contributing to the delinquency of a minor, threat of harm educational neglect, threat of harm medical neglect, threat of harm mental injury, threat of harm physical abuse, threat of harm sexual abuse.

²⁷ S.C. Department of Social Services, unpublished report: Children in Founded CPS Investigations During SFYs based on determination date. Generated December 2011. In order to have consistent format, data from CAPSS on November 2011 was used to compile reports for SFY 2007 through 2011.

²⁸ CSFR 2005-2010.

²⁹ <http://www.sccommitteeonchildren.org/doc/PublicHearingFinalReport.pdf>.

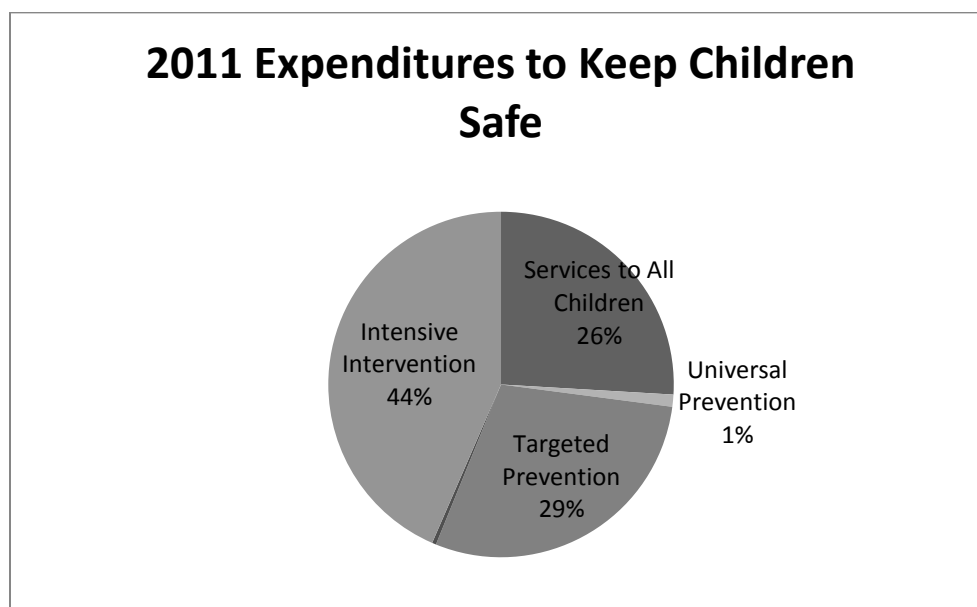
³⁰ National Child Traumatic Stress Network, The Effects of Trauma on Schools and Learning, <http://www.nctsn.org/resources/audiences/school-personnel/effects-of-trauma#q2> (last visited January 19, 2012).

³¹ Id.

Resource Mapping: For fiscal year 2011, the state’s larger child-serving agencies collectively spent approximately \$348 million dollars to promote safety outcomes for children in South Carolina. Most child-serving agencies reported at least one program dedicated to children’s safety.








The majority, or approximately 44%, of federal, state, and other funds to promote safety were spent on **intensive intervention** services such as foster care and child protective services. **Services to all children** comprised 26% of all expenditures to keep children safe and included services such as support for public education facilities. **Targeted prevention** programs for children at risk of being unsafe comprised 29% of 2011 expenditures. **Universal prevention** of harm such as disability prevention programs were relatively small expenditures and comprised 1% of expenditures to keep children safe.

No funds were reportedly spent on **initial intervention** programs designed to keep children safe. Data suggest that if targeted prevention is not effective, child safety requires intensive intervention.



2. “Healthy” Indicators of Child Well-Being

Healthy children generally have good eating and exercise habits, live free from chronic conditions such as diabetes, cancer, and heart disease, and miss fewer days from school. Early and effective health interventions avoid expensive medical costs when children reach adulthood. Data in this report include information on low and very low birth weight babies, mental health diagnoses, mental health treatment, and overweight and obese youth. Data about low and very low birth weight babies born to mothers on Medicaid, children’s access to primary care, and drug and alcohol inpatient treatment is available in the Data Workbook which may be found at <http://www.sccommitteeonchildren.org/>.

2. Index of Health Indicators				
Indicator		Data from Earliest Available Year ^{32 33}	Data from Latest Available Year ³⁴	Percent Change from Earliest to Latest Available Year
Low Birth Weight Babies		5,895	6,057	+3% 
Very Low Birth Weight Babies		1,195	1,111	-7% 
Low Birth Weight Babies Born to Mothers on Medicaid		2,896	2,614	n/a
Very Low Birth Weight Babies Born to Mothers on Medicaid		579	615	n/a
Immunizations		82%	73%	n/a
Children on Medicaid with Access to Primary Care Practitioners ³⁵	1-2 years	96.1	97.6	n/a
	2-6 years	80.4	86	n/a
	7-11 years	78.7	87.6	n/a
	12-17 years	74.7	84.7	n/a
Children with a Mental Health Diagnosis in Community Treatment Centers		34,102	30,614	-10% 
Children Receiving Mental Health Treatment by Delivery Location	School Setting	13,310	11,518	-13% 
	Community Treatment Center (includes school setting)	34,102	30,614	-10% 
	Inpatient and Residential	533	506	-5% 
Treatment for Drug and Alcohol Abuse		3,040	2,693	-11% 
High School Children who are ³⁶	Overweight	14%	16%	n/a
	Obese	13%	13%	n/a

³² Either four or five years of data is presented for each indicator. The earliest year of data collection is 2005 and the latest is 2011.

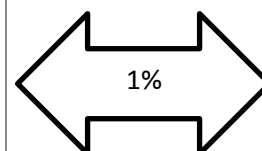
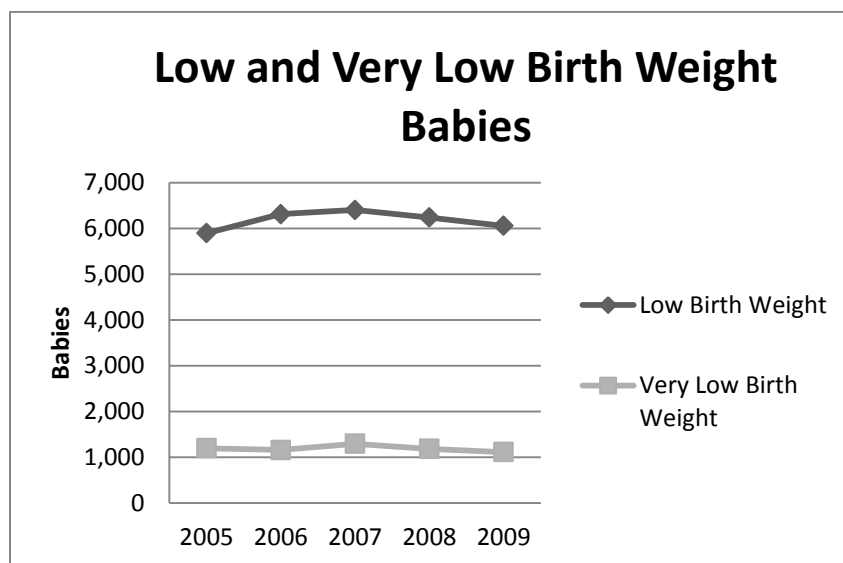
³³ In some cases percent of children in a specific population is more informative and is used instead.

³⁴ In some cases percent of children in a specific population is more informative and is used instead.

³⁵ This indicator is measured in state weighted rate. The state weighted rate refers to the rate of the South Carolina Medicaid population enrolled in the health care plan. This provides more detailed information about the impact of the measure on our state. This is different from a percentage which is always represented as a proportion of 100.

³⁶ Office of Health and Nutrition South Carolina Department of Education, 2011 Youth Risk Behavior Survey Results: High School Student Trend Analysis Report. (not available online as of January 25, 2012).

Low and Very Low Birth Weight Babies: Low birth weight is divided into two categories: low and very low birth weight. Low birth weight babies weigh between 1,500 grams (three pounds, four ounces) and 2,499 grams (five pounds, eight ounces) at birth. Very low birth weight babies weigh less than 1,500 grams (three pounds, four ounces) at birth.³⁷ Data was collected using DHEC interactive table SCANGIS. This indicator measures the low and very low birth weight babies born to all women in South Carolina hospitals.³⁸



Relevance: There has not been a significant change in the number of low and very low birth weight babies from 2005 through 2009. Low and very low birth weight babies comprise 10% of all births in South Carolina.³⁹ The challenges later in life for low and very low birth weight babies are significant. Research has shown that low birth weight babies are associated with higher rates of delayed motor and social development, and are more likely to have a learning disability, be enrolled in special education, have a lower IQ, and drop out of high school.⁴⁰ Maternal experiences associated with low and very low birth weight include smoking, maternal or fetal stress, infections, and violence.⁴¹

Mothers with chronic health conditions such as obesity, type-2 diabetes, and cardiovascular disease are also more likely to have low birth weight babies.⁴² Programs designed to improve women's long-term health prior to and during child bearing years can decrease the number of low birth weight infants. Studies have also linked depression during the

³⁷ Child Trends DataBank, <http://www.childtrendsdatabank.org/?q=node/67>, (last visited January 11, 2012).

³⁸ S. C. Department of Health and Environmental Control, <http://scangis.dhec.sc.gov/scan/CommunityProfile/input.aspx> (last visited, January 12, 2012).

³⁹ Holmes, Baron, South Carolina Kids Count, The Wrong Start: Adverse Birth Outcomes, July 2008.

⁴⁰ Child Trends DataBank, <http://www.childtrendsdatabank.org/?q=node/67>, (last visited January 12, 2012).

⁴¹ Id.

⁴² Kids Count Indicator Brief, Preventing Low Birthweight, The Annie E. Casey Foundation, July 2009.

<http://www.aecf.org/~media/Pubs/Initiatives/KIDS%20COUNT/K/KIDSCOUNTIndicatorBriefPreventingLowBirthWeig/PreventingLowBirthweight.pdf> (last visited January 12, 2012).

second trimester of pregnancy with slower fetal growth, also suggesting the need for mental health screening and treatment for pregnant women.⁴³

Given the greater risk that low birth weight babies have for long-term physical, academic, and emotional challenges later in life, intervention for mothers at risk of having low birth weight babies is crucial. An example of innovative and collaborative agency intervention is the recently announced Screening, Brief Intervention and Referral to Treatment (SBIRT) program. The SBIRT program is designed to improve the health of newborns for pregnant mothers on Medicaid.⁴⁴ Doctors will screen women to determine if a pregnant woman is using harmful substances, suffers from depression, or is the victim of domestic violence. Based on this screening, women will be referred to agencies such as the Department of Mental Health, the Department of Alcohol and Other Drug Abuse Services, or non-profits such as the S.C. Coalition Against Domestic Violence and Sexual Assault. The Department of Health and Human Services will provide an enhanced payment for doctors using SBIRT.⁴⁵ This program is a promising intervention to improve outcomes for low and very low birth weight babies.

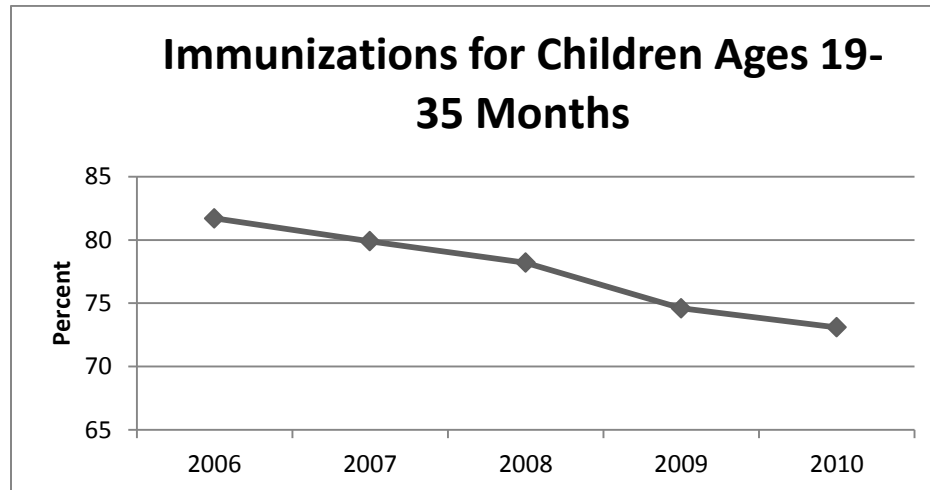
⁴³ Kids Count Indicator Brief, Preventing Low Birthweight, The Annie E. Casey Foundation, July 2009. <http://www.aecf.org/~media/Pubs/Initiatives/KIDS%20COUNT/K/KIDSCOUNTIndicatorBriefPreventingLowBirthWeig/PreventingLowBirthweight.pdf> (last visited January 12, 2012).

⁴⁴ The State, New State Program Aims to Improve Health of Moms, Babies, January 17, 2012.

<http://www.thestate.com/2012/01/17/2117569/new-state-program-aims-to-improve.html#storylink=misearch> (last visited January 19, 2012).

⁴⁵ Id.

Immunizations: The Center for Disease Control recommends children be vaccinated against serious illness around the age of two. An estimate of the children who have completed the combination of recommended vaccines between 19 and 35 months has been compiled using the National Immunization Survey.^{46 47}



Relevance: Since 2006, there has been a steady decrease in the immunization coverage of children ages 19 to 35 months in South Carolina. This decrease in immunizations results in the increase of vaccine preventable illness in children which may affect a child's long term health. Children who are not receiving the all recommended vaccination are at increased risk of contracting and spreading contagious, yet preventable diseases. At particular risk are children without a medical home and children who are underinsured.⁴⁸ Initial data do not show an increase in many vaccine preventable diseases since 2006. However, from 2007 to 2010, there was a 320% increase in the rate of pertussis, a potentially fatal disease for infants.⁴⁹

Promoting universal vaccination for children will help eliminate the lack of access to vaccinations that children who are underinsured often face.⁵⁰ Some children who can prove they meet the federal definition of underinsured can receive vaccinations through DHEC county offices. Often, it is difficult to receive vaccinations without confirmation that insurance will cover them, putting many children at risk of contracting and spreading preventable diseases.

⁴⁶ S.C. Department of Health and Environmental Control. Immunization Coverage for Children in South Carolina FY 2006-2010. Unpublished report generated January 2012.

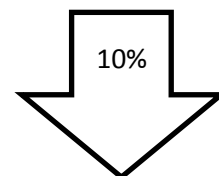
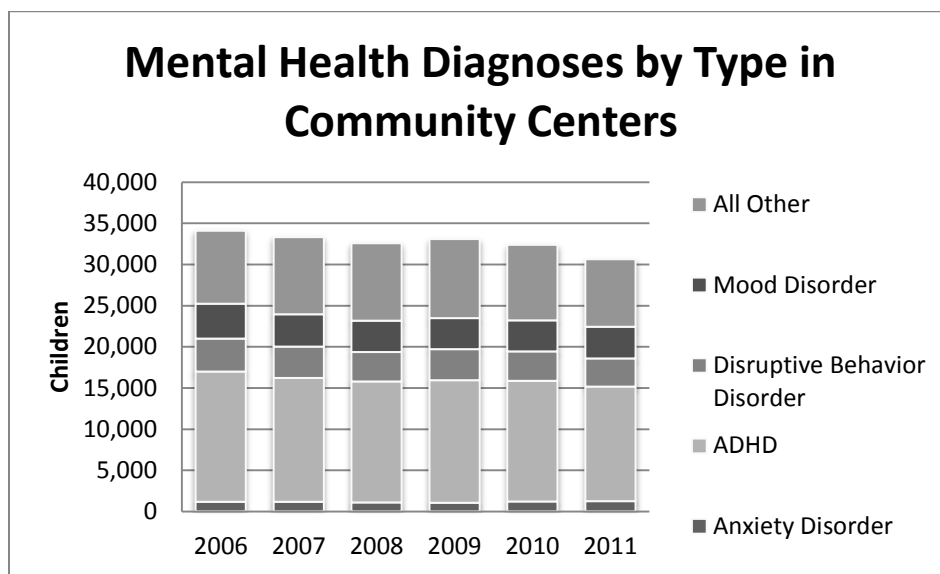
⁴⁷ The recommended combination of vaccines is commonly referred to as the 431331 combination (4 DTap, 3 Polio, 1 MMR, 3 Hep B, 3 HIB and 1 Var).

⁴⁸ S.C. Joint Citizens and Legislative Committee on Children. Summary of Testimony 2011 Public Hearings. <http://www.sccommitteeonchildren.org/doc/PublicHearingFinalReport.pdf> (last visited January 27, 2012).

⁴⁹ S.C. CHESS, Vaccine Preventable Diseases in South Carolina, unpublished report generated February 2012.

⁵⁰ S.C. Joint Citizens and Legislative Committee on Children. Summary of Testimony 2011 Public Hearings. <http://www.sccommitteeonchildren.org/doc/PublicHearingFinalReport.pdf> (last visited January 27, 2012).

Children with a Mental Health Diagnosis in Community Treatment Centers: Good mental health is central to positive relationships, appropriate behavior, and academic success. This indicator illustrates the number of children treated in Department of Mental Health community mental health centers with a diagnosis of attention deficit hyperactivity disorder (ADHD), disruptive behavior disorder, mood disorders, and other types of mental health diagnoses.⁵¹



Relevance: ADHD is consistently the most common child and adolescent mental health diagnosis.⁵² The total number of children with mental health diagnoses treated in public mental health centers has decreased 10% since 2006. This reduction in state services may be a reflection of reduced capacity to identify and serve children with mental health conditions due to budget reductions, rather than a decline in the prevalence of children with mental health conditions.

Research suggests that one-half of all mental disorders experienced in a person's life begin by age fourteen.⁵³ Identifying children at risk of developing psychosocial problems caused by parental depression or child maltreatment is crucial because early intervention may prevent lifelong problems.⁵⁴ Undiagnosed, untreated, and undertreated mental health needs can have devastating consequences for children later in life, including substance abuse, juvenile crime, school dropouts, and births to teens. Effective diagnostic tools and treatment may dramatically reduce lifelong problems for children with mental health needs.

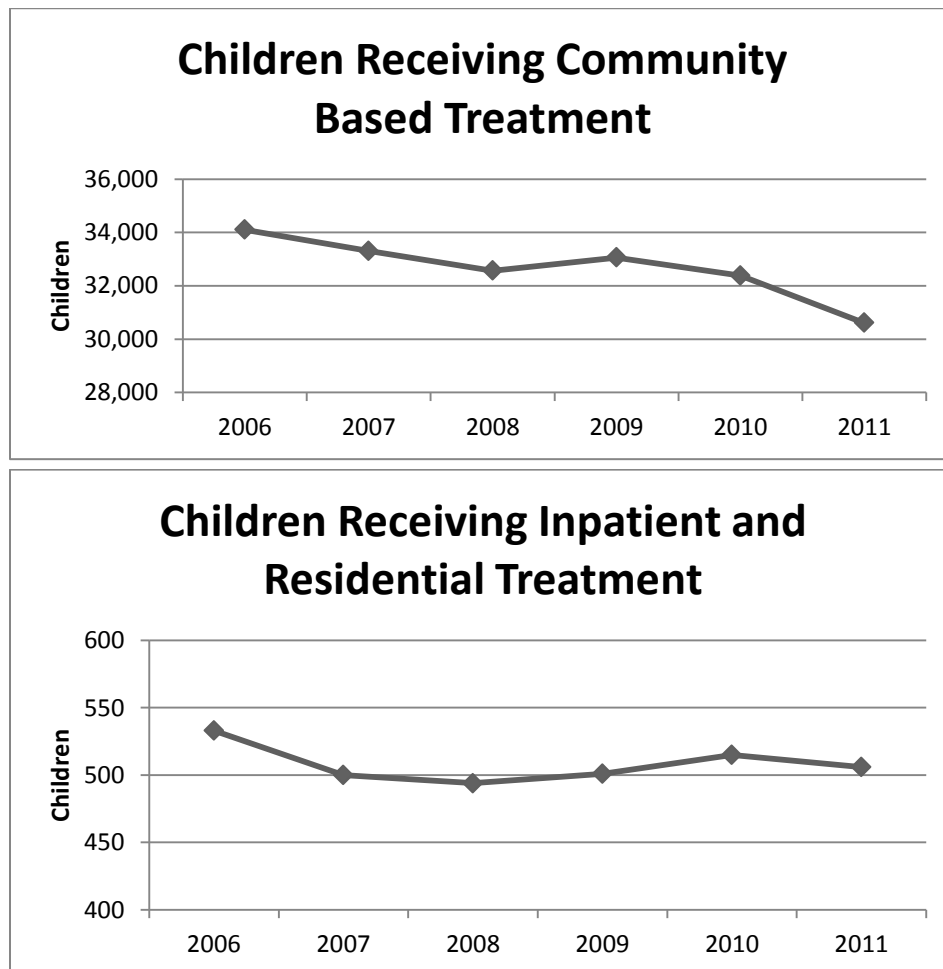
⁵¹ S.C. Department of Mental Health, Unpublished report generated December 2011, Mental Health Diagnoses in Children Served in Community Centers.

⁵² Psychotic disorders and developmental delay disorders are included with "all other" category.

⁵³ The Commonwealth Fund, Unmet Need for Mental Health Care: Children and Adolescents, <http://www.commonwealthfund.org/Performance-Snapshots/Unmet-Needs-for-Health-Care/Unmet-Need-for-Mental-Health-Care--Children-and-Adolescents.aspx> (last visited January 12, 2012).

⁵⁴ Id.

Children Receiving Mental Health Services by Location: This indicator illustrates the number of children receiving inpatient or residential and community mental health treatment, which includes school based services, through the Department of Mental Health.⁵⁵ Because children may receive services in multiple locations throughout a fiscal year, these delivery locations are not mutually exclusive.



Relevance: Overall, the number of children receiving mental health treatment has decreased since 2006 as budget restrictions limit capacity. Far more children receive community treatment, which includes school based services, than inpatient and residential treatment. Since 2008 the number of children served in inpatient and residential treatment centers has not changed dramatically.

The above data also do not indicate whether children are placed on waiting lists for service or are receiving sufficient visits to address their mental health needs. Testimony was submitted at the public hearings that due to reductions in services, children in foster care in need

⁵⁵ S.C. Department of Mental Health, Children Receiving Mental Health Treatment by Service Delivery Location. Unpublished report generated December 2012.

of mental health services are placed on waiting lists.⁵⁶ Also during the public hearings, mental health practitioners recommended the adoption of statewide uniform screening tools to determine the best treatment options for children.⁵⁷

The importance of robust community-based and school-based mental health diagnosis and treatment for children cannot be overstated. Effective mental health services impact the school environment for all children, the utilization of foster care, and the number of juveniles committed to the Department of Juvenile Justice. The national Substance Abuse and Mental Health Services Administration (SAMHSA) has recommended that an effective approach to community-based mental health services is through an integrated system of care among different child-serving agencies such as child welfare, juvenile justice, and education.⁵⁸ Data from such system of care approaches have found significant improvements in mental health, school performance and juvenile arrests.⁵⁹ In October 2011, South Carolina received a System of Care grant to coordinate the work of all agencies that serve children with mental health needs. The Committee on Children looks forward to the promising work from this multi-agency collaboration.

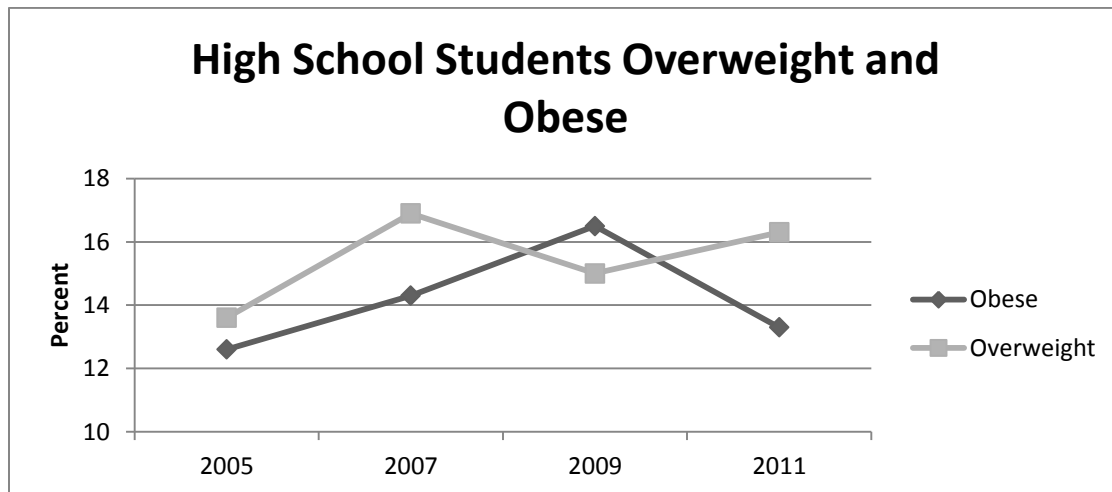
⁵⁶S.C. Joint Citizens and Legislative Committee on Children, Summary of Testimony of 2011 Public Hearings. <http://www.sccommitteeonchildren.org/doc/PublicHearingFinalReport.pdf> (last visited, January 31, 2012).

⁵⁷*Id.*

⁵⁸ U.S. Department of Health and Human Services, SAMHSA, http://www.samhsa.gov/samhsaNewsletter/Volume_17_Number_4/CoordinatingCare.aspx (last visited January 12, 2012).

⁵⁹*Id.*

Overweight High School Students: Data collected from the Youth Risk Behavior Survey (YRBS) refers to students who are greater than or equal to the 85th percentile in weight, but less than the 95th percentile for body mass index (BMI) based on age and sex.⁶⁰ **Obese High School Students:** Data collected from the YRBS refers to students who are greater than or equal to the 95th percentile rank for body mass index (BMI) based on age and sex.⁶¹



Relevance: According to the most recently available data from the Youth Risk Behavior Survey in 2011, 30% of high school students are either obese or overweight. Particular geographical areas may have even higher rates. According to DHEC, in one county 58.7% of all 8th graders were obese or overweight.⁶²

Obese children are more likely to become obese adults and have a greater risk for diabetes, high cholesterol, and heart disease. Testimony from the Committee on Children’s public hearings indicated that Type 2 diabetes, high cholesterol, hypertension, depression, and poor self esteem are evident in obese children. One pediatrician reported that 30% to 40% of her child patients were overweight or obese. The same pediatrician reported a child patient who died from an obesity related pulmonary embolism and obese teen patients with the blood vessel elasticity of persons in their 50s.⁶³ Evidence on the benefits of breastfeeding indicate that the cells, hormones, and antibodies in breast milk improve babies’ health overall and protect babies from illnesses. Babies who are not breastfed have higher risks of health issues including obesity.⁶⁴

Collaborative, community-based interventions are crucial to reduce this indicator. Consistently collected statewide data available at the county level is also extremely important.

⁶⁰ Office of Health and Nutrition South Carolina Department of Education, 2011 Youth Risk Behavior Survey Results: High School Student Trend Analysis Report. (not available online as of January 25, 2012).

⁶¹Id.

⁶² S.C. Department of Health and Environmental Control, 2011 South Carolina Obesity Burden Report, p. 11, <https://www.scdhec.gov/health/epidata/docs/Obesity%20Burden%20Report%202011.pdf> (last visited January 18, 2012).

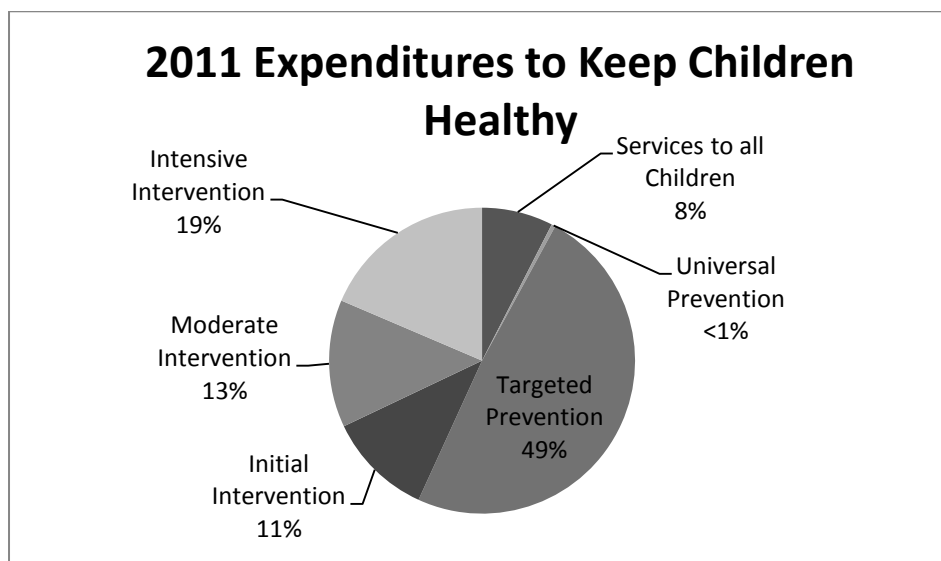
⁶³ S.C. Joint Citizens and Legislative Committee on Children Report on 2011 Public Hearings. <http://www.sccommitteeonchildren.org/doc/PublicHearingFinalReport.pdf> (last visited January 13, 2012).

⁶⁴ U.S. Department of Health and Human Services, Office on Women’s Health, Why Breastfeeding is Important, <http://www.womenshealth.gov/breastfeeding/why-breastfeeding-is-important/> (last visited January 24, 2012).

Resource Mapping: During fiscal year 2011, the lead child-serving agencies spent approximately \$3.2 billion on children's health. The majority of health expenditures for children are oriented towards preventing or mitigating negative outcomes.



Approximately one-half of funds, or 49%, were identified as **targeted prevention** to focus on specific at-risk groups including wellness exams for children on Medicaid and Early and Periodic Screening Diagnostic and Treatment (EPSDT), home visitation programs, and identification of birth defects programs. Proportionally fewer funds, less than 1%, were spent on **universal prevention** programs such as immunizations, youth smoking cessation, diabetes prevention, public health emergency preparedness, and maternal and child health services.

Early, moderate, and intensive interventions comprised 43% of expenditures. **Initial interventions** include prenatal identification of birth defects and monitoring and comprised 11% of 2011 expenditures to keep children healthy. **Moderate interventions** include school-based mental health; environmental health programs to protect food, water, and sanitation systems; services for children with chronic illnesses and disabilities; and various waiver programs for children with disabilities to remain at home. Moderate interventions comprised 13% of 2011 expenditures to keep children healthy. **Intensive interventions** include Medicaid expenses for children in neonatal intensive care; psychiatric and behavioral residential care; training care homes and intermediate care facilities; and drug assistance for children with AIDS. Intensive interventions comprised 19% of 2011 expenditures to keep children healthy. The remaining 8% of funds were spent on **services to all children**, primarily in support of county health centers and chronic disease and cancer education programs. The combined work of all child-serving health oriented programs indicates a balance between early, moderate, and intensive interventions.



3. “Educated” Indicators of Child Well-Being

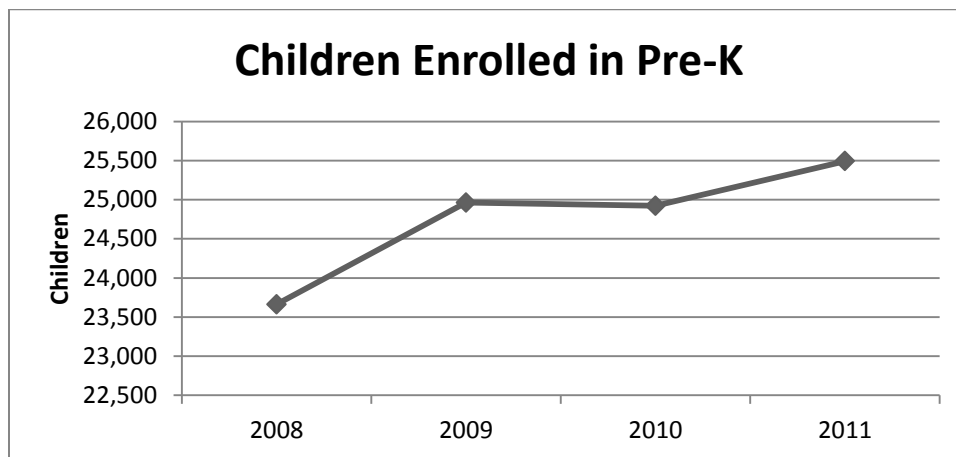
Educated children are more likely to become productive citizens as adults. Data in this report include public pre-kindergarten enrollment, 4th grade NAEP test scores, and graduation rates. Data about 8th grade NAEP scores and PASS scores is available in the Data Workbook which may be found at <http://www.sccommitteeonchildren.org/>.

3. Index of Education Indicators			
Indicator	Data from Earliest Available Year ^{65 66}	Data from Latest Available Year	Percent Change from Earliest to Latest Available Year
Children Enrolled in Public Pre-K	23,187	24,954	+8% 
Children with a Disability	97,783	94,216	-4% 
Average 4th Grade NAEP Reading Score	215	215	n/a
Average 4th Grade NAEP Math Score	236	237	n/a
Average 8th Grade NAEP Reading Score	258	260	n/a
Average 8th Grade NAEP Math Score	277	281	n/a
Third Grade PASS Scores			n/a
Writing	Exemplary	40%	
	Met	29%	
	Not Met	31%	
English and Language Arts	Exemplary	46%	
	Met	32%	
	Not Met	22%	
Math	Exemplary	31%	
	Met	36%	
	Not Met	33%	
Eighth Grade PASS Scores			n/a
Writing	Exemplary	26%	
	Met	42%	
	Not Met	32%	
English and Language Arts	Exemplary	29%	
	Met	39%	
	Not Met	33%	
Math	Exemplary	24%	
	Met	39%	
	Not Met	37%	
Graduation Rate	75%	74%	n/a

⁶⁵ Either four or five years of data is presented for each indicator. The earliest year of data collection is 2003 and the latest is 2011.

⁶⁶ Some indicators are most informative when the average scale score or the percent of an eligible population is presented instead of raw number of children.

Children Enrolled in Public Pre-K: Children participating in public pre-kindergarten are included in this indicator.⁶⁷ This group includes both three and four-year-olds and children attending private pre-kindergarten programs only if paid with CDEPP funds.



Relevance: An increasing number of children are participating in public pre-kindergarten programs. From 2008 to 2011, the total number of children participating in public pre-kindergarten has increased by almost 1,800 students or 8%.⁶⁸ Research has demonstrated the value of providing comprehensive interventions such as pre-kindergarten to close the achievement gap for disadvantaged students and to give children skills and knowledge to prepare for kindergarten.⁶⁹ Participation in pre-kindergarten programs is important to help children understand the culture and process of education and to prepare them to enter the first grade ready to learn.

In June of 2006, the General Assembly created the Child Development Education Pilot Program (CDEPP) to expand four-year-old kindergarten in response to Circuit Court Judge Cooper's ruling in the case of Abbeville County School District, et al. v. The State of South Carolina, et al (2005).^{70 71} This program has provided many low income families with increased pre-school access in both private and public classrooms. Continued support of effective, proven preschool programs will assist at-risk children.

⁶⁷ S.C. Department of Education, unpublished report, Children Enrolled in 3 and 4 Year Old Pre-Kindergarten generated December 2011.

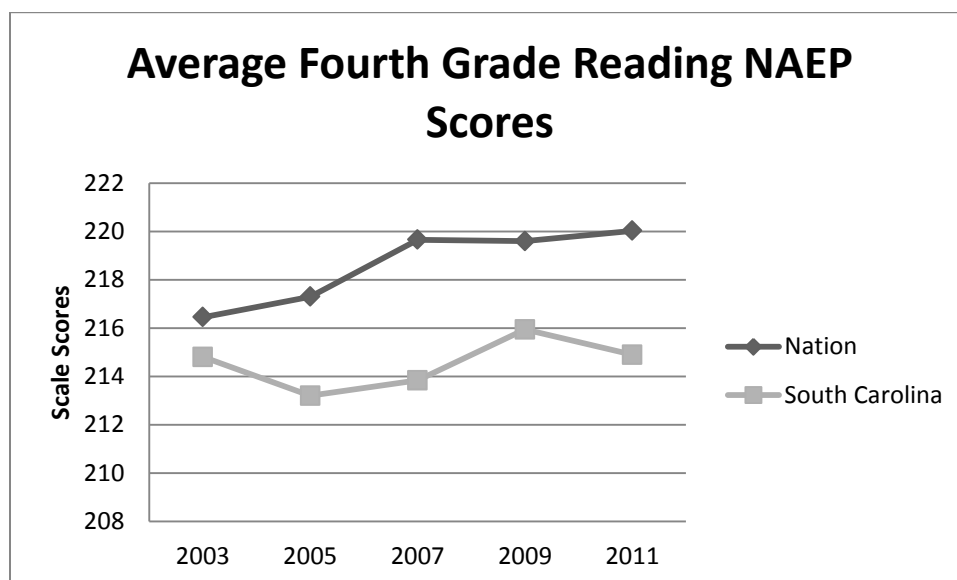
⁶⁸ Because five years of data are not available, trends in pre-kindergarten enrollment are not available.

⁶⁹ U.S. Department of Health and Human Services, State-Funded Pre-Kindergarten: What the Evidence Shows, December 2003, <http://aspe.hhs.gov/hsp/state-funded-pre-k/report.htm> (last visited January 13, 2012).

⁷⁰ S.C. First Steps, Child Development Education Pilot Program, 2008 Annual Report, <http://www.scfirststeps.org/fy08annualreport/cdepp.htm> (last visited January 13, 2012).

⁷¹ S.C. Education Oversight Committee, "Results of Student and Classroom Assessments in School Year 2009-10 for the Child Development Education Pilot Program (CDEPP)," can be found online at www.eoc.sc.gov. The report was presented to the Education Oversight Committee (EOC) at a full committee meeting on October 11, 2010.

Average Fourth Grade NAEP Scores in Reading: This indicator shows the average scale score that fourth grade students in earned on the NAEP compared to the national average. The National Assessment of Educational Progress (NAEP) reports comprehensive information regarding what fourth, eighth, and twelfth grades students have learned and their performance levels in various subject areas.^{72 73}



Relevance: From 2005 to 2011, the average fourth grade NAEP Reading assessment scores have fluctuated, but not changed significantly.⁷⁴ South Carolina has consistently scored below the national average. Most recently, that gap has increased. Research has shown that children who have not mastered grade level reading skills by the third grade, face greater academic challenges than children with strong reading skills,⁷⁵ and that children who are not reading on grade level in the early years are at risk of failure to graduate.⁷⁶ Consequently, children with poor reading skills face negative long term consequences on their earning potential, employability, and general productivity.⁷⁷ A trained and supervised corps of volunteers to read with children in public schools may improve reading scores for children.

⁷² National Center for Education Statistics, Institute of Education Sciences, <http://nces.ed.gov/nationsreportcard/> (last visited January 8, 2012).

⁷³ S.C. Department of Education, unpublished report, NAEP Scores generated December 2011.

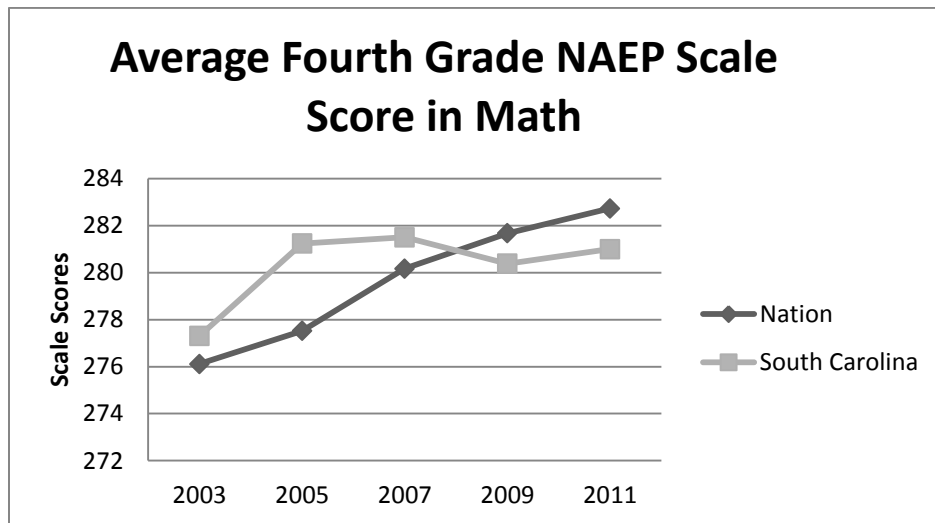
⁷⁴ Because NAEP scores are based on samples of students, some apparent differences in scale scores are not statistically significant.

⁷⁵ Third Grade Reading Level Indicates Students' Chances of Graduation, http://www.huffingtonpost.com/2011/04/10/third-grade-reading_n_846947.html (last visited January 13, 2012).

⁷⁶ Anne E. Casey Foundation, 2010 Special Report: Why Reading by the End of Third Grade Matters, <http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid={EBC84A89-722A-4985-9E5D-7AB0803CB178}> (last visited January 13, 2012).

⁷⁷ Id.

Average Fourth Grade NAEP Scores in Math: This indicator is the average scale score that fourth grade students in South Carolina earned on the NAEP in math. The National Assessment of Educational Progress (NAEP) reports comprehensive information regarding what fourth, eighth, and twelfth grades students have learned and their performance levels in various subject areas.^{78 79}



Relevance: From 2003 through 2011, there has not been a statistically significant change in the average NAEP Math Score for fourth graders in South Carolina.⁸⁰ Since 2007, South Carolina has scored consistently below the national average on math. Basic math skills are the building blocks to more complex thinking, higher level math and science courses, and ultimately better paying jobs.⁸¹ Children who do not master foundational math skills early in elementary school experience difficulty catching up with other students and are often set on a trajectory of low achievement.⁸²

⁷⁸ National Center for Education Statistics, Institute of Education Sciences, <http://nces.ed.gov/nationsreportcard/> (last visited January 8, 2012).

⁷⁹ S.C. Department of Education, unpublished report, NAEP Scores generated December 2011.

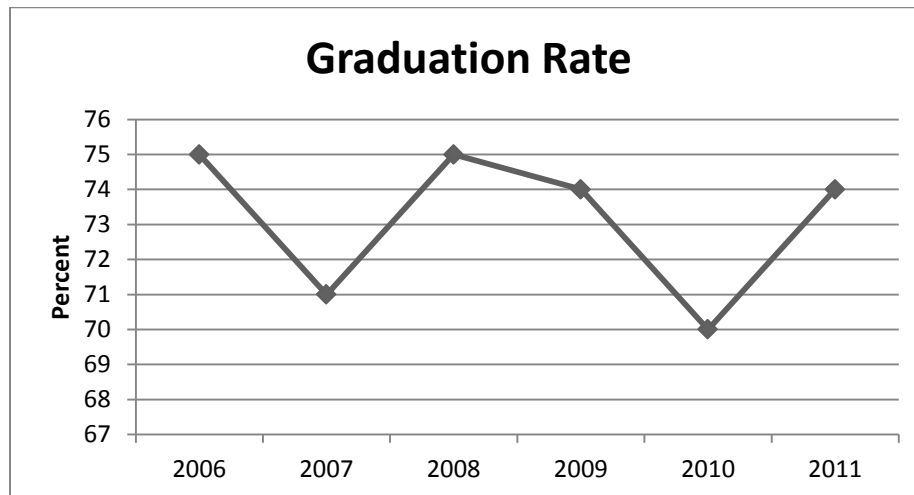
⁸⁰ Because NAEP scores are based on samples of students, some apparent differences in scale scores are not statistically significant.

⁸¹ Anne E. Casey Foundation, 2010 Special Report: Why Reading by the End of Third Grade Matters.

<http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid={EBC84A89-722A-4985-9E5D-7AB0803CB178}> (last visited January 13, 2012).

⁸² Id.

High School Graduation Rates: The graduation rate for South Carolina students in public schools was calculated using data from the Department of Education. This indicator reflects the percentage of eligible 9th grade students who graduated in four years.⁸³



Relevance: For students who graduate in four years, the graduation rate for the past six years has fluctuated between 70% and 75% of eligible students.⁸⁴ From 2006 to 2011, the graduation rate decreased overall by 1%. The rate has fluctuated in intervening years.

Graduation from school can affect a young adult's ability to earn a living. In 2009, the average worker who did not have a high school diploma earned \$21,000 per year, compared to \$30,000 per year for a student who graduated from high school.⁸⁵ Interventions to improve the graduation rate include, among others, strategies to diagnose and address reading and math skills during children's elementary years.

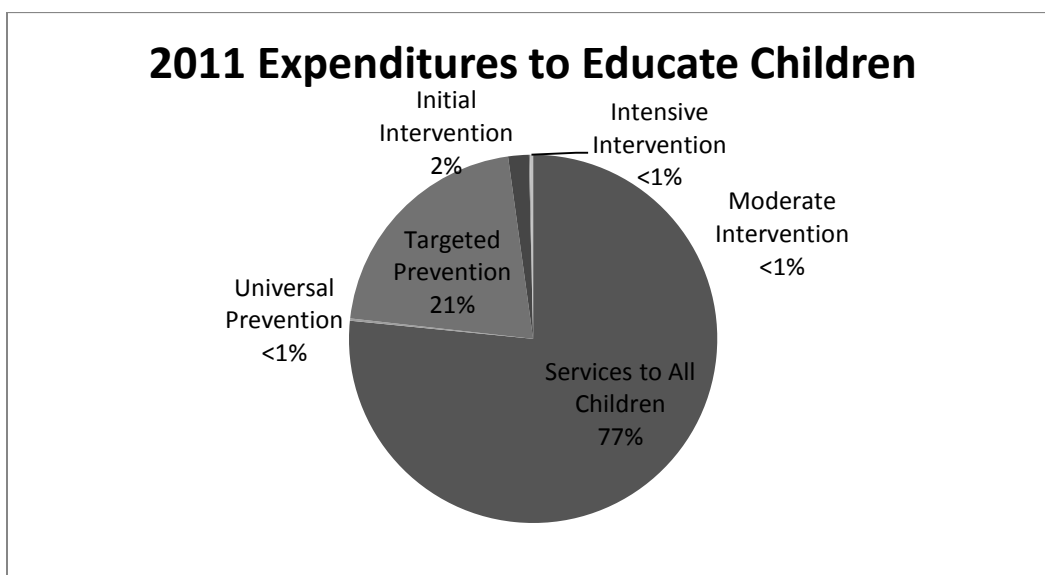
⁸³ S.C. Department of Education, unpublished report, Four Year High School Graduation Rate generated December 2011.

⁸⁴ This indicator does not include the number of students who graduate in five years or those who later complete their GED.

⁸⁵ U.S. Department of Education, National Center for Education Statistics. (2011). *The Condition of Education 2011* (NCES 2011-033), Indicator 17. http://nces.ed.gov/pubs2011/2011033_3.pdf (last visited, January 23, 2012).

Resource Mapping: During fiscal year 2011, the lead child-serving agencies spent approximately \$1.9 billion to educate children.

Over 77% of educational funds were spent on **services to all children** for public education.⁸⁶ **Targeted prevention** comprised 21% of expenditures on programs such as child care quality enhancement services, home visitation programs to improve school readiness, and instructional assistance to high poverty schools and students. **Initial interventions** comprised 2% of expenditures on programs such as early intervention for infants and toddlers with disabilities and academic assistance to neglected and delinquent children. Relatively small amounts were spent on **intensive interventions** such as pre-kindergarten for three and four-year-olds. Data suggest that there are very little expenditures for initial, moderate, and intensive interventions.



⁸⁶ Not all expenditures within the public education system were reported as education expenditures. For example, expenditures in the school lunch program categorized were categorized as expenditures to keep children healthy.

4. “Responsible” Indicators of Child Well-Being

When youth are responsible, contributing members of a community, they are less likely to commit crimes and more likely to stay in school and have positive social interactions. Youth responsibility is nurtured by participation in constructive activities, connections with helpful adults, and the encouragement of positive interests. Involved youth are more likely to contribute their input and ideas into programs, policies, and practices that affect them.⁸⁷ Meaningful opportunities to participate actively in society give youth the life skills (living, learning, and working skills) to prepare them for future success. There are many ways to measure youth responsibility; however, very little of this data is currently captured in South Carolina. Data in this report include information about youth employment, juvenile crime, and teen pregnancy. Data about attendance rates in public school, truancy, juvenile charges and juvenile recidivism is available in the Data Workbook which may be found at <http://www.sccommitteeonchildren.org/>.

Graduation from school is an important indicator of a young person’s ability to earn adequate income and become self-sufficient. Graduation rates are addressed more fully in the previous section under education indicators. For students who graduate in four years, the graduation rate for the past six years has fluctuated between 70% and 75% of eligible students.⁸⁸

4. Index of Responsible Indicators			
Indicator	Data from Earliest Available Year^{89 90}	Data from Latest Available Year⁹¹	Percent Change from Earliest to Latest Available Years
Attendance Rate in Public School	95.8%	95.9%	n/a
Truancy	19,159	10,072	n/a
Youth Employment	70,000	58,000	-17% ↓
Youth Using Tobacco	30%	28%	n/a
Youth Binge Drinking	24%	22%	n/a
Youth Using Marijuana	19%	24%	n/a
Number of Juveniles Charged with a Crime or Status Offense	19,115	13,680	-28% ↓
Number of Juvenile Charges	24,699	18,114	-27% ↓
Juvenile Recidivism	14%	15%	n/a
Births to Teens	2,825	2,124	-25% ↓

⁸⁷ Sullivan, Theresa K. and Rebecca N. Saito, University of Minnesota Extension, Center for Youth Development, Rings of Engagement, August 2008, <http://www1.extension.umn.edu/youth/docs/Rings.pdf> (last visited January 13, 2012).

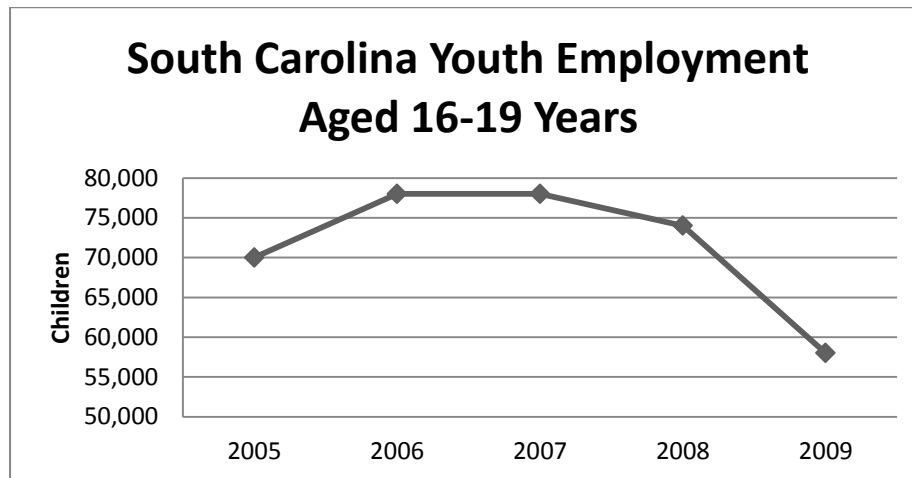
⁸⁸ This indicator does not include the number of students who graduate in five years or those who later complete their GED.

⁸⁹ Either four or five years of data is presented for each indicator. The earliest year of data collection is 2007 and the latest is 2011.

⁹⁰ Some data is better represented by a percentage of children in a specific population and is presented as such.

⁹¹ Some data is better represented by a percentage of children in a specific population and is presented as such.

Youth Employment: The number of civilian youth aged sixteen through nineteen who are employed outside the home as in non-institutional settings as reported by the Bureau of Labor and Statistics.⁹²



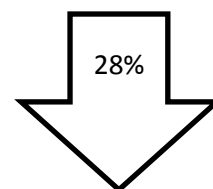
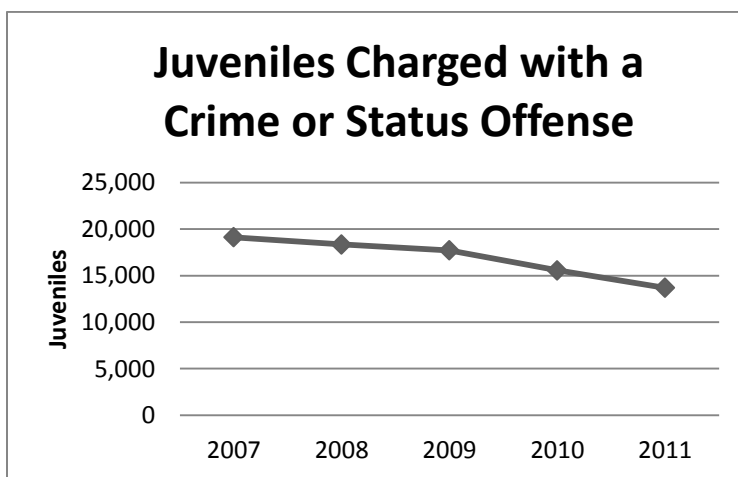
Relevance: The number of youth employed outside the home has decreased by 17% since 2005. This decrease is likely due in part to fewer job opportunities as the unemployment rate for youth has increased during the Great Recession.⁹³ The rate of unemployed youth coincides with the rate of unemployed adults. Data indicate that African American youth are more likely to be unemployed than white youth.⁹⁴

⁹² Bureau of Labor and Statistics, Geographic Profiles of Employment and Unemployment by Year. <http://www.bls.gov/opub/gp/laugp.htm> (last visited January 19, 2012).

⁹³ Bureau of Labor and Statistics, Geographic Profile of Employment and Unemployment 2009. <http://www.bls.gov/opub/gp/laugp.htm> (last visited January 19, 2012).

⁹⁴Id.

Number of Juveniles Charged with a Crime or Status Offense: This indicator represents the number of juveniles charged for either a criminal offense or status offense. Status offenses are acts which would not be a crime if committed by an adult. Status offenses include truancy, underage drinking, and tobacco use.⁹⁵ The most frequently charged status offenses in South Carolina include truancy, incorrigibility and running away.⁹⁶



Relevance: The number of juveniles charged with a crime or status offense has steadily decreased since 2007. National juvenile arrest rates for all juvenile and adult crimes have also declined since the late 1990s.⁹⁷

Reductions in this indicator may in part be due to favorable interventions through the Department of Juvenile Justice such as the intensive supervision officer (ISO) program and the reinstatement of teen after school centers. Research has also demonstrated that life skills programs such as marine institutes, wilderness camps, and juvenile arbitration programs give young people a positive identity and feelings of personal empowerment which help them acquire the sense of belonging and self-governance that reduce juvenile crime.⁹⁸

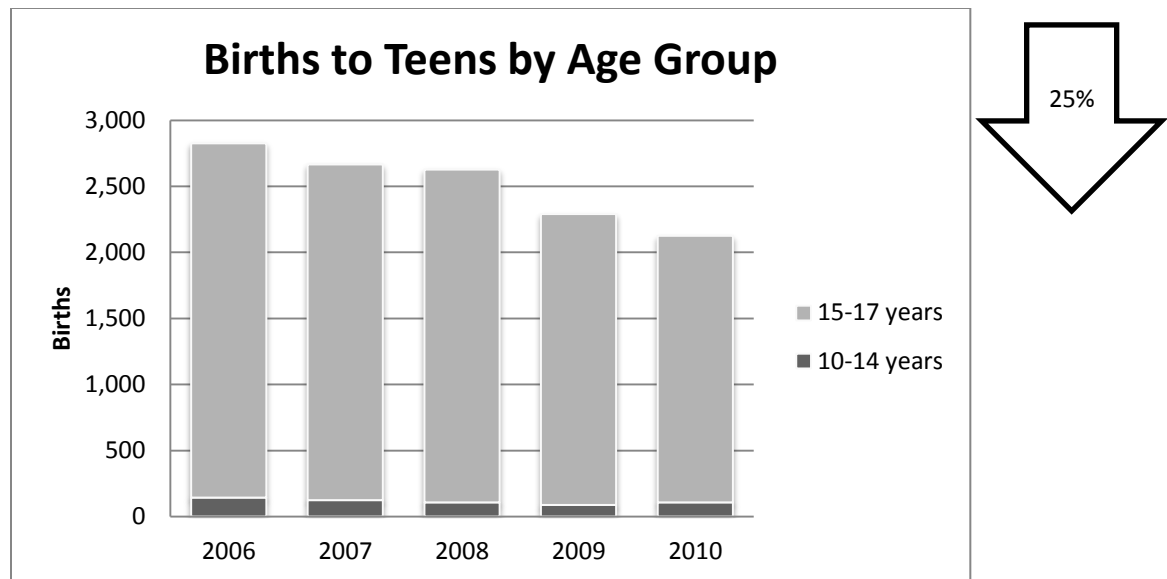
⁹⁵ S.C. Department of Juvenile Justice, unpublished report, Number of Juveniles Charged with a Crime FY 2007-2011. Generated December 2011.

⁹⁶Id.

⁹⁷ U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, http://www.ojjdp.gov/ojstatbb/crime/JAR_Display.asp?ID=qa05200 (last visited January 7, 2012).

⁹⁸ AMI Kids, AMIKids Personal Growth Model, <http://www.amikids.org/our-services/amikids-personal-growth-model> (Last visited, January 23, 2012).

Births to Teens: This indicator reflects the number of live births to teens under the age of 18.⁹⁹



Relevance: Births to teens in the state have decreased steadily since 2006. Births to teens may result in poor outcomes for both children and mothers. Children born to teen mothers are more likely to be premature, have low birth weight, and die as infants than children born to women in their twenties and thirties.¹⁰⁰ Compared with older mothers, teens who have children are less likely to finish high school or attend college themselves.¹⁰¹

The concerted effort of public agencies and private non-profits to reduce teen births has contributed to this decline. Home visitation programs designed to support first time mothers, and in particular teens, have also likely contributed the decline. Continued support of public agencies, private non-profits and home visitation programs will contribute to continued success in this measure.

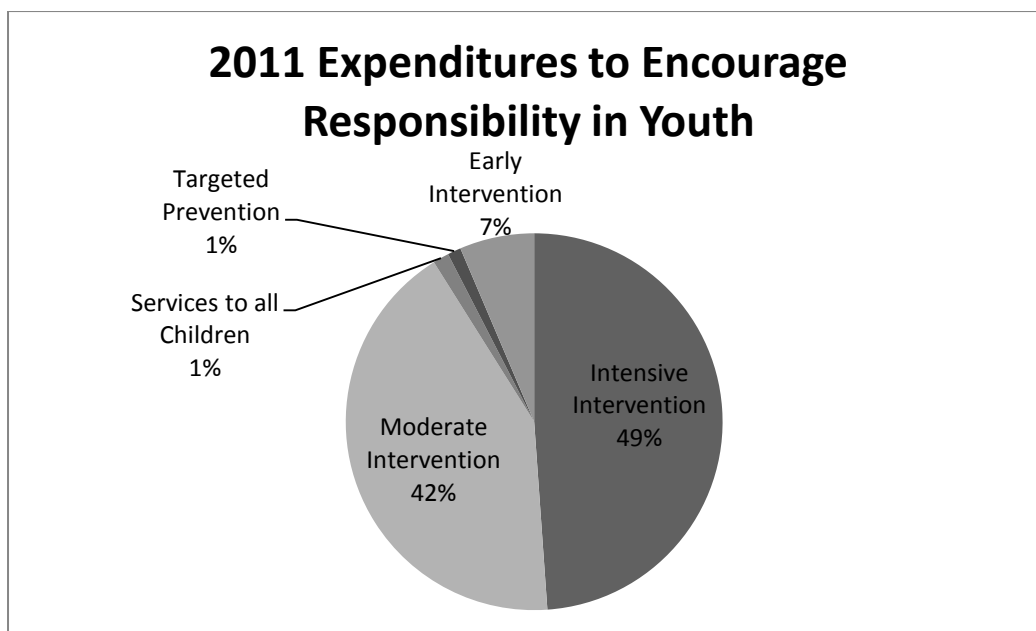
⁹⁹ S.C. Department of Health and Environmental Control, unpublished report, Births to Teens, generated December 2011.

¹⁰⁰ Child Trends, Teen Births, <http://www.childtrendsdatabank.org/?q=node/52> (last visited January 19, 2012).

¹⁰¹ Id.

Resource Mapping: During fiscal year 2011, the lead child-serving agencies spent approximately \$107 million to encourage responsibility for youth. Nearly 80% of funds to promote youth responsibility include **moderate or intensive intervention** services, such as intensive probation supervision and detention of juvenile offenders. One percent was reportedly spent on **universal prevention** and an additional 1% was spent on **targeted prevention** for programs aimed at foster children and middle school youth. Approximately 7% was spent on **initial intervention** for programs such as teen after school centers, juvenile arbitration and early intervention programs for tobacco, alcohol, and other drug use.

Many programs promoting youth responsibility are provided by private non-profit, faith-based, and volunteer organizations throughout the state and are not fully captured by this report. Encouraging responsibility is by far the smallest reported allocation of resources for youth; however, these programs often better prepare youth for successful adulthood. Programs designed to develop responsibility in at-risk youth create an excellent opportunity for further research and potential recommendations for public/private partnerships.



5. “Supported” Indicators of Child Well-Being

When children have adequate emotional and financial support throughout their childhood, they have a better opportunity to reach their full potential. Data in this report include information about children living in poverty and low income households. Data about children receiving free and reduced lunch, Temporary Aid to Needy Families (TANF), Women, Infants and Children (WIC), children in therapeutic foster care placements, and court ordered parental child support may be found at <http://www.sccommitteeonchildren.org/>.

5. Index of Supported Indicators of Child Well-Being			
Indicator	Data from Earliest Available Year ^{102 103}	Data from Latest Available Year ¹⁰⁴	Percent Change from Earliest to Latest Available Year
Children living in Poverty	194,157	255,737	+32% ↑
Children living in Low Income Families	436,940	511,162	+17% ↑
Children Receiving Free and Reduced Lunch	52%	55%	n/a
Children Participating in TANF	55,907	65,276	+17% ↑
Children Participating in WIC	84,181	103,602	+23% ↑
Children in Therapeutic Foster Care Placements	1,585	1,369	-14% ↓
Child Support	212,085	223,218	+5% ↑

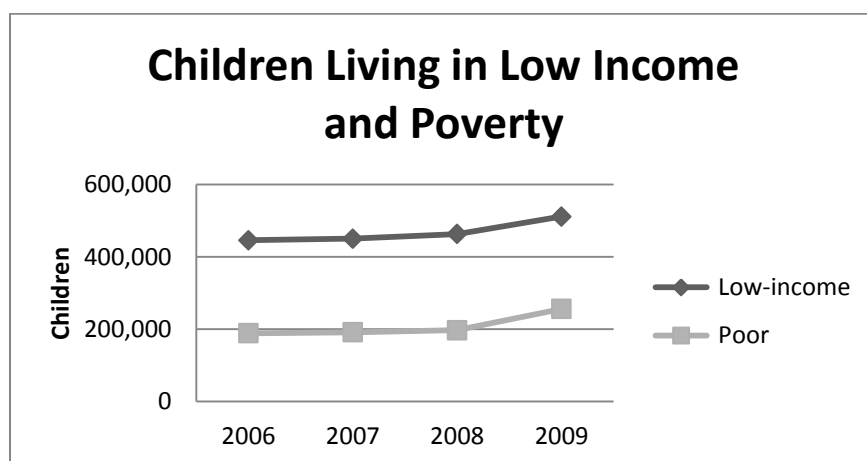
¹⁰² Either four or five years of data is presented for each indicator. The earliest year of data collection is 2005 and the latest is 2011.

¹⁰³ For the indicator of Free and Reduced lunch, the measure is more informative by using the percent of children in school instead of a raw number.

¹⁰⁴ For the indicator of Free and Reduced lunch, the measure is more informative by using the percent of children in school instead of a raw number.

Children in Poverty: Each year, the United States Census Bureau sets a poverty threshold known as the federal poverty level. Families with an annual income at or below the federal poverty level are categorized as being in poverty. In 2011 the federal poverty level, also referred to as 100% of poverty, for a family of four was set at an annual income of less than \$22,350. For a single parent with two children, the federal poverty level was set at an annual income less than \$18,530.

Families with an annual income twice or below the federal poverty level are categorized as low income.¹⁰⁵ Low income, or 200% of poverty, was set at an annual income less than \$44,700 for a family of four. For a single parent with two children, low income was set at annual income less than \$37,060.



Relevance: The recession has resulted in an increase of the number of children living in some federally measured degree of poverty. The effects of living in poverty can have a detrimental impact on child development. The number of children living in poverty in South Carolina has increased by 32% and the number of children living in low income families has increased 17% since 2007.

Currently, 49% of all children in South Carolina live in either poor or low income households. Because of the numerous challenges children in poverty face, the number of children in poor or low income households is an immense challenge in moving child well-being forward. Millions and even billions of dollars are spent maintaining the status quo when families cannot provide for their children's most basic necessities. It is impossible to improve the well-being of all children in the state without considering the impact of child poverty.

¹⁰⁵ The National Center for Children in Poverty, South Carolina Children at 100% and 200% of the Federal Poverty Level. <http://nccp.org/topics/childpoverty.html> (Last visited, January 12, 2012).

The Impact of the Recession on Children

The eighteen month period from December 2007 until June of 2009,¹⁰⁶ dubbed the “Great Recession,” has profoundly impacted children in South Carolina. Children’s needs for shelter, nutrition, and healthcare are challenges for the families already poor and for middle class families who became unemployed during the recession. Unemployment, food and housing instability, and family financial stress can create a harmful environment for a developing child.

Research demonstrates that poverty affects the academic achievement, emotional development, and physical health of children. Biological research has shown that poverty and its related conditions such as persistent, unrelenting stress and extreme neglect physically alter a child’s brain.¹⁰⁷ Studies have also shown that the duration and severity of poverty are critical, as children who are poor for a shorter period of time experience fewer problems than children in deep poverty for many years. Children who grow up in poverty are more likely to engage in violent crime, use illicit drugs, and develop chronic health problems.¹⁰⁸

Children who experience chronic, unrelenting stress in early childhood caused by extreme poverty, abuse, or severe maternal depression have longer lasting negative effects.¹⁰⁹ From development prior to birth through the first years of life, the brain develops rapidly.¹¹⁰ In one of the longest studies to follow children from birth to adulthood, research showed that children exposed to significant stress prior to birth experienced increased neonatal health problems, learning disabilities, and mental disabilities. These same children later showed increased rates of delinquency and teen pregnancy.¹¹¹ Extreme poverty, abuse, or neglect can weaken developing brain architecture and permanently cause the body’s stress response system to remain on high alert.¹¹² The effects of poverty on children’s academic achievement, emotional development, and physical health can require significant intervention.

Academic Achievement: Children from low socioeconomic households acquire language skills more slowly and are at risk for reading difficulties.¹¹³ High school dropout rates are also higher in low-income families. National data show that 16.7% of children from low income families dropped out of high school, while only 3.2% of children in more affluent families dropped out.¹¹⁴

¹⁰⁶ National Bureau of Economic Research, <http://www.nber.org/> (last visited January 4, 2012).

¹⁰⁷ Center on the Developing Child, Harvard University, In Brief: The Science of Early Childhood Development, http://developingchild.harvard.edu/resources/briefs/inbrief_series/ (last visited January 4, 2012).

¹⁰⁸ The Urban Child Institute, Children Raised in Poverty Are at Greater Risk for Developing Cognitive Deficits, January 2011, <http://www.theurbanchildinstitute.org/articles/research-to-policy/research/children-raised-in-poverty-are-at-greater-risk-for-developing> (last visited January 4, 2012).

¹⁰⁹ Center on the Developing Child, Harvard University, In Brief: The Science of Early Childhood Development, http://developingchild.harvard.edu/resources/briefs/inbrief_series/ (last visited January 4, 2012).

¹¹⁰Id.

¹¹¹ Charles Oberg, M.D. M.P.H., University of Minnesota, Maternal and Child Health Program, School of Public Health, The Impact of Childhood Poverty on Health and Development, Healthy Generations, May 2003, http://www.epi.umn.edu/mch/resources/hg/hg_childpoverty.pdf (last visited January 4, 2012).

¹¹² Center on the Developing Child, Harvard University, In Brief: The Impact of Early Adversity on Children’s Development, http://developingchild.harvard.edu/resources/briefs/inbrief_series/ (last visited January 4, 2012).

¹¹³ American Psychological Association, Education and Socioeconomic Status, citing a 2008 study by Parlardy <http://www.apa.org/pi/ses/resources/publications/factsheet-education.pdf> (last visited January 4, 2012).

¹¹⁴ American Psychological Association, Education and Socioeconomic Status, citing a 2008 statistics from the National Center for Education Statistics, <http://www.apa.org/pi/ses/resources/publications/factsheet-education.pdf> (last visited January 4, 2012).

Emotional Development: Poverty has a negative influence on a child's emotional growth and development. Poverty impacts family functioning and increases the likelihood of marital conflict, psychological distress, depression, and negative self-esteem.¹¹⁵ Children from lower socioeconomic households are about twice as likely to have behavior problems that may affect academic performance.¹¹⁶ Impulsiveness, disobedience, and difficulty in getting along with peers are also more prevalent among children living in poverty.¹¹⁷ Mental health problems are two to four times as prevalent among children in poverty, child welfare, and juvenile justice systems.¹¹⁸

Physical Health: Children who live in poverty have a high incidence of negative health outcomes. Children born into poverty are more likely to have low birth weight and to die during their first month of life.¹¹⁹ Children who live in poverty are at greater risk for accidents and injuries¹²⁰ and for other physical health issues including higher rates of asthma, anemia¹²¹ or a physical impairment.¹²²

Understanding the academic, emotional, and physical impacts of poverty underscores the need to assess what children in South Carolina experienced during the recession. During the recession, the unemployment rate in South Carolina nearly doubled. In 2007, the unemployment rate was 5.6%; however, in 2009 the rate increased to 11.3%. Prior to the recession, roughly one in five children lived in poverty, and since 2009 that number has increased to one in four children.¹²³ During the recession, median family income in South Carolina decreased almost to the levels of twenty years ago. The constant dollar per capita family income in 2009 was \$31,799 in South Carolina, only 2% higher than it was in 1989. Families in South Carolina have lost two decades of improvement in purchasing power and have significantly less money to provide basic necessities than before the recession.

Of all children receiving Temporary Assistance to Needy Families (TANF) in 2010, 24% were added during the recession. Of the persons receiving supplemental nutrition assistance (SNAP, formerly known as food stamps) in 2010, 27% were added during the recession. Of the children receiving free and reduced lunch in 2010, 5% percent were added during the recession. These financial and nutrition assistance programs were designed to ease the burden on children hard hit by the recession. The increase in children receiving these benefits is an important indicator of the sheer volume of children who have been impacted.

¹¹⁵ Charles Oberg, M.D. M.P.H., University of Minnesota, Maternal and Child Health Program, School of Public Health, The Impact of Childhood Poverty on Health and Development, Healthy Generations, May 2003, http://www.epi.umn.edu/mch/resources/hg/hg_childpoverty.pdf (last visited January 4, 2012).

¹¹⁶ American Psychological Association, Education and Socioeconomic Status, citing a 2009 study by Morgan et al. <http://www.apa.org/pi/ses/resources/publications/factsheet-education.pdf> (last visited January 4, 2012).

¹¹⁷ Moore, Kristen Anderson, Ph.D, Zakia Redd, M.P.P. Child Trends, Research Brief, Children in Poverty: Trends Consequences and Policy Options, April 2009, http://www.childtrends.org/Files/Child_Trends-2009_04_07_RB_ChildreninPoverty.pdf (last visited January 4, 2012).

¹¹⁸ Garland, A.E. et al, "Prevalence of Psychiatric Disorders in Youths Across Five Sectors of Care," *Journal of the American Academy of Child and Adolescent Psychiatry* 40, no. 4 (2001) and S. Glied et al., "Children's Access to Mental Health Care: Does Insurance Matter?" *Health Affairs*, Jan/Feb 1997.

¹¹⁹ Moore, Kristen Anderson, Ph.D, Zakia Redd, M.P.P. Child Trends, Research Brief, Children in Poverty: Trends Consequences and Policy Options, April 2009, http://www.childtrends.org/Files/Child_Trends-2009_04_07_RB_ChildreninPoverty.pdf (last visited January 4, 2012).

¹²⁰ Id.

¹²¹ Id.

¹²² Id.

¹²³ Poor is defined as annual income at or below the federal poverty level. In 2007 the federal poverty level was annual income of \$20,650 for a family of four. The federal poverty level for a single parent with two children was \$17,170.

The recession particularly impacted minority children. During the recession, the percentage of African American children classified as living in poverty increased to 41% and those classified as low income increased to 71%.¹²⁴ This means that less than 30% of the African American children in South Carolina now live in the middle or upper economic class. Emphasizing the effects on African American families and their children is the devastating impact the recession has had on African American men to provide for their families. The unemployment rate for African American men more than doubled from 10.2% in 2007 to 21.9% in 2010.

The total number of homeless students in South Carolina as defined by the McKinney-Vento Homeless Assistance Act has almost doubled from 2006 to 2010. In 2006 the total number of homeless students was 6,033. By 2010, the number had climbed to 10,820.¹²⁵ Many homeless students were classified as “doubled-up,” which includes families living with relatives. The number of doubled up students rose from 3,756 in 2007 to 5,479 in 2009, an increase of 68%.¹²⁶

Areas of the state were also impacted differently by the recession. Primarily rural counties had the worst average rates of child poverty, unemployment, and median family income during the recession. The five worst rates are found in Allendale, Marion, Marlboro, Williamsburg, and Bamberg counties. For SNAP, TANF, free and reduced lunch, the highest participation counties are rural. The lowest participation counties are primarily urban or suburban or areas with high numbers of retirees and tourism. Children in rural counties are nearly two and a half times more likely participate in safety net programs than in urban or suburban counties.

From 2007 to 2009, counties that experienced the greatest increases in children using safety net programs such as TANF, SNAP, and free and reduced lunch were suburban communities, including Kershaw, Dorchester, Lexington, Spartanburg, and Horry counties. The powerful impact of unemployment among the suburban families rose more markedly than in rural counties. Middle class families experiencing unemployment and underemployment for the first time may account for more suburban families accessing safety net services during this time period.

Even though the most recent news indicates that the state has made great strides in reducing unemployment, many families and children still struggle with the after-effects of the economic downturn and will likely for some time to come.

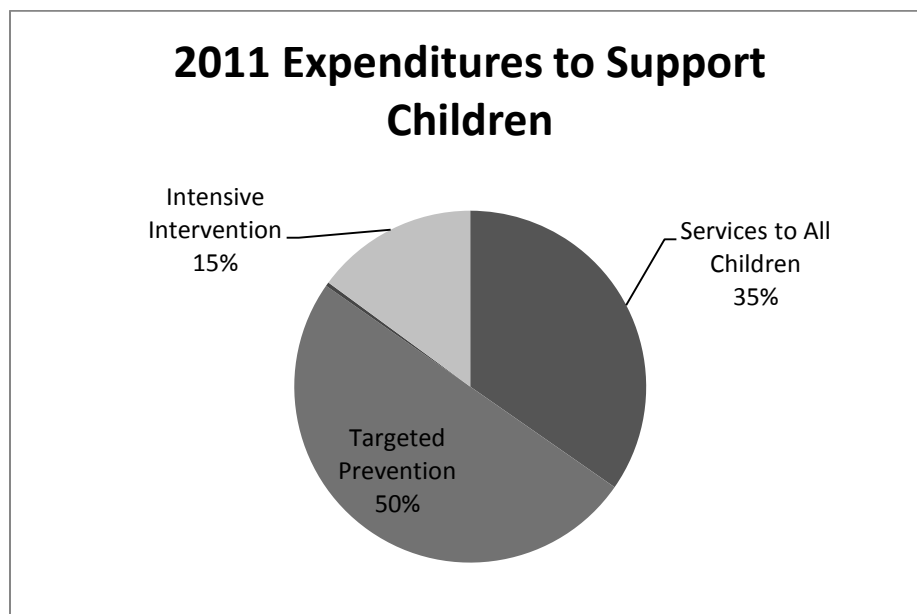
¹²⁴ Poor is defined as annual income at or below the federal poverty level. In 2007 the federal poverty level was annual income of \$20,650 for a family of four. The federal poverty level for a single parent with two children was \$17,170.

¹²⁵ South Carolina Department of Education, Information on Homeless Education in the State of South Carolina, Last Revision October 2006 and information provided to the Committee on Children October 6, 2010.

¹²⁶ South Carolina Department of Education, Information on Homeless Education in the State of South Carolina, Last Revision October 2009.

Resource Mapping: During fiscal year 2011, the lead child-serving agencies spent approximately \$269 million in support related programs for children.

Half of expenditures to support children were used for **targeted prevention** programs such as child support enforcement, TANF, and family literacy skills programs. Thirty-five percent of funds were spent on **services to support all children** such as programs to support teachers and parent/community partnerships in public education. **Intensive intervention** programs were 15% of expenditures and included services such as programs to facilitate the adoption of children in foster care. No funds were spent on **initial or moderate intervention**. Data suggest that when neither services to all children nor targeted prevention are provided, support services require intensive intervention.



II. Resource Mapping

A. Methodology

A resource map categorizes public spending on children.¹²⁷ This report would not have been possible without the diligent assistance of the directors and program and financial staff of several child-serving agencies. Their contributions are gratefully acknowledged.¹²⁸

Some matters are beyond the scope of this report. This report does not analyze whether children were underserved or not served at all. Limited resources may mean that services can be offered only on a limited basis or to just the most severely affected children.¹²⁹

Private expenditures for children's services paid by families, private insurance, non-profits, and faith-based groups are not included in resource mapping, despite their importance in addressing children's mental health or school readiness. In-kind and private donations to public agencies are an increasing area of interest, but are also beyond the scope of this report. As public spending has declined, agencies have leveraged in-kind donations and public-private partnerships. Examples of in-kind and public-private partnerships include:

- South Carolina First Steps: nearly \$2.5 million in in-kind services
- State Guardian ad Litem Program volunteer services: \$2.8 million.¹³⁰
- Department of Mental Health, the Department of Social Services, and the Department of Juvenile Justice have also secured significant private funding to benefit the children they serve.

Funding streams for children's services, transfers between agencies, and matching state and federal dollars are complex. Every effort has been made to avoid a duplication of dollars by considering agency cost sharing and reimbursement process. Resource mapping is a useful tool to examine expenditures to gain a broad statewide overview of critical issues, rather than to represent exact dollars spent on specific projects.

¹²⁷ Other states have prepared resource maps through grant funding, legislation, and budget allocations. This report was prepared by the Joint Citizens and Legislative Committee on Children using only existing resources. While resource maps in this state have been constructed for a specific age group or for a smaller group of agencies, never before has South Carolina had a survey of this breadth and scope at the state level. The willingness of these agencies to share what they have learned has contributed significantly to this project.

¹²⁸ Financial data were collected and coded by the Department of Alcohol and Other Drug Abuse Services, Continuum of Care, Department of Education, Department of Health and Environmental Control, Department of Juvenile Justice, Department of Mental Health, Department of Social Services, South Carolina State First Steps, South Carolina Department of Health and Human Services, and the University of South Carolina.

¹²⁹ Resource mapping does not measure program efficiency; respective agencies perform their internal quality assurance or program evaluations for that purpose. This report also does not include benefits that are not based on the presence or number of children, such as unemployment compensation benefits. Tax credits for child care expenses are important for working families, but are not included in this report.

¹³⁰ Cass Elias McCarter Guardian ad Litem Program, Office of Executive Policy and Programs, report to Guardian ad Litem Study Committee for July 1, 2010 to June 30, 2011. Volunteer guardians at litem provided 143,244 total hours of services to children at an estimated \$20 per hour.

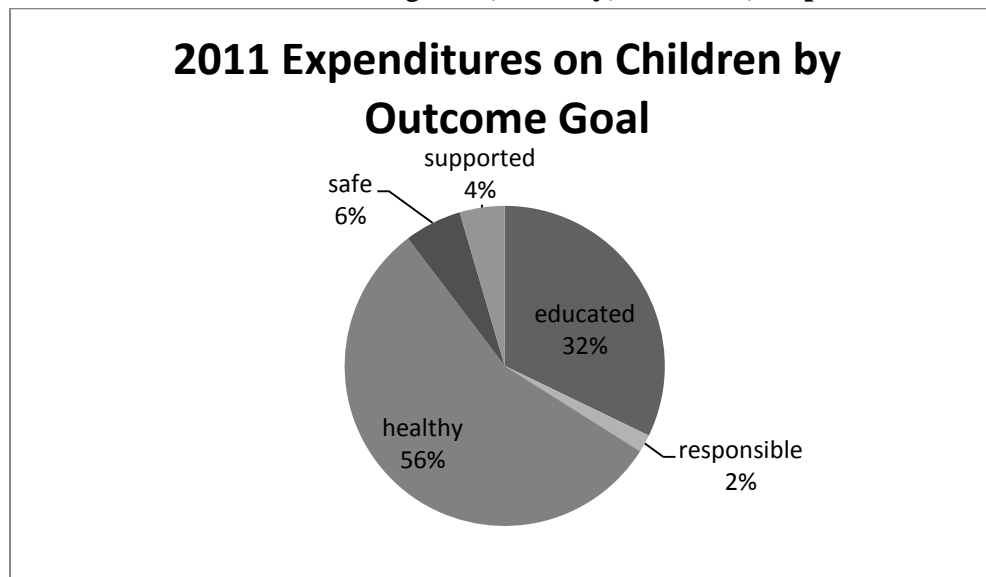
B. Presentation

Agencies were asked to exercise their informed judgment to report their expenditures in five major ways: by outcome goals; by source of funds; by programmatic focus; by location; and by ages of children served. Where programs fit into more than one category, agency staff chose the primary purpose of the program. The nature of resource mapping is that it is based upon informed, calculated financial data and estimations where necessary.

For fiscal year 2011, the South Carolina Budget and Control Board reported the total of all appropriated funds was \$21.1 billion.¹³¹ Agencies reported for this project approximately \$6.0 billion allocated towards serving children.

1. Outcome Goals

Agencies categorized expenditures into five **outcome goals** that mirror the five areas presented in indicators of child well-being: **safe**, **healthy**, **educated**, **responsible** and **supported**.



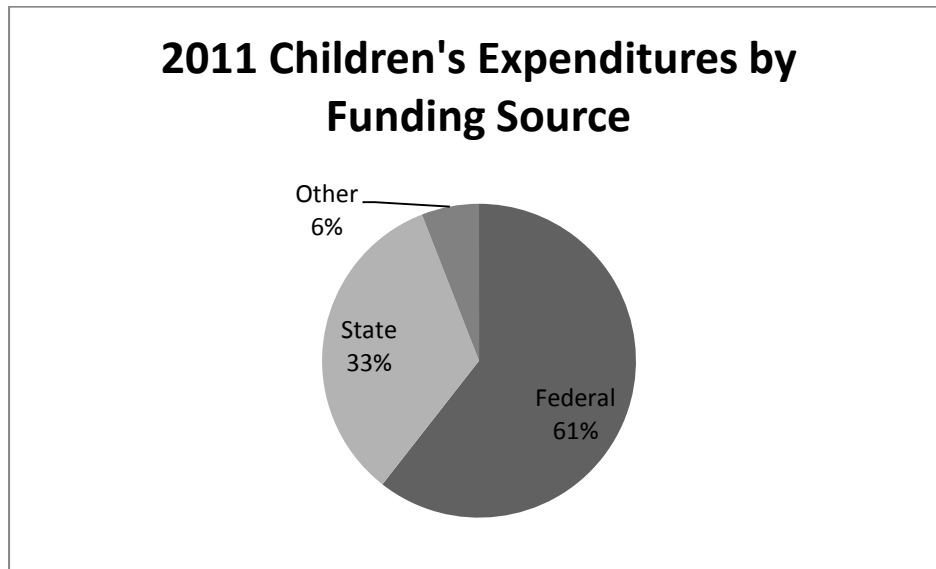
Analysis: The majority of federal, state, and other funds are spent to keep children **healthy**. These expenditures include funds for public health, health care, mental health, and nutrition programs for children. The second largest category, **educated**, is represented largely by public school funding.

Proportionately, fewer expenditures are spent to keep children **safe** such as accident prevention or child protective services, **supported** such as financial resources, and child support enforcement, home visitation and parental information services, or **responsible** such as youth employment and life skills programs promoting youth responsibility.

¹³¹ S.C. Budget and Control Board, Historical Analyses, A Compilation of Analyses of Certain Revenue, Appropriation, Expenditure, FTE, and Other Data through November 15, 2011. http://www.budget.sc.gov/webfiles/OSB/historical/FY_2011_Historical_Analyses_for_webpage.pdf (last visited January 20, 2012).

2. Source of Funds

Agencies also categorized expenditures by the **source of funds** in three basic categories. **State** funds are those appropriated by the General Assembly during the annual budget process. **Federal** funds typically include federal grants or matches. The category of **other** funds is somewhat complex and includes a blend of state and federal funds which lose their specific identity as a result of matching funds and inter-agency transfers for the purchase of services.¹³² Other funds may also include funds generated through fees or fines.



Analysis: Roughly one-third of all funds spent on children are state funds. Other and federal sources comprise the remaining two-thirds. Federal funds comprised 61% of children's expenditures.

When expenditures for public education are removed from the analysis, 73% of funds are federal. This percentage falls in line with data reported by two other states that have completed similar resource mapping analyses. For 2010, Tennessee reported 78% of funds for children were federal.¹³³ For 2011, New Mexico reported 70% of funds for children were federal.¹³⁴ Both were calculated without expenditures for public education.

¹³² For a child on Medicaid receiving services provided by a state agency, often the state pays for 30% of the service and the federal match is 70%. Depending on the federal program, several different funding formulas are possible. Some programs are 100% federally funded, others are 90% federal and 10% state, and yet others are 80% federal and 20% state. These rates vary by federal program and also from year to year. Often the South Carolina Department of Health and Human Services includes the federal match and transfers funds to the agency that provided the service. The mechanics of federal matching funds vary from agency to agency. Not all agencies follow this process.

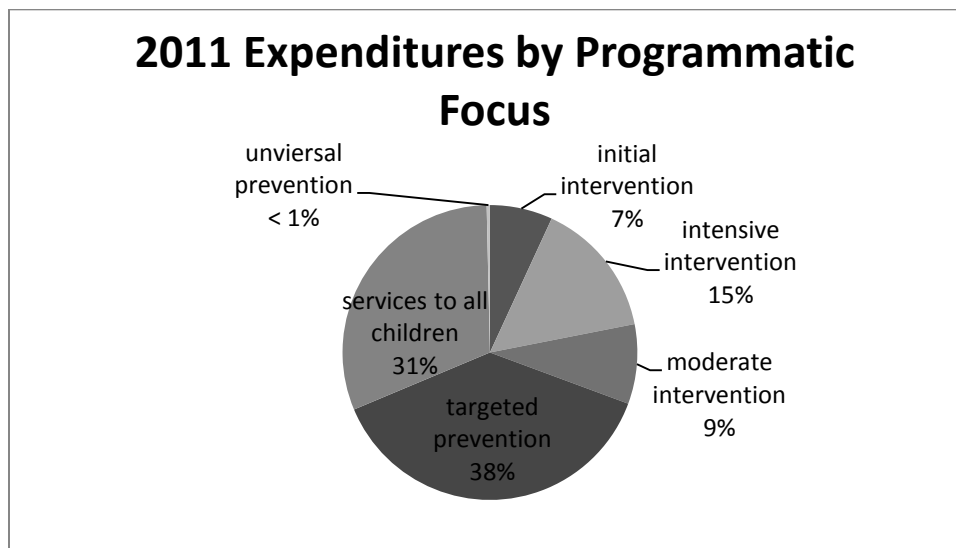
¹³³ Tennessee Commission on Children and Youth, Funding Services for Children in Tennessee, page 2, Funding Sources, excluding BEP, <http://www.tn.gov/tccy/MAP-brochure.pdf> (last visited January 23, 2012).

¹³⁴ New Mexico Children's Cabinet, 2011 Report Card & Budget Report, page 8, State vs. federal funding for children graph, http://forumfyi.org/files/2011_NMCC.pdf (last visited January 23, 2012). The figure of 70% was calculated by adding 769.8 million in state funds (which excluded public education) and 1,796.6 million to obtain a total of 2,566.4 million. The federal funds were then divided by the total.

3. Programmatic Focus

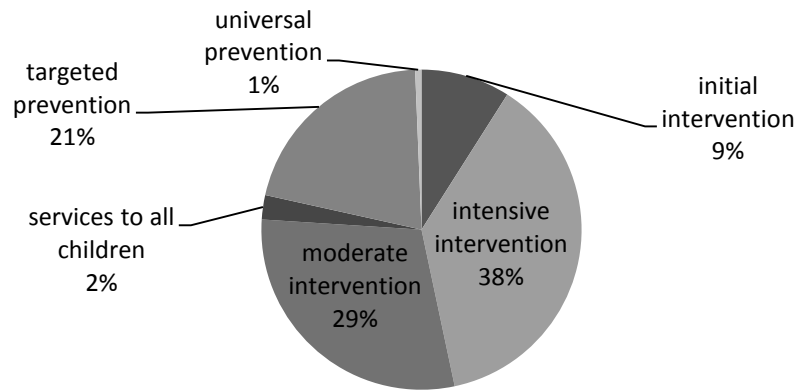
Expenditures were categorized into six **programmatic focus** categories: services to all children; universal prevention; targeted prevention; initial intervention; moderate intervention; and intensive intervention. Agencies offer an array of services at various times and levels of intensity in a child's life. Those at the top of the list require less intensive intervention than those at the bottom.

- **Services to all children** are available to any child in South Carolina, such as public education.
- **Universal prevention** services are broadly offered to prevent a certain risk such as drug abuse awareness in schools.
- **Targeted prevention** services are designed to reach a specifically identified at-risk group such as pre-kindergarten programs for children who may be unready for school.
- **Initial intervention** services are an early attempt to mitigate an identified problem.
- **Moderate intervention** services are a second step of intervention designed to prevent further negative outcomes.
- **Intensive intervention** services are an agency's most comprehensive services and generally occur when a child is not able to remain in the home or community.



Analysis: This graph presents how the total of state, federal, and other funds are allocated by programmatic focus. Over one-third of all funds are targeted to at-risk groups to prevent children's problems. Nearly one-third of all expenditures are for services to all children. The three categories of intervention (initial, moderate, and intensive) comprise slightly less than one-third of expenditures. Less than 1% of all funds are spent for universal prevention.

2011 State Expenditures by Program Focus Without Public Education



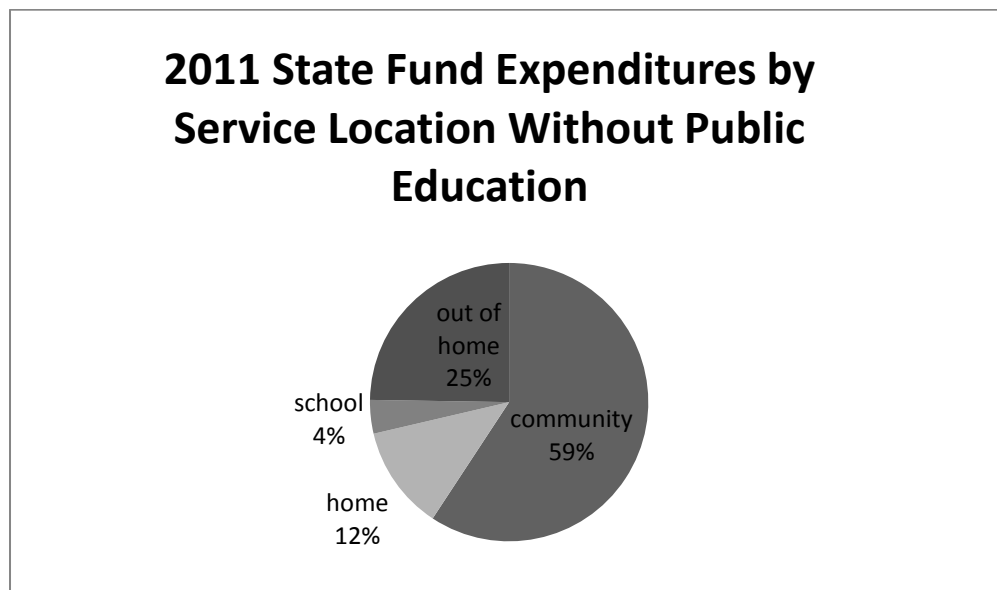
Analysis: The above graph shows a very different picture when viewing only state funds for services without public education.¹³⁵ Because prevention and early intervention programs are not funded as a first line of defense, more costly moderate and intensive intervention services are necessary. Over two-thirds of state expenditures for children are spent on moderate and intensive interventions. Approximately one-fifth of funds are spent on targeted prevention.

¹³⁵ Approximately half of all expenditures for children are for public education. For purposes of looking at state allocation of resources for all other services to children, State Department of Education and all federal expenditures are removed.

4. Service Delivery Location

Agencies categorized services into four locations based on the **service delivery location**: home, school, community, or out-of-home. Certain services may be provided in homes, communities, or schools and other less costly community-based settings. Services may also be more effective, less expensive, and more convenient depending on where the service is provided.

- **Home** services include in-home early intervention and visitation programs.
- **School** services include after school mentoring programs and school-based mental health counseling services during the school day.
- **Community** services occur when the child is still living with a parent or guardian and are not provided in the home or at school. Examples include well child visits at a doctor's office or treatment at a community mental health center.
- **Out-of-home** services occur when a child is not living with a parent or guardian and include services provided in a residential placement or inpatient and residential treatment center.

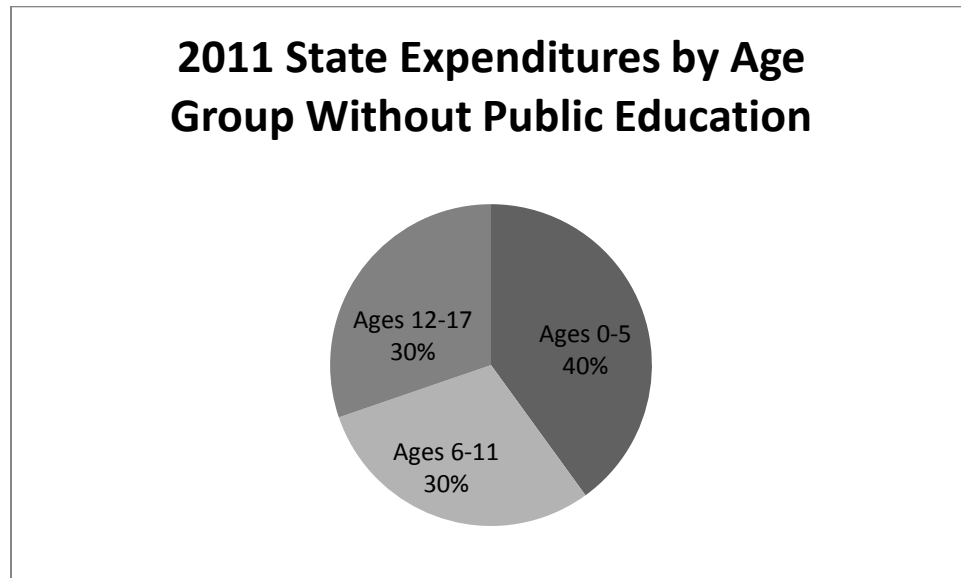


Analysis: This graph shows only state funds for services other than public education.¹³⁶ Over one-half of state expenditures for services are in the community; one-fourth are for out-of-home services; and very few expenditures are for in-home or school services.

¹³⁶ Approximately half of all expenditures for children are for public education. For purposes of looking at state allocation of resources for all other services to children, State Department of Education and all federal expenditures are removed.

5. Ages of Children Served

Agencies categorized expenditures into three **age groups of children served**: **early childhood** which is birth through age five; **middle childhood** which is age six through eleven; and **adolescence** which is age twelve through seventeen.



Analysis: This graph shows only state funds for services other than those reported by the State Department of Education.¹³⁷ Slightly more expenditures are made for children ages birth through age five than are made for children in middle childhood and adolescence. Funding interventions early in life are crucial and many programs address the birth through age five age group; however, state expenditures are not significantly directed towards children in this age group.

¹³⁷ Approximately half of all expenditures for children are for public education. Because the majority of school aged children are in middle childhood and adolescence, when including State Department of Education expenditures, those age groups are overrepresented. For purposes of looking at state allocation of resources for all other services to children, State Department of Education and all federal expenditures are removed.

IV. Findings and Recommendations of the Committee:

A. Findings

- Sound public policy that promotes healthy child well-being must holistically consider many diverse factors which influence how well a child develops emotionally and physically.
- Taken together, the indicators which measure the status of child well-being and the report of expenditures of state funds identify numerous children's issues and provide opportunities to develop substantive policy.
- The impacts of childhood trauma are pervasive; and, if unidentified and untreated will have a profoundly negative effect on the person's life and will enhance the likelihood they will need state funded services for support and care. For starters, undiagnosed child trauma affects physical health, academic achievement, teen pregnancy, and juvenile crime.¹³⁸ Ultimately, these factors can contribute to adulthood dependence on state services. State services in education, child protection, health, courts, and juvenile justice should consider identification and treatment of childhood trauma to promote more positive outcomes and to help direct resources toward early treatment rather than later intensive interventions.
- Selected, significant **indicators of child well-being** in South Carolina:

Safety: Non-fatal injuries of children are increasing, particularly for adolescents. The overall number of child fatalities is decreasing. The number of children living in foster care is decreasing. The most recently available data from 2009 indicates that there were at least 37 children who died due to unsafe sleeping conditions. There are likely more, as 213 cases were reported to SLED that year, but because investigations have not been completed at the time of printing, they have not been brought to the South Carolina State Child Fatality Advisory Committee.¹³⁹ According to the 1999-2002 South Carolina State Child Fatality Advisory Committee Records, 188 child deaths were associated with unsafe sleeping arrangements.¹⁴⁰

Health: The high number of children who are obese or overweight poses a significant health concern for the state. Fewer children are receiving needed mental health treatment. The number of very low birth weight babies has declined. The percent of two-year-olds who received recommended vaccinations has decreased.

Education: Participation in public pre-kindergarten has increased. However, the NAEP scores of children in the 4th grade remain below the national average.

¹³⁸ S.C. Joint Citizens and Legislative Committee on Children, Summary of Testimony 2011 Public Hearings. <http://www.sccommitteeonchildren.org/doc/PublicHearingFinalReport.pdf>. (last visited January 30, 2012).

¹³⁹ S.C. State Child Fatality Advisory Committee, Child Deaths due to Unsafe Sleeping Conditions. unpublished report generated February 1, 2012.

¹⁴⁰ S.C. KidsCount, Children Ages 0-4 Are Most Susceptible to Unintentional Injury and Death. <http://www.sckidscount.org/report05/cdeath05.php> (last visited, February 1, 2012).

Responsible: Youth employment has declined. The number of juveniles charged with criminal offenses (both status offenses and criminal offenses) has declined. The number of births to teens has declined.

Supported: Nearly one-half of the children in South Carolina live in families that are categorized as poor or low income. The number of these children has increased during the recession, and their many and interrelated needs give rise to significant public needs and state expenditures.

- **Resource mapping** of children's expenditures in south Carolina shows the following:

Of the state funds appropriated for children, health costs represent over one-half of the expenditures for programs such as health care, public health, and nutrition.

The state often delays action when a child's problem is at a developmental stage; and, at a later date, the state funds a more expensive and intensive intervention rather than intervene early to provide less intensive, preventive interventions which are less costly and more effective.

State expenditures for the early childhood age group are only slightly higher than expenditures for middle childhood and adolescence age groups, despite research touting the benefits of early intervention.

B. Recommendations of the Committee on Children

The information contained in this report confirms that South Carolina frequently reacts to children's issues far too late in a child's life, at the point in time too far beyond when the need initially arose, and with too few and inadequately coordinated resources.

The data of indicators of child well-being and resource mapping in this report inform us that South Carolina expends some funds to sustain the poor status quo of children which could be more wisely spent on preventive care and early intervention services.

To impact identified needs and to encourage an emphasis on more effective, less costly preventive services, the Committee on Children recommends an initial focus of state efforts and resources to respond to specific topical areas. Based upon the three frameworks presented in this report, the Committee recommends immediate action in the following four focus areas:

Immunizations

The testimony of healthcare providers presented at the Committee on Children's public hearings in September 2011, expressed significant concern regarding the number of preventable childhood diseases that occur in children. Children on Medicaid and children with high quality health insurance receive immunizations; however, many children living just above poverty do

not have adequate insurance coverage that pays for recommended immunizations. Such non-immunized children are exposed to costly long term illnesses and place other children and adults at risk of contracting their illnesses. **The Committee on Children recommends that a comprehensive initiative be undertaken to secure the immunization of all children and prevent unnecessary childhood illness.**

Safe Sleeping for Infants

The death of an infant caused by the accidental rollover of an adult when the two are sleeping together is preventable. Such a death may occur when an adult shares a bed with an infant and during sleep, the adult rolls over on top of the baby causing its suffocation. Good work is currently being done to educate and create public awareness of the risk of unsafe sleeping practices which has the potential to prevent infant deaths, and this work needs to be expanded. **The Committee on Children recommends that a comprehensive initiative be undertaken to coordinate and mobilize the resources of state and private resources to prevent infants from dying from unsafe sleeping practices.**

Childhood Obesity

Testimony presented at the Committee's public hearings reported that childhood obesity is reaching epidemic levels and that many children face related numerous and costly life-long effects. Testimonial evidence confirmed that improved nutrition and increased exercise among children will decrease the numbers of obese and overweight youth. Should the state fail to address this problem, it will result in unnecessary and significant long term costs to the state for public support and health care as these children become adults. Children living in poverty generally experience poor nutrition which contributes to their obesity. **The Committee on Children recommends that a comprehensive initiative be undertaken to improve nutrition and to involve children in physical activities which promote healthy lifestyles.**

“Trauma Informed” Practices

Testimony from the Committee’s public hearings and extensive research confirm that when a child experiences trauma in childhood which is not resolved, the long range effects of the trauma will haunt the child’s healthy development. The effects of childhood trauma caused by abuse, neglect, or family violence are often misdiagnosed as acting out or behavior issues. As a result of experiencing trauma, younger children may be irritable, aggressive, or distracted,¹⁴¹ and older children may engage in self-destructive or reckless behaviors.¹⁴² When child trauma is properly diagnosed, a child can receive appropriate treatment for the underlying issue and avoid spiraling downward into an aftermath of preventable problems. “Trauma informed” practices for schools, child protection and treatment systems, courts, and juvenile justice will lead to more positive outcomes and save the state the cost of unnecessary and more intensive interventions which are proven to be more costly and less successful. **The Committee on Children recommends that a comprehensive initiative be undertaken to overlay “trauma informed” practices for state services which properly diagnose and treat childhood trauma as positive steps toward healthy child development.**

¹⁴¹ National Child Traumatic Stress Network, The Effects of Trauma on Schools and Learning, <http://www.nctsn.org/resources/audiences/school-personnel/effects-of-trauma#q2> (last visited January 19, 2012).

¹⁴² Id.

Appendix A

The Children's Policy of South Carolina

The General Assembly enacted the Children's Policy for South Carolina to affirm that all laws and regulations to provide for children's services should strengthen and encourage family life, serve and protect all children. This Policy applies to all children including those who are mentally, socially, economically, physically, developmentally, culturally, educationally, or economically disadvantaged or disabled; those who are neglected or abused; and those who violate the laws of South Carolina and are in need of rehabilitation.¹⁴³

The Children's Policy of South Carolina includes the following as guiding principles for children's services:

- Prevent children's problems
- Encourage community involvement in the provision of services
- Maximize resources and coordinate children's services
- Strengthen and encourage family life
- Serve children in the least restrictive environment
- Protect children from harm
- Unify children with their families
- Place permanently and facilitate adoption for children who cannot return home
- Provide child services based on the greatest need

These guiding principles direct state leaders to concentrate efforts and resources on preventing children's problems as the most important strategy for children and their families.¹⁴⁴

The Children's Policy of South Carolina Provides:

The State shall encourage community involvement in the provision of children's services including, as an integral part, local government, public and private voluntary groups, public and private nonprofit groups and private-for-profit groups in order to encourage and provide innovative strategies for children's services. To maximize resources in providing services to children in need, all agencies providing services to children shall develop methods to coordinate their services and resources. For children with multiple needs, the furtherance of this policy requires all children's services agencies to recognize that their jurisdiction in meeting these children's needs is not mutually exclusive.¹⁴⁵

When children or their families request help, state and local government resources shall be utilized to compliment community efforts to help meet the needs of children by aiding in the prevention and resolution of their problems. The State shall direct its efforts first to strengthen and encourage family life as the most

¹⁴³ S.C. Code Ann. §63-1-20(B) (2010).

¹⁴⁴ S.C. Code Ann. §63-1-20(D) (2010).

¹⁴⁵ S.C. Code Ann. §63-1-20(C) (2010).

appropriate environment for the care and nurturing of children. To this end, the State shall assist and encourage families to utilize all available resources. For children in need of services, care and guidance the State shall secure those services as are needed to serve the emotional, mental and physical welfare of children and the best interests of the community, preferably in their homes or the least restrictive environment possible.¹⁴⁶

When children must be placed in care away from their homes, the State shall insure that they are protected against any harmful effects resulting from the temporary or permanent inability of parents to provide care and protection for their children. It is the policy of this State to reunite the child with his family in a timely manner, whether or not the child has been placed in the care of the State voluntarily. When children must be permanently removed from their homes, they shall be placed in adoptive homes so that they may become members of a family by legal adoption or, absent that possibility, other permanent settings.¹⁴⁷

The children's policy provided for in this chapter shall be implemented through the cooperative efforts of state, county and municipal legislative, judicial and executive branches, as well as other public and private resources. Where resources are limited, services shall be targeted to those children in greatest need.¹⁴⁸

¹⁴⁶ S.C. Code Ann. §63-1-20(D) (2010).

¹⁴⁷ S.C. Code Ann. §63-1-20(D) (2010).

¹⁴⁸ S.C. Code Ann. §63-1-20(E) (2010).

Appendix B

2012 Data Workbook

To survey the status of children across five main areas of priority for healthy development: safe, healthy, educated, involved, and supported and nurtured, a total of 39 indicators were collected. These indicators were selected to address all priority areas and measure across childhood lifespan. When possible, indicator data was broken into three age groups: 1) early childhood--ages birth through five, 2) middle childhood--ages six through eleven, and 2) adolescence--ages twelve through seventeen. This section contains detailed information about each of the Committee on Children's 39 indicators.

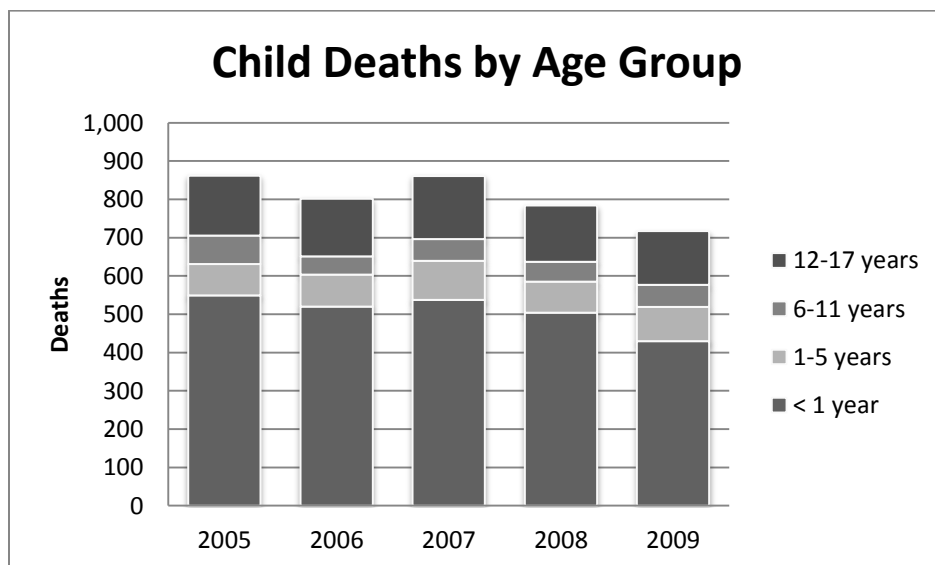
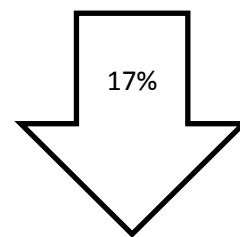
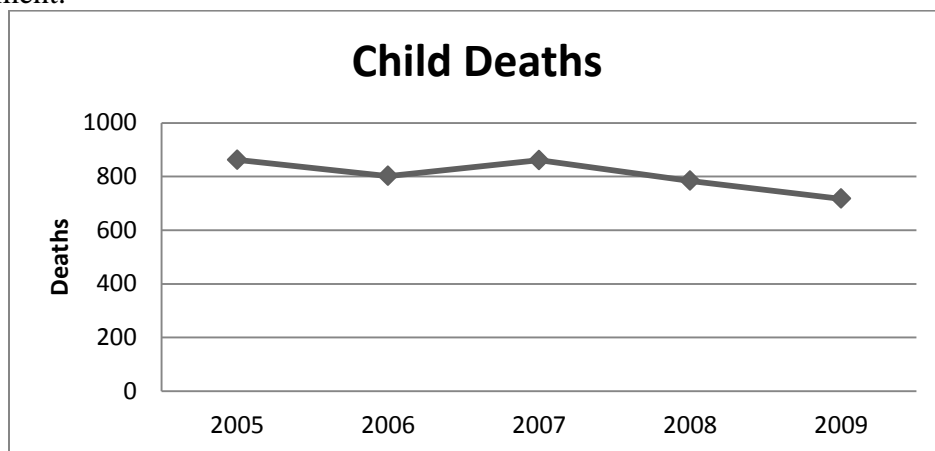
1. Index of Safety Indicators				
Indicator		Data from Earliest Year ¹⁴⁹	Data from Latest Available Year	Percent Change from Earliest to Latest Available Year
1a. Total Child Deaths		862	717	-17% ↓
1b. Non-fatal Injuries		94,837	102,950	+9% ↑
1c. Children with Founded Maltreatment ¹⁵⁰		12,358	11,802	n/a ↑
1d. Selected Founded Maltreatment Types ¹⁵¹	Physical Abuse	1,680	1,498	-11% ↓
	Neglect	8,127	5,381	-34% ↓
	Sexual Abuse	411	390	-5% ↓
1e. Total Children in Foster Care		5,150	3,797	-26% ↓
Rate of Children in Foster Care		5	3.5	n/a
1f. Children Leaving Foster Care to Live with a Family		3,067	3,356	+9% ↑
1g. Absence of Maltreatment Within 6 Months of Case Closure		5,051	5,569	10% ↑
Percent of Children Absent Maltreatment Within 6 Months of Case Closure		97.2%	96.8%	-.4% ↔
1h. Adult and Child Victims of Domestic Violence		52,001	52,023	+.04% ↔

¹⁴⁹ Either four or five years of data is presented for each indicator. The earliest year of data collection is 2006 and the latest is 2011.

¹⁵⁰ This indicator represents the number of children with founded maltreatment. "Maltreatment" includes abuse, neglect and other types of harm that children experience at the hands of a parent, guardian, or other person responsible for the child's welfare. The Department of Social Services categorizes maltreatment into the following types of cases: abandonment, contributing to the delinquency of a minor, educational neglect, medical abuse, medical neglect, mental injury, neglect, other, physical abuse, sexual abuse, threat of harm abandonment, threat of harm contributing to the delinquency of a minor, threat of harm educational neglect, threat of harm medical neglect, threat of harm mental injury, threat of harm neglect, threat of harm physical abuse, threat of harm sexual abuse.

¹⁵¹ The number of physical abuse, physical neglect and sexual abuse maltreatments make up between 41% and 73% of all founded maltreatments for 2007-2011.

1a. Child Deaths: Child fatalities are the number of children who died due to illness, accident, or maltreatment.¹⁵²

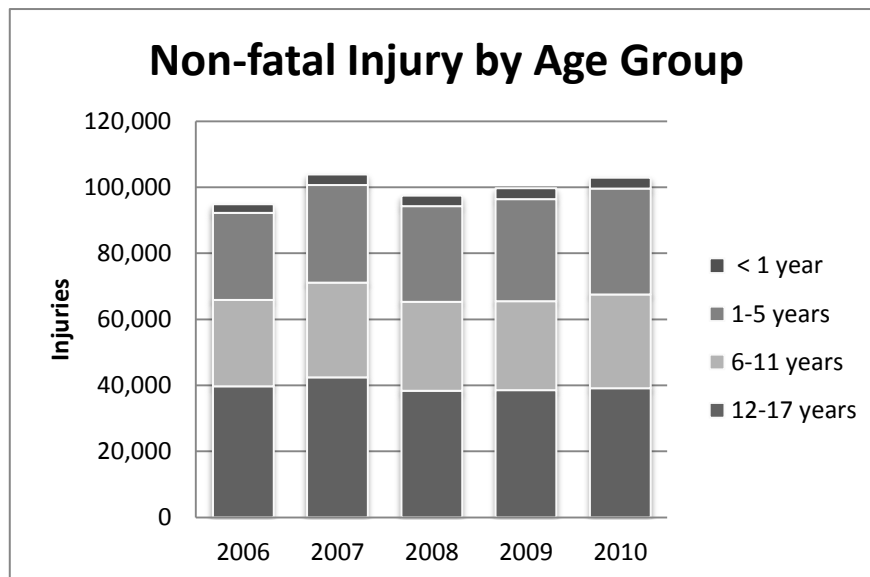
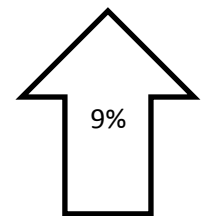
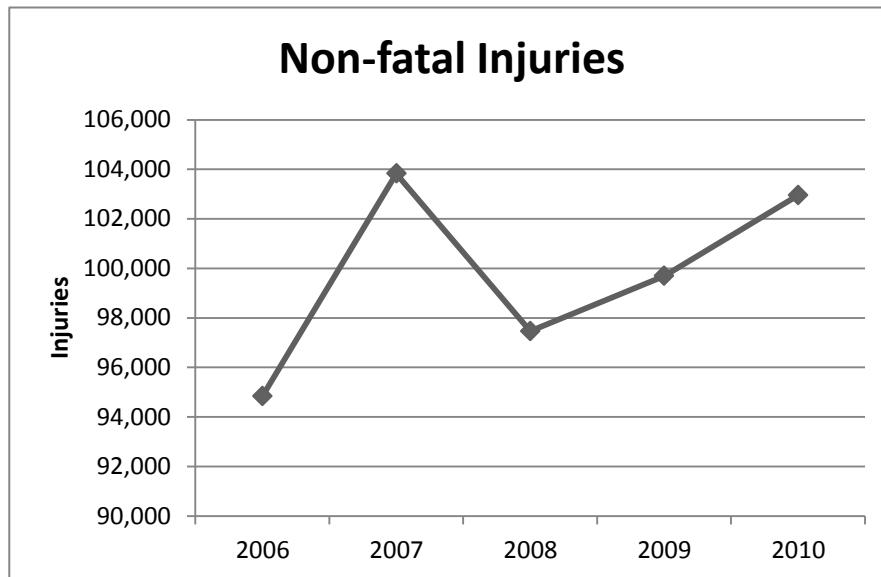


Relevance: From 2005 to 2009 the number of child fatalities in South Carolina decreased 17%. In 2009, 20 of these child fatalities occurred to children who were in the in custody of the state or in out of home treatment facilities.¹⁵³ This number includes child deaths that occur due to illness, maltreatment, homicide or suicide.

¹⁵² S.C. Department of Health and Environmental Control, unpublished report generated December 2011, Child Fatalities by Age Group.

¹⁵³ Number compiled using data from published sources and all state agencies with residential facilities for children. U.S. Department of Health and Human Services Administration for Children and Families Administration on Children Youth and Families Children's Bureau, Child Maltreatment 2010. <http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf> (last visited, February 22, 2012).

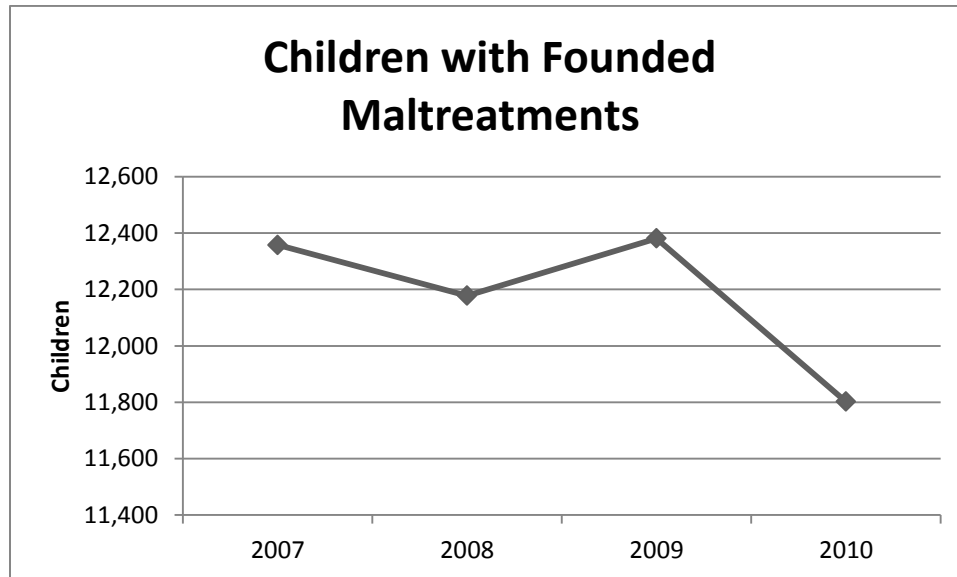
1b. Non-Fatal Injuries: Non-fatal injuries include accidental and intentional injuries that do not result in death.¹⁵⁴ Injuries vary in severity and cause.



Relevance: From 2006 to 2010, injuries to children increased 9%. Adolescents ages 12 through 17 are most likely to suffer injuries.

¹⁵⁴ S.C. Department of Health and Environmental Control, unpublished report generated December 2011, Child Injuries by Age Group.

1c. Children with Founded Maltreatment¹⁵⁵: When a report of child abuse or neglect is made to the Department of Social Services (DSS), an investigation determines whether the allegation is founded.¹⁵⁶ “Maltreatment” includes abuse, neglect, or other categories and refers to the unduplicated number of children.¹⁵⁷



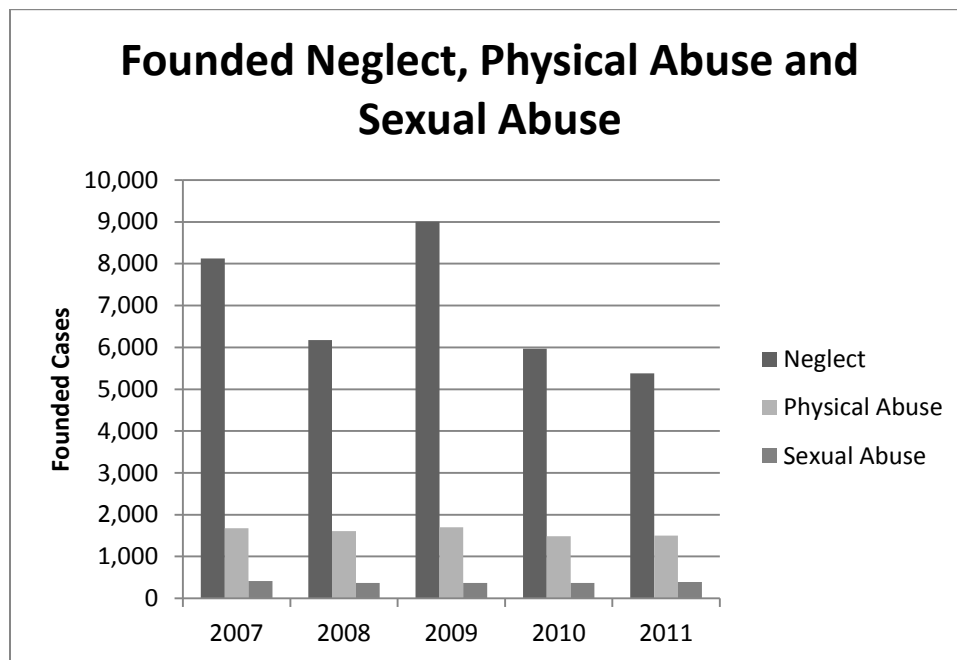
Relevance: Founded maltreatment has remained consistent since 2007 in number of cases and the age of child. Younger children and those with special needs are more likely to be victims of abuse and neglect. From 2007 to 2010, there has been a -4% decrease in the number of children with founded maltreatments, which is a negligible change.

¹⁵⁵“Maltreatment” includes abuse, neglect and other types of harm that children experience at the hands of a parent, guardian, or other person responsible for the child’s welfare. The Department of Social Services categorizes maltreatment into the following types of cases: abandonment, contributing to the delinquency of a minor, educational neglect, medical neglect, mental injury, neglect, other, physical abuse, sexual abuse, threat of harm abandonment, threat of harm contributing to the delinquency of a minor, threat of harm educational neglect, threat of harm medical neglect, threat of harm mental injury, threat of harm physical abuse, threat of harm sexual abuse.

¹⁵⁶ S.C. Department of Social Services, unpublished report: Children in Founded CPS Investigations During SFYs based on determination date. Generated December 2011. In order to have consistent format, data from CAPSS on November 2011 was used to compile reports for SFY 2007 through 2011.

¹⁵⁷ CSFR 2005-2010.

1d. Founded Maltreatment Types by Abuse, Neglect, and Other:¹⁵⁸ Founded maltreatments that children experience has been broken into three broad categories: physical abuse, neglect, and sexual abuse.¹⁵⁹



Relevance: Consistently, neglect cases comprise the majority of founded maltreatments in South Carolina. Nationally, neglect has been difficult to define which has caused inconsistencies nationally in policies, practice, and research.¹⁶⁰ The South Carolina Department of Social Services is has recognized the high prevalence of neglect cases and continues to improve data collection and practices in responding to neglect cases.¹⁶¹

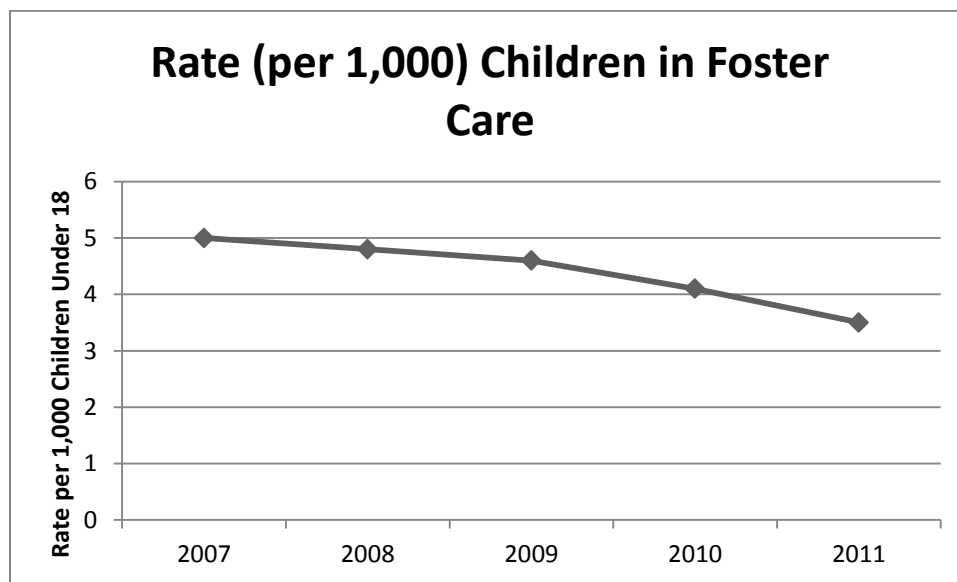
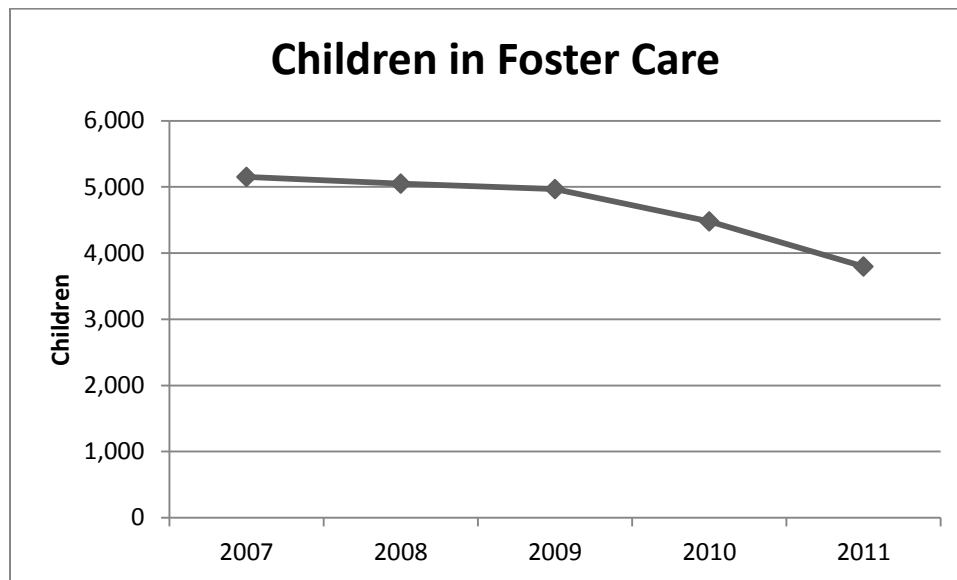
¹⁵⁸ S.C. Department of Social Services, CPSI Maltreatment Types Founded for Fiscal Years 2008-2011, <https://dss.sc.gov/content/library/statistics/cw/subcatdesc.aspx?ID=8> (last visited, January 23, 2012).

¹⁵⁹ S.C. Department of Social Services, South Carolina Child and Family Services Review Data Profiles: 2005-2010.

¹⁶⁰ U. S. Department of Health and Human Services, Administration for Children and Families, Office of Child Abuse and Neglect, Child Neglect: A Guide for Prevention, Assessment, and Intervention, 2006. <http://www.childwelfare.gov/pubs/usermanuals/neglect/neglect.pdf> (last visited January 18, 2012).

¹⁶¹ S.C. Department of Social Services, Palmetto Power Meeting on October 27, 2011.

Children in Foster Care: Children in foster care is the number of children in the custodial care of the Department of Social Services who have been removed from their parents or guardians.¹⁶² These children may be in the care of foster families, group homes, or other placements.

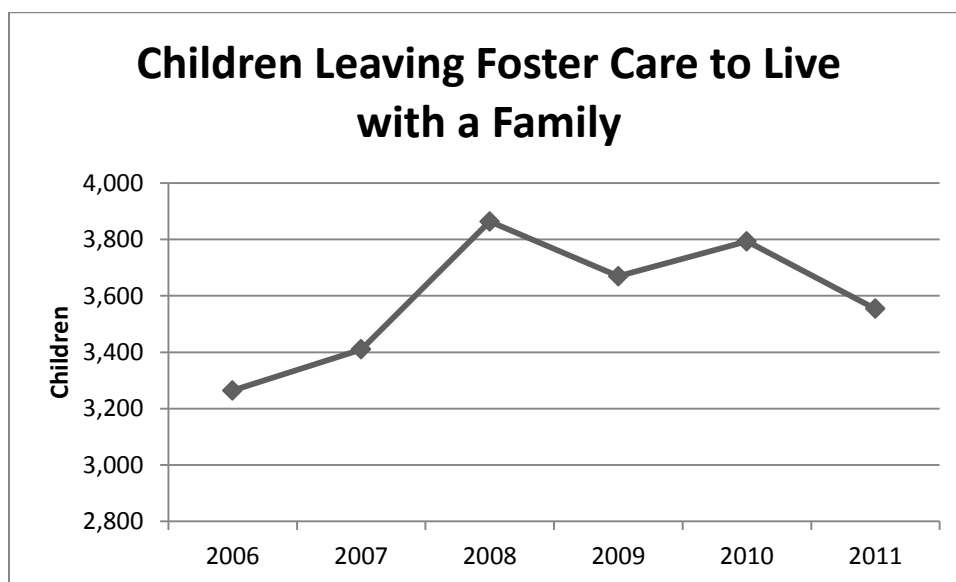


Relevance: From 2007 to 2011, there was a 26% decrease in the number of children in foster care for all ages. From 2007 to 2011 the number of founded physical abuse, sexual abuse and neglect cases has decreased as well. Since 2010, the reduction in foster care can be attributed largely to greater numbers of children exiting care than they enter care. From 2007 to 2010, the

¹⁶² S.C. Department of Social Services, unpublished report generated November 2011. Total Children in Foster Care on the Last Day of the SFY. In order to have consistent format, data from CAPSS on November 1, 2011, was used to compile the reports for SFY 06-07 through SFY 10-11.

number of children in foster care has decreased by 16% nationally, and South Carolina has followed the national trend with a decrease of 13%.¹⁶³

1f. Children Leaving Foster Care to Live with a Family: When a child leaves foster care with a successful resolution to the abuse or neglect case and placement with a family, the closure is called a “positive permanency outcome.”¹⁶⁴ Children may leave foster care for four positive reasons: returned to original caregiver, adoption, guardianship and living with a relative.



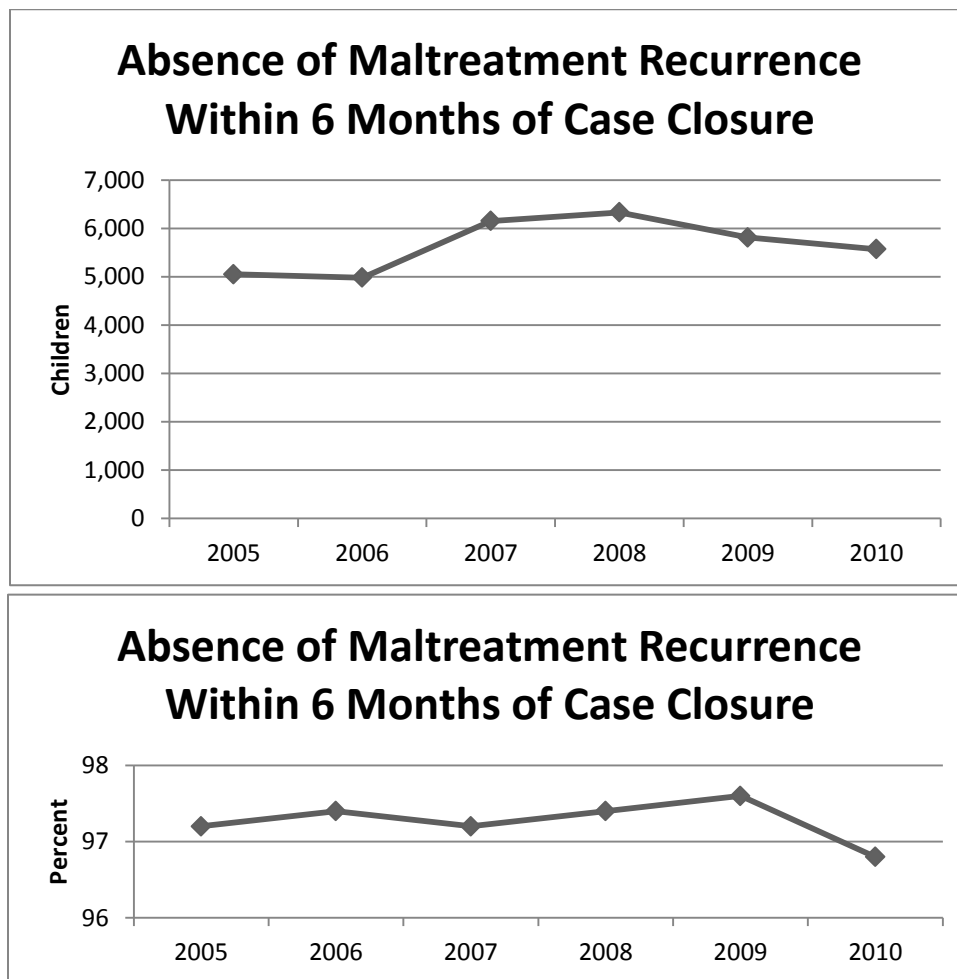
Relevance: Since 2007, there has been an overall 9% increase in the number of positive permanency outcomes. Identified goals of the Department of Social Services have been to increase the number of children with a permanent family.¹⁶⁵ With this mission, the agency has engaged a number of program initiatives and activities to increase the number of children who have a permanent family. While there has been an overall increase in the number of children leaving foster care to live with a family since 2006, there has been a decline since 2008, which was the year with the highest number of children exiting care to positive permanency.

¹⁶³ Casey Family Programs, Foster Care by Numbers, <http://www.casey.org/press/mediakit/pdf/FosterCareByTheNumbers.pdf> (last visited, February 15, 2012).

¹⁶⁴ S.C. Department of Social Services, unpublished report generated November 2011. Children Leaving Foster Care for Positive Closure Reasons. In order to have consistent format, data from CAPSS on November 1, 2011, was used to compile the reports for SFY 06-07 through SFY 10-11.

¹⁶⁵ S. C. Department of Social Services, Children in Our Care, DSS Imperatives, Data and Strategies, July 2011.

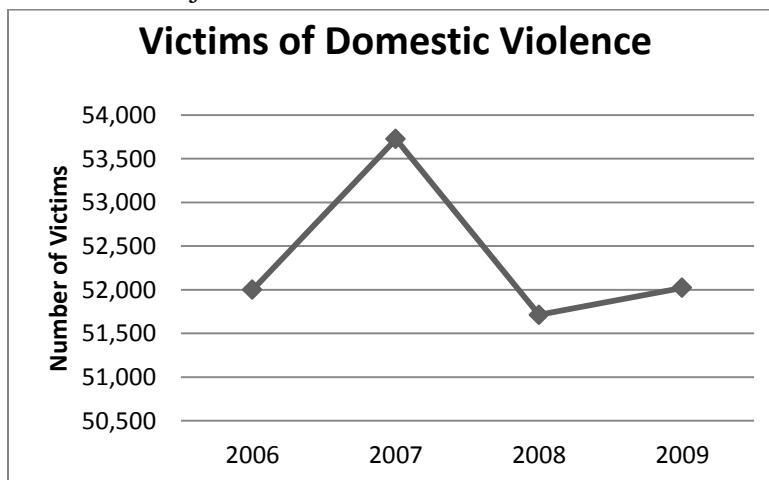
1g. Absence of Maltreatment Recurrence: This indicator examines the reoccurrence of maltreatment after the child protective services case has been closed.¹⁶⁶ Once a child's case is closed, if no further abuse or neglect occurs within six months then there is absence of maltreatment.



Relevance: This indicator shows an increase in the raw number of children who are not abused or neglected again within six months after the family's interaction with the Department of Social Services. The goal of services for families is to address the reasons the abuse or neglect occurred and prevent abuse or neglect in the future. Increases in this indicator may be influenced by effective Department of Social Services interventions. The second graph takes into account the total number of cases closed during the year and the pool of eligible children for recurrence of abuse within 6 months. The second graph illustrates a slight increase in recurrence of maltreatment from 2009 to 2010, however this change is less than 1% and is therefore negligible.

¹⁶⁶ S.C. Department of Social Services, unpublished report generated November 2011. Foster Children Who Returned Home During the Previous SFY (SFY 06-07) Showing the Number and Percent of Children Who Re-Entered Foster Care During the 12 Months Following their Return Home. In order to have consistent format, data from CAPSS on November 1, 2011, was used to compile the reports for SFY 06-07 through SFY 10-11.

1h. Victims of Domestic Violence: Domestic violence is defined as murder, negligent homicide, rape, sexual assault, robbery, aggravated assault, simple assault or intimidation where the victim was married at any time to or was romantically involved with the offender, or involved family relationships by blood or marriage other than spouses.¹⁶⁷ The victims included in this graph represent adult and juvenile victims.



Relevance: From 2006 to 2009, there has not been a significant change in the number of victims of domestic violence. Currently, there is no statewide data on the number of children who experience domestic violence in South Carolina, but estimates have been generated based on population from 2005 through 2009.¹⁶⁸ From 2005 through 2009 there were 27,709 victims of domestic violence under the age of 18, or approximately 10% of all victims from years 2005 through 2009 were under the age of 18.¹⁶⁹

Research has demonstrated that domestic violence has lasting impacts on children. These impacts fall into three main categories: behavioral, social and emotional; cognitive and attitudinal; and long term relationship problems.¹⁷⁰ Although specific data is not available for the number of children who witness domestic violence, its impact on children is significant and affects children's future relationships, health and cognitive functioning.¹⁷¹ The effects of witnessing violence for children are significant. Agencies which serve children often deal with the aftermath of early childhood traumatic events that occurred in unhealthy and violent family environments. When child trauma is properly diagnosed, children can receive treatment for the underlying issue. Interventions to reduce domestic violence will have positive effects for children in the areas of mental health, child abuse, and juvenile justice.








¹⁶⁷ S.C. Department of Public Safety Office of Justice Programs, Rule of Thumb: A Five Year Overview of Domestic Violence in South Carolina 2005-2009.

¹⁶⁸ Id. Sources for this data published by S.C. Department of Public Safety Office of Justice Programs include: SCIBRS, SLED, population estimates, and ORS.

¹⁶⁹ Id.

¹⁷⁰ U.S. Department of Health and Human Services, Children and Domestic Violence and Bulletin for Professionals. <http://www.childwelfare.gov/pubs/factsheets/domesticviolence.cfm> (last visited, January 13, 2012). And "Emotional Injury and Recovery in Children Exposed to Domestic Violence" Workshop Session 3 presentation by Vickie Bourus, MSW, LISW. Children's Law Center Annual Conference 2011 "Childhood Trauma: Seeking Positive Outcomes." November 4, 2011.

¹⁷¹ Id.

2. Index of Health Indicators				
Indicator		Data from Earliest Year ^{172 173}	Data from Latest Available Year ¹⁷⁴	Percent Change from Earliest to Latest Available Year
2a. Low Birth Weight Babies		5,895	6,057	+3% 
2a. Very Low Birth Weight Babies		1,195	1,111	-7% 
2b. Low Birth Weight Babies Born to Mothers on Medicaid		2,896	2,614	n/a
2b. Very Low Birth Weight Babies Born to Mothers on Medicaid		579	615	n/a
2c. Immunizations		82%	73%	
2d. Children on Medicaid with Access to Primary Care Practitioners ¹⁷⁵	1-2 years	96.1	97.6	n/a
	2-6 years	80.4	86	n/a
	7-11 years	78.7	87.6	n/a
	12-17 years	74.7	84.7	n/a
2e. Children with a Mental Health Diagnosis in Community Treatment Centers		34,102	30,614	-10% 
2f. Children Receiving Mental Health Treatment by Delivery Location	School Setting	13,310	11,518	-13% 
	Community Treatment Center (includes school setting)	34,102	30,614	-10% 
	Inpatient and Residential	533	506	-5% 
2g. Treatment for Drug and Alcohol Abuse		3,040	2,693	-11% 
2h. High School Children who are ¹⁷⁶	Overweight	14%	16%	n/a
	Obese	13%	13%	n/a

¹⁷² Either four or five years of data is presented for each indicator. The earliest year of data collection is 2005 and the latest is 2011.

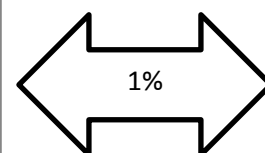
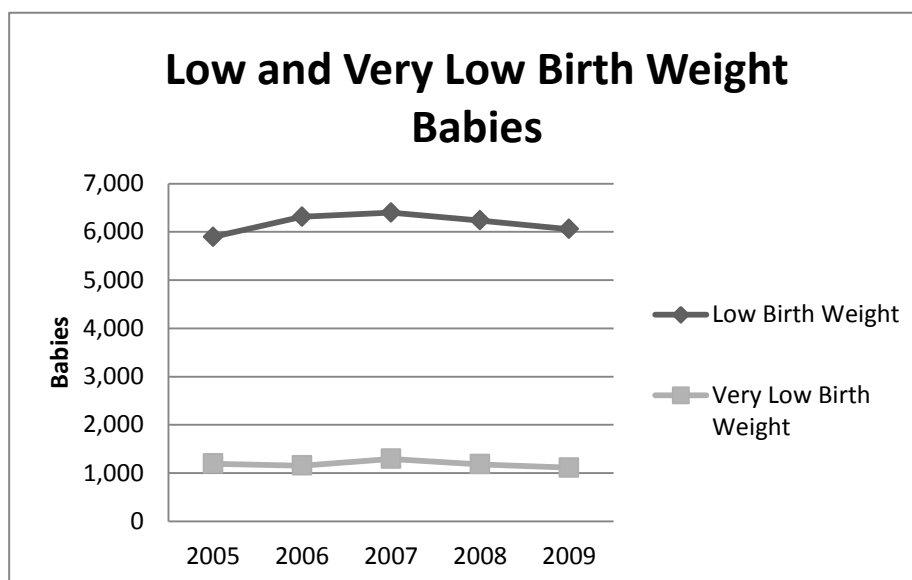
¹⁷³ In some cases percent of children in a specific population is more informative and is used instead.

¹⁷⁴ In some cases percent of children in a specific population is more informative and is used instead.

¹⁷⁵ This indicator is measured in state weighted rate. The state weighted rate refers to the rate of the South Carolina Medicaid population enrolled in the health care plan. This provides more detailed information about the impact of the measure on our state. This is different from a percentage which is always represented as a proportion of 100.

¹⁷⁶ Office of Health and Nutrition South Carolina Department of Education, 2011 Youth Risk Behavior Survey Results: High School Student Trend Analysis Report. (not available online as of January 25, 2012).

2a. Low and Very Low Birth Weight Babies: Low birth weight is divided into two categories: low and very low birth weight. Low birth weight babies weigh between 1,500 (three pounds, four ounces) and 2,499 grams (five pounds, eight ounces) at birth. Very low birth weight babies weigh less than 1,500 grams (three pounds, four ounces).¹⁷⁷ Data was collected using DHEC interactive table SCANGIS, this indicator measures the low and very low birth weight babies born to all women in South Carolina hospitals.¹⁷⁸



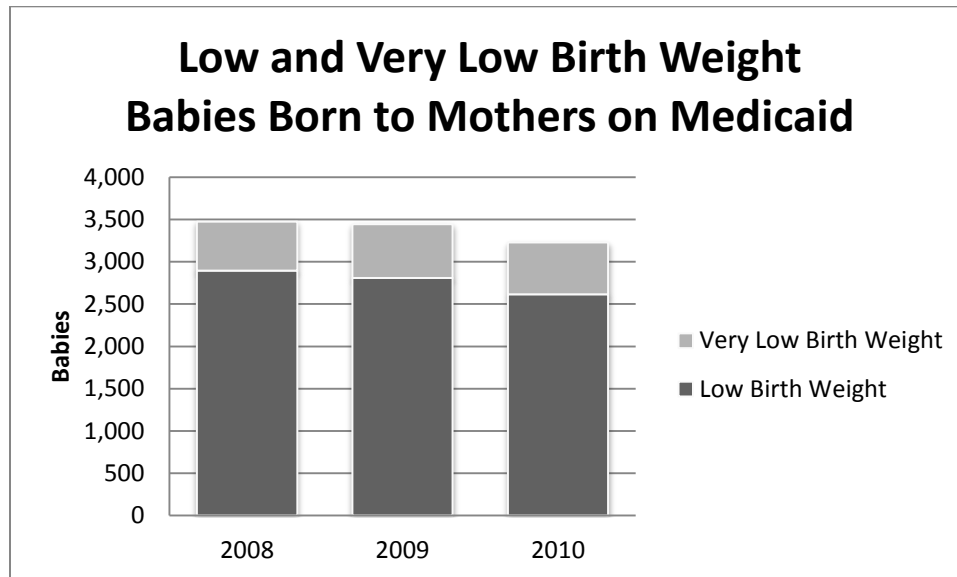
Relevance: There has not been a significant change in the number of low and very low birth weight babies from 2005 through 2009. Low and very low birth weight babies comprise 10% of all births in South Carolina.¹⁷⁹

¹⁷⁷ Child Trends DataBank, <http://www.childtrendsdatabank.org/?q=node/67>, (last visited January 11, 2012).

¹⁷⁸ S. C. Department of Health and Environmental Control, <http://scangis.dhec.sc.gov/scan/CommunityProfile/input.aspx>, (last visited January 9, 2012).

¹⁷⁹ Holmes, Baron, South Carolina Kids Count, The Wrong Start: Adverse Birth Outcomes, July 2008.

2b. Low Birth Weight Babies Born to Mothers on Medicaid: Low and very low birth weight babies¹⁸⁰ born to mothers on Medicaid are a subset of all low birth weight babies.¹⁸¹



Relevance: The number of low and very low birth weight babies born to mothers on Medicaid is decreasing slightly since 2008, however low birth weight babies are at greater risk of death within the first month of life and are susceptible to chronic illness, psychological and emotional distress.¹⁸² The recently announced Screening, Brief Intervention and Referral to Treatment (SBIRT)¹⁸³ program designed to improve diagnosis of substance abuse, depression, and domestic violence for pregnant mothers on Medicaid is a promising intervention to improve outcomes for low and very low birth weight babies.

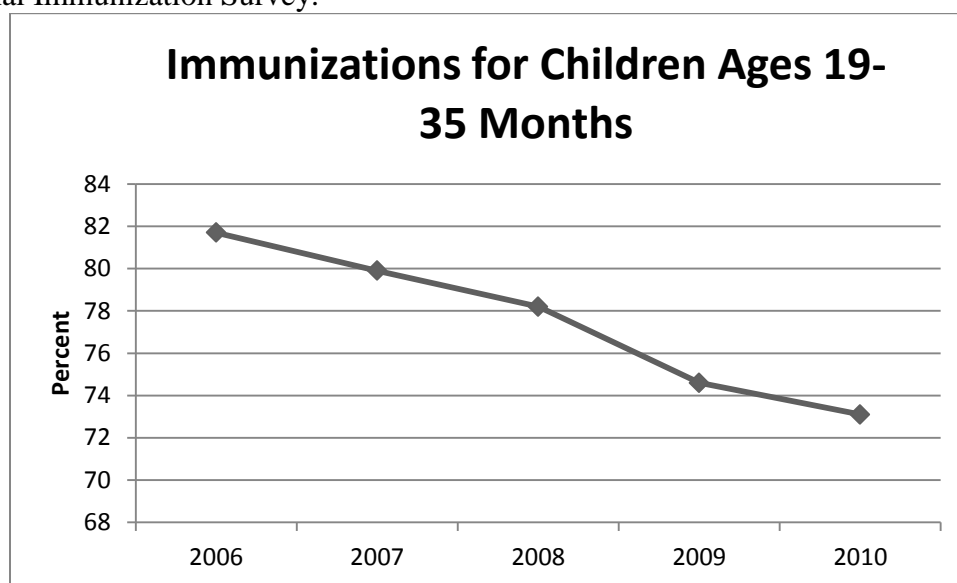
¹⁸⁰ Low birth weight is divided into two categories: low and very low birth weight. Low birth weight babies weigh between 1,500 (three pounds, four ounces) and 2,499 grams (five pounds, eight ounces) at birth. Very low birth weight babies weigh less than 1,500 grams (three pounds, four ounces).

¹⁸¹ The Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, University of South Carolina, South Carolina. Unpublished report, Low and Very Low Birth Weight Babies Born to Mothers on Medicaid. Generated January 2012.

¹⁸² Center for Health Transformation, Healthy Babies, http://www.healthtransformation.net/cs/healthy_babies (last visited, January 30, 2012).

¹⁸³ The State, New State Program Aims to Improve Health of Moms, Babies, January 17, 2012 <http://www.thestate.com/2012/01/17/2117569/new-state-program-aims-to-improve.html#storylink=misearch> (last visited January 19, 2012).

2c. Immunizations: The Center for Disease Control recommends children are vaccinated against serious illness around the age of two. An estimate of the children who have completed the combination of recommended vaccines between 19 to 35 months has been compiled using the National Immunization Survey.^{184 185}



Relevance: Since 2006 there has been a steady decrease in the immunization coverage of children ages 19 to 35 months in South Carolina. This decrease in immunizations results in the increase of vaccine preventable illness in children that are more devastating to the child's long term health, and more costly to treat. Children who are not receiving the full recommended vaccination are at increased risk of contracting and spreading these contagious, yet preventable diseases. An unsustainable human and financial cost will burden our state if children are not inoculated against these diseases. Those who are at particular risk are children without a medical home, and those who are underinsured.¹⁸⁶ Initial data do not show an increase in many vaccine-preventable diseases since 2006. However, from 2007 to 2010, there was a 320% increase in the rate of Pertussis which can be fatal to infants.¹⁸⁷

Mandating that South Carolina insurance companies cover vaccinations and preventative care at first dollar coverage will eliminate the lack of access to vaccinations that children who are underinsured often face.¹⁸⁸ Some children who can prove they meet the federal definition of underinsured can access vaccinations through DHEC county offices. Often, it is difficult to access vaccinations without confirmation that insurance will cover them. This takes a great deal of time, and puts many children at risk of contracting and spreading preventable diseases.

¹⁸⁴ S.C. Department of Health and Environmental Control. Immunization Coverage for Children in South Carolina FY 2006-2010. Unpublished report generated January 2012.

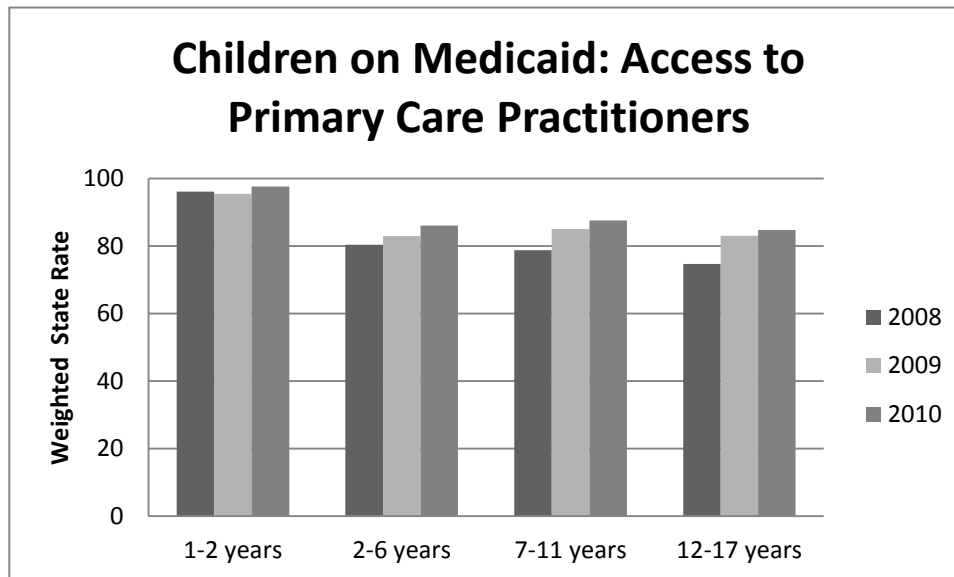
¹⁸⁵ The recommended combination of vaccines is commonly referred to as the 431331 combination (4 DTap, 3 Polio, 1 MMR, 3 Hep B, 3 HIB and 1 Var).

¹⁸⁶ S.C. Joint Citizens and Legislative Committee on Children. Summary of Testimony 2011 Public Hearings. <http://www.sccommitteeonchildren.org/doc/PublicHearingFinalReport.pdf> (last visited January 27, 2012).

¹⁸⁷ S.C. Chess, Vaccine Preventable Diseases in South Carolina, unpublished report generated February 2012.

¹⁸⁸ S.C. Joint Citizens and Legislative Committee on Children. Summary of Testimony 2011 Public Hearings. <http://www.sccommitteeonchildren.org/doc/PublicHearingFinalReport.pdf> (last visited January 27, 2012).

2d. Children on Medicaid: Access to Primary Care Practitioners: The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures for the health care industry.¹⁸⁹ This HEDIS measure shows ages of children who have access to a primary care practitioner. Access to primary care can reduce the number of ambulatory health services, making treatment timely and less costly.¹⁹⁰ This indicator is based on the state health plan's eligible population for that age group. Because the number of children eligible for Medicaid can fluctuate, a rate provides more information than a total number of children.

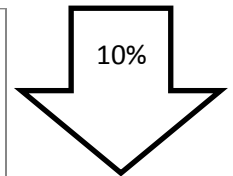
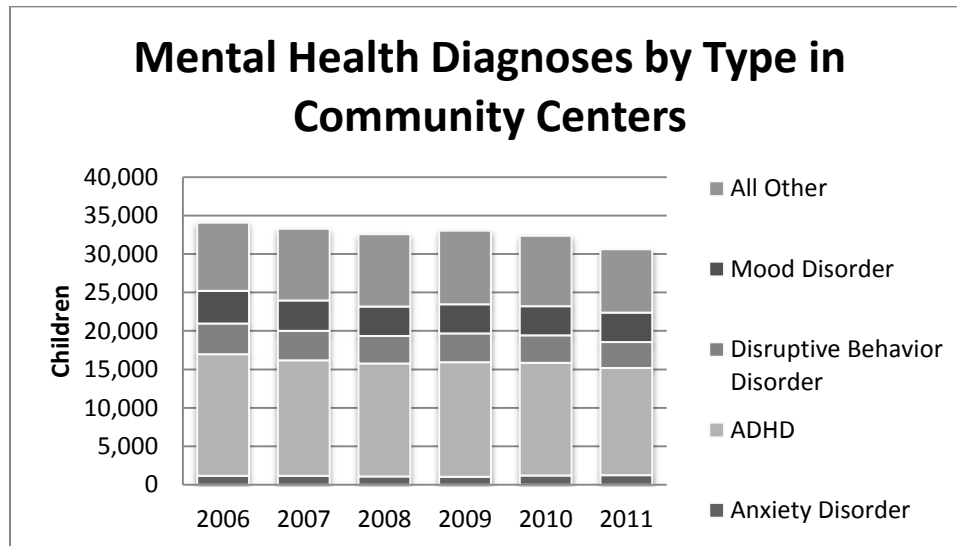


Relevance: This indicator shows that as children on Medicaid age, they are less like to have access to a primary care provider. Comparing 2008, 2009 and 2010, however, all age groups have improved access to primary care practitioners. Access to primary care practitioners helps children stay current on immunizations, provide opportunities for early detection and developmental screenings, track healthy growth and development, reduce the number of emergency visits for routine illnesses, and encourage children to maintain a healthy lifestyle.

¹⁸⁹ National Committee for Quality Assurance, What is HEDIS?, <http://www.ncqa.org/tabid/187/Default.aspx> (last visited January 19, 2012).

¹⁹⁰ The Institute for Families in Society, Policy and Research Unit on Medicaid and Medicare, University of South Carolina, South Carolina Medicaid Health Care Performance CY 2010: A Report on Quality, Access to Care, and Customer Experience and Satisfaction. September 2011.

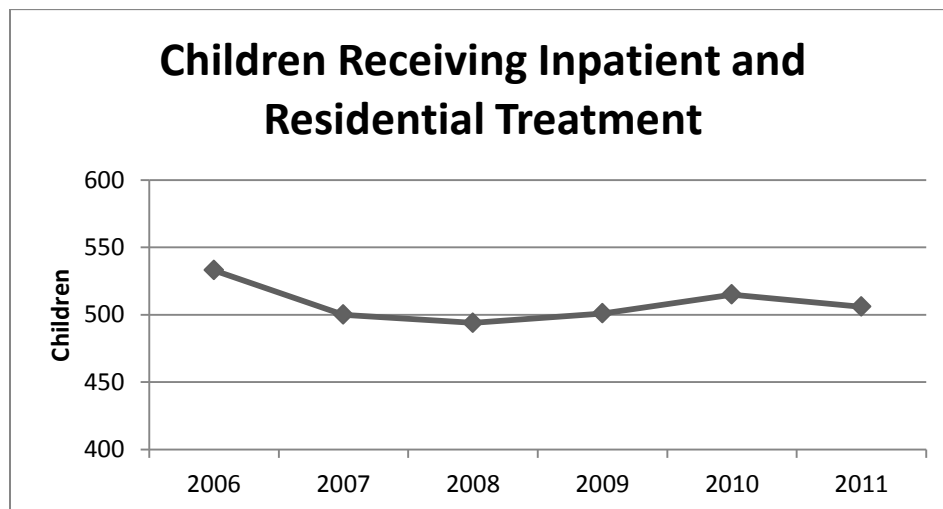
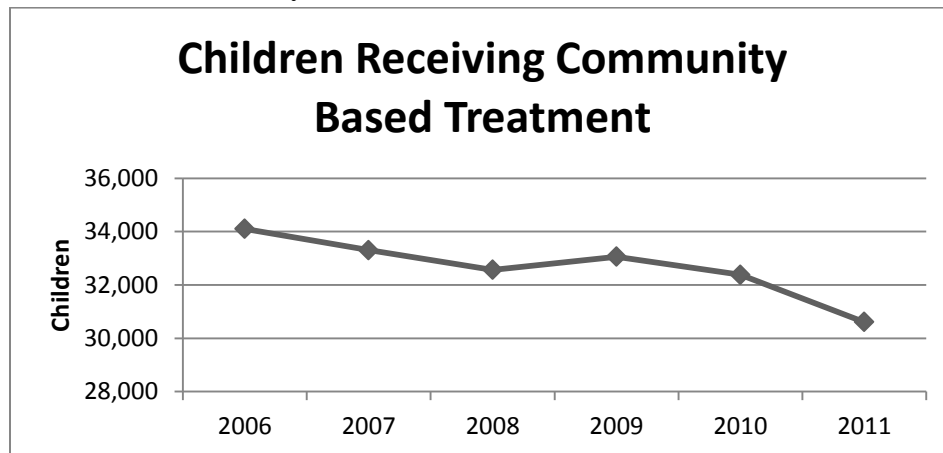
2e. Children with a Mental Health Diagnosis in Community Treatment Centers: Mental health is central to positive relationships, appropriate behavior, and academic success. This indicator illustrates the number of children treated in Department of Mental Health community mental health centers with a diagnosis Attention Deficit Hyperactivity Disorder (ADHD), disruptive behavior disorder, mood disorders, and other types of mental health diagnoses.¹⁹¹



Relevance: Consistently, ADHD is the most common child and adolescent mental health diagnosis. The total number of children with mental health diagnoses treated in public mental health centers has decreased 10% since 2006.

¹⁹¹ S.C. Department of Mental Health, Unpublished report generated December 2011, Mental Health Diagnoses in Children Served in Community Centers.

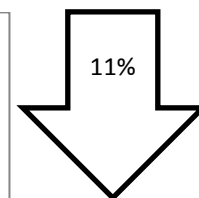
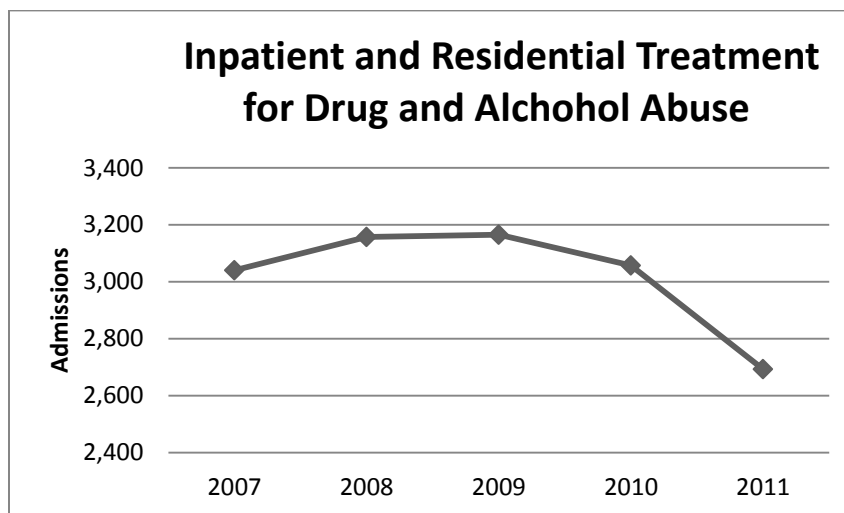
2f. Children Receiving Mental Health Services by Location: This indicator illustrates the number of children receiving inpatient or residential treatment and community mental health treatment, which includes school based services, through the Department of Mental Health.¹⁹² Because children may receive services in multiple locations throughout a fiscal year, these delivery locations are not mutually exclusive.



Relevance: Overall, the number of children receiving mental health treatment has decreased since 2006 as budget restrictions limit capacity. Far more children receive community treatment, which includes school based services, than inpatient or residential treatment.

¹⁹² S.C. Department of Mental Health, Children Receiving Mental Health Treatment by Service Delivery Location. Unpublished report generated December 2012.

2g. Treatment for Drug and Alcohol Abuse: This indicator presents the number of children under the age of 18 who received inpatient, residential or outpatient treatment for drug and alcohol abuse.¹⁹³



Relevance: Since 2007, there has been a decrease in the number of children who were treated for drug abuse.

Self reported data from South Carolina high school students indicated there is less drug and alcohol use among youth. The Youth Risk Behavior Survey (YRBS), given to high school students in odd numbered years, monitors six types of health-risk behaviors that contribute to the leading causes of death among youth.¹⁹⁴ South Carolina has seen reductions in the numbers of students who consumed five or more drinks in a couple of hours at least once in the past 30 days, used marijuana at least once in the past 30 days, and used any form of cocaine, such as crack, at least once in the past 30 days and the number of students who received illegal drugs on school property with the past 12 months.¹⁹⁵ Conversely, the YRBS indicated a slight increase in the number of students who sniffed glue, breathed in aerosol, or inhaled paints to get high.¹⁹⁶ No data is available on drugs such as bath salts and synthetic marijuana.

Reductions in the number of children receiving treatment for drug use may be due to an actual decline in drug use consistent with the YRBS data above, but may also be due to budget cuts for these services.

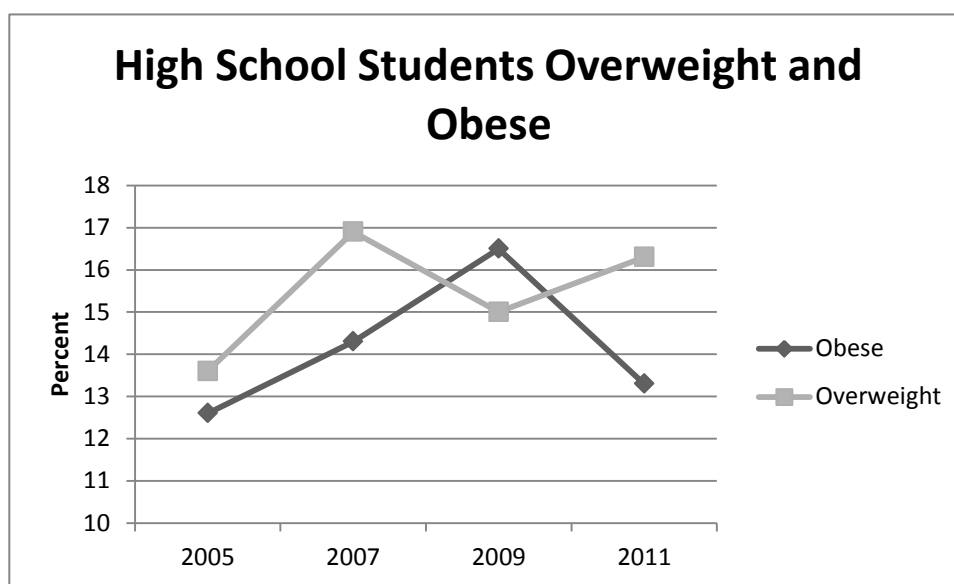
¹⁹³ S.C. Department of Alcohol and Other Drug Addiction Services, unpublished reports “Inpatient Treatment for Drug Abuse” generated November 2011.

¹⁹⁴ Centers for Disease Control and Prevention, Adolescent and School Health, <http://www.cdc.gov/HealthyYouth/yrbs/index.htm> (last visited January 18, 2012).

¹⁹⁵ Office of Health and Nutrition South Carolina Department of Education, 2011 Youth Risk Behavior Survey Results: High School Student Trend Analysis Report. (not available online as of January 25, 2012)..

¹⁹⁶ Office of Health and Nutrition South Carolina Department of Education, 2011 Youth Risk Behavior Survey Results: High School Student Trend Analysis Report. (not available online as of January 25, 2012)..

2h. Overweight High School Students: Data collected from the YRBS refers to students who are greater than or equal to the 85th percentile in weight, but less than the 95th percentile for body mass index (BMI) based on age and sex.¹⁹⁷ **Obese High School Students:** Data collected from the YRBS refers to students who are greater than or equal to the 95th percentile rank for body mass index (BMI) based on age and sex.¹⁹⁸





Relevance: According to the most recently available data from the Youth Risk Behavior Survey in 2011, 30% of high school students are either obese or overweight. Particular areas may have even higher rates. According to DHEC in one county, 58.7% of all 8th graders were obese or overweight.¹⁹⁹

¹⁹⁷ Office of Health and Nutrition South Carolina Department of Education, 2011 Youth Risk Behavior Survey Results: High School Student Trend Analysis Report. (not available online as of January 25, 2012).

¹⁹⁸ Office of Health and Nutrition South Carolina Department of Education, 2011 Youth Risk Behavior Survey Results: High School Student Trend Analysis Report. (not available online as of January 25, 2012).

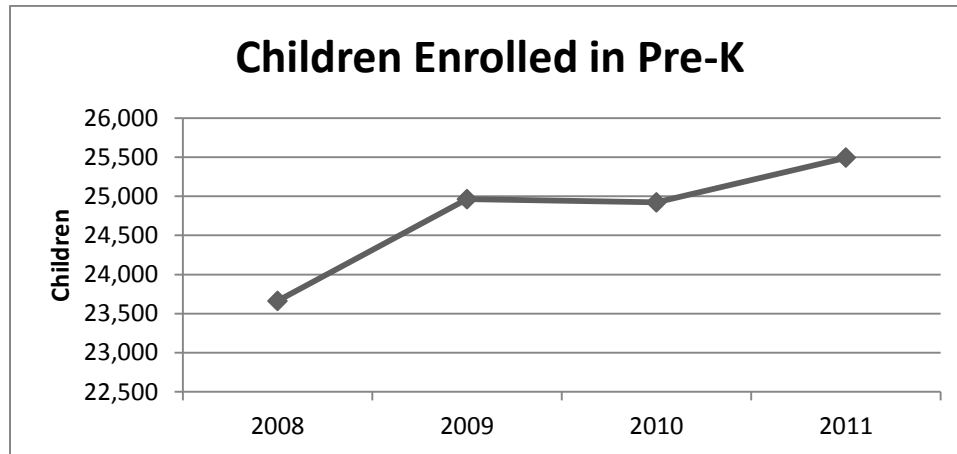
¹⁹⁹ S.C. Department of Health and Environmental Control, 2011 South Carolina Obesity Burden Report, <https://www.scdhec.gov/health/epidata/docs/Obesity%20Burden%20Report%202011.pdf> (last visited January 18, 2012).

3. Index of Education Indicators			
Indicator	Data from Earliest Year ²⁰⁰ 201	Data from Latest Available Year	Percent Change from Earliest to Latest Available Year
3a. Children Enrolled in Public Pre-K	23,187	24,954	+8% 
3b. Children with a Disability	97,783	94,216	-4% 
3c. Average 4th Grade NAEP Reading Score	215	215	n/a
3d. Average 4th Grade NAEP Math Score	236	237	n/a
3e. Average 8th Grade NAEP Reading Score	258	260	n/a
3f. Average 8th Grade NAEP Math Score	277	281	n/a
3g. Third Grade PASS Scores			n/a
Writing	Exemplary	40%	
	Met	29%	
	Not Met	31%	
English and Language Arts	Exemplary	46%	
	Met	32%	
	Not Met	22%	
Math	Exemplary	31%	
	Met	36%	
	Not Met	33%	
3h. Eighth Grade PASS Scores			n/a
Writing	Exemplary	26%	
	Met	42%	
	Not Met	32%	
English and Language Arts	Exemplary	29%	
	Met	39%	
	Not Met	33%	
Math	Exemplary	24%	
	Met	39%	
	Not Met	37%	
3i. Graduation Rate	75%	74%	n/a

²⁰⁰ Either four or five years of data is presented for each indicator. The earliest year of data collection is 2003 and the latest is 2011.

²⁰¹ Some indicators are most informative when the average scale score or the percent of an eligible population is presented instead of raw number of children.

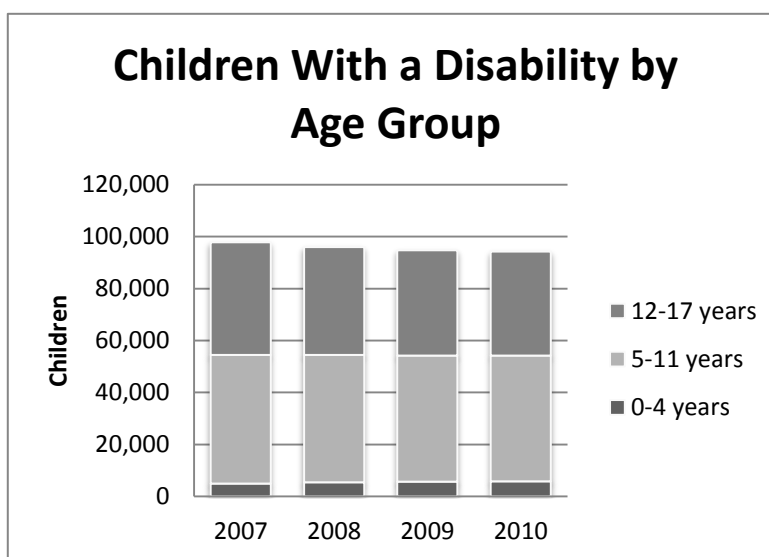
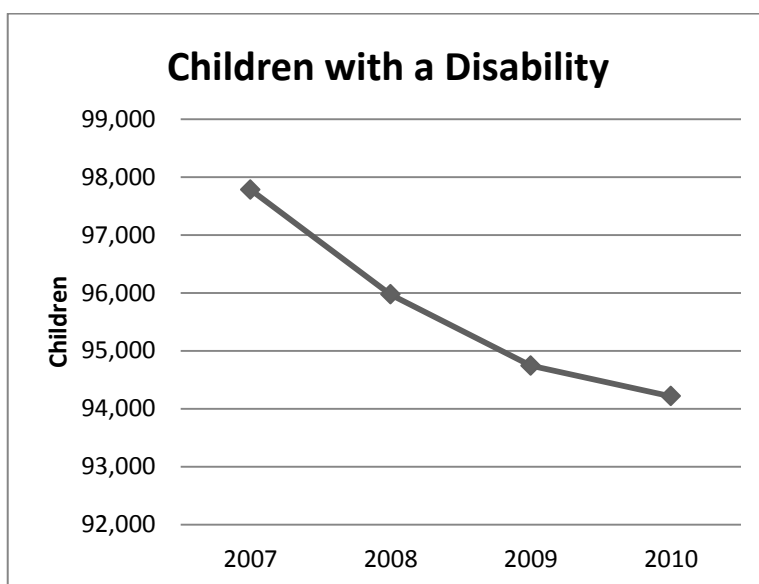
3a. Children Enrolled in Public Pre-K: Children participating in public three and four-year-old pre-kindergarten are included in this indicator.²⁰² This group includes both three and four-year-olds and children attending private pre-kindergarten programs only if paid with CDEPP funds.



Relevance: An increasing number of children are participating in publicly funded pre-kindergarten programs.

²⁰² S.C. Department of Education, unpublished report, Children Enrolled in 3 and 4 Year Old Pre-Kindergarten. generated December 2011.

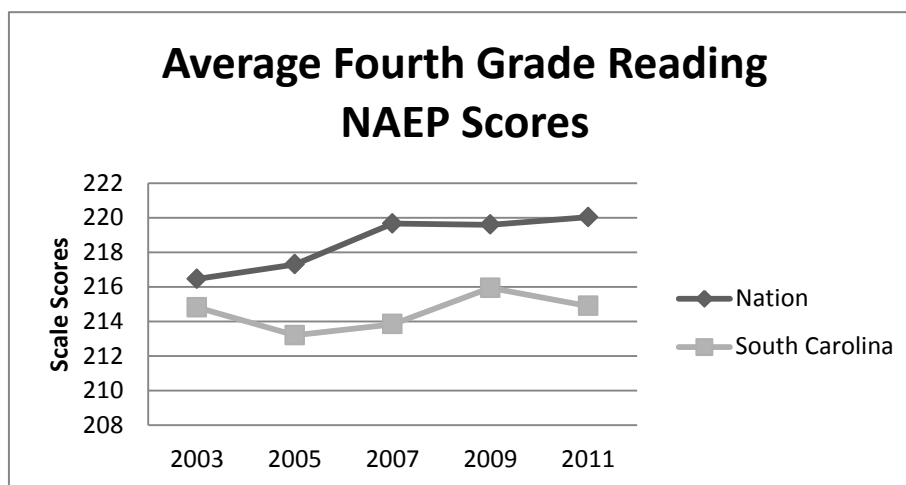
3b. Children with a Disability: Children with disabilities may be eligible for special education services and have an individualized education program to ensure they receive a free appropriate public education. Special education eligibility categories include autism, deaf and hard of hearing, deaf and blind, developmental delays, emotional disability, intellectual disabilities, multiple disabilities, orthopedic impairments, other health impairments, specific learning disabilities, speech and language impairment, traumatic brain injury, and visual impairments.²⁰³



Relevance: The number of children with individualized education programs has steadily decreased since 2007. Some of this decrease for children with more mild impairments may be due increased participation in pre-kindergarten programs and early intervention programs. However, the decline may also be due to fewer resources to serve children with disabilities.

²⁰³ S.C. Department of Education, unpublished report, Children Receiving Special Education Services. generated December 2011.

3c. Average Fourth Grade NAEP Scores in Reading: This indicator shows the average scale score that fourth grade students in South Carolina earned on the NAEP as compared to the national average. The National Assessment of Educational Progress (NAEP) reports comprehensive information regarding what fourth, eighth, and twelfth grades students have learned and their performance levels in various subject areas.^{204 205}



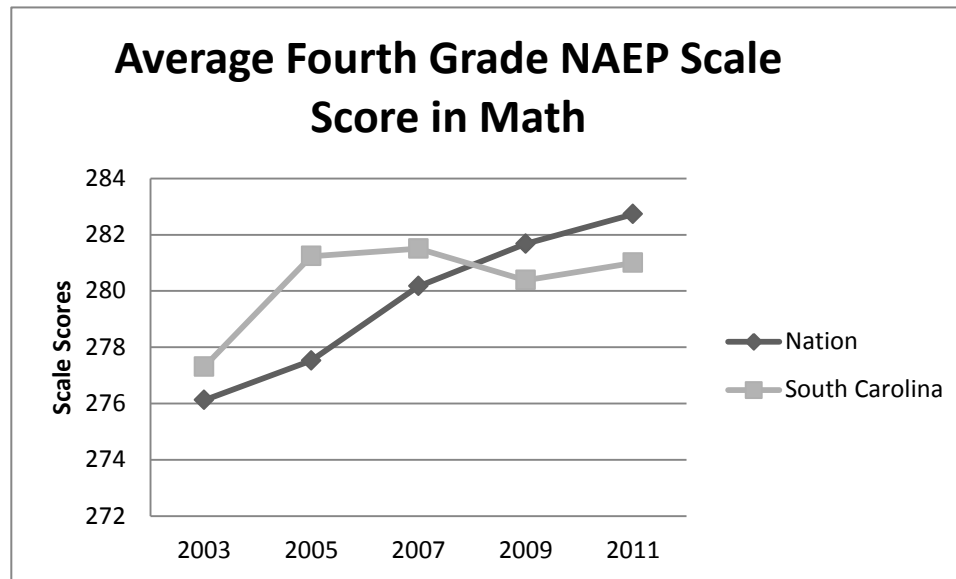
Relevance: From 2005 to 2011, the average fourth grade NAEP Reading assessment scores have fluctuated, but have not changed significantly.²⁰⁶ Compared to the nation, South Carolina has consistently scored below the national average.

²⁰⁴ National Center for Education Statistics, Institute of Education Sciences, <http://nces.ed.gov/nationsreportcard/> (last visited January 8, 2012).

²⁰⁵ S.C. Department of Education, unpublished report, NAEP Scores generated December 2011.

²⁰⁶ Because NAEP scores are based on samples of students, some apparent differences in scale scores are not statistically significant.

3d. Average Fourth Grade NAEP Scores in Math: This indicator is the average scale score that fourth grade students in South Carolina earned on the NAEP. The National Assessment of Educational Progress (NAEP) reports comprehensive information regarding what fourth, eighth, and twelfth grades students have learned and their performance levels in various subject areas.^{207 208}



Relevance: From 2003 through 2011 there has not been a statistically significant change in the average NAEP Math Score for fourth graders in South Carolina.²⁰⁹ Since 2007, South Carolina has scored consistently lower than the National average on math. Basic math skills are the building blocks to more complex thinking, higher level math and science courses, and ultimately high paying jobs.²¹⁰ If children do not master foundational math skills early in elementary school, catching up later is extremely difficult. This often sets children on a trajectory of low achievement.²¹¹

²⁰⁷ National Center of Educational Statistics, National Assessment of Educational Progress (NAEP) Summary, <http://nces.ed.gov/nationsreportcard/> (last visited January 13, 2012).

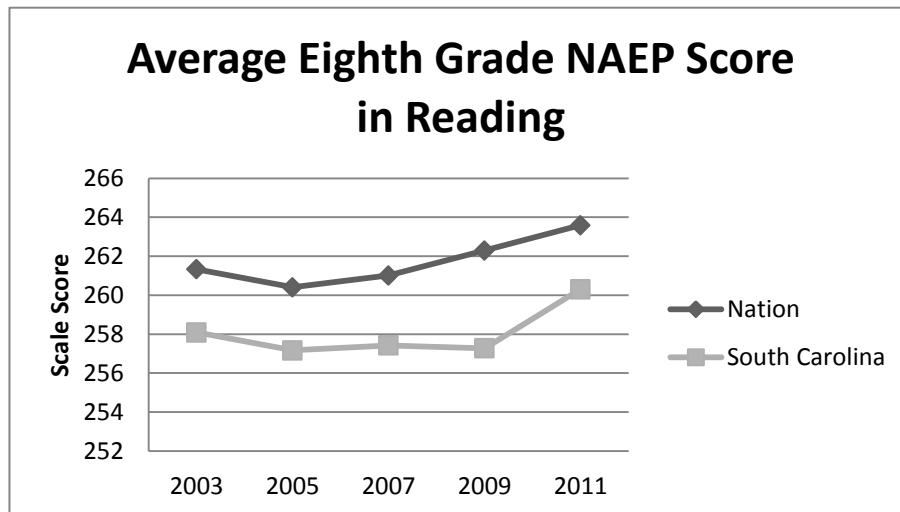
²⁰⁸ S.C. Department of Education, unpublished report, NAEP Scores generated December 2011.

²⁰⁹ Because NAEP scores are based on samples of students, some apparent differences in scale scores are not statistically significant.

²¹⁰ Anne E. Casey Foundation, 2010 Special Report: Why Reading by the End of Third Grade Matters, <http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid={EBC84A89-722A-4985-9E5D-7AB0803CB178}> (last visited January 13, 2012).

²¹¹ Id.

3e. Average Eighth Grade NAEP Scores in Reading: The National Assessment of Educational Progress (NAEP) reports comprehensive information about what fourth, eighth, and twelfth grades students have learned and can do in various subject areas.^{212 213}

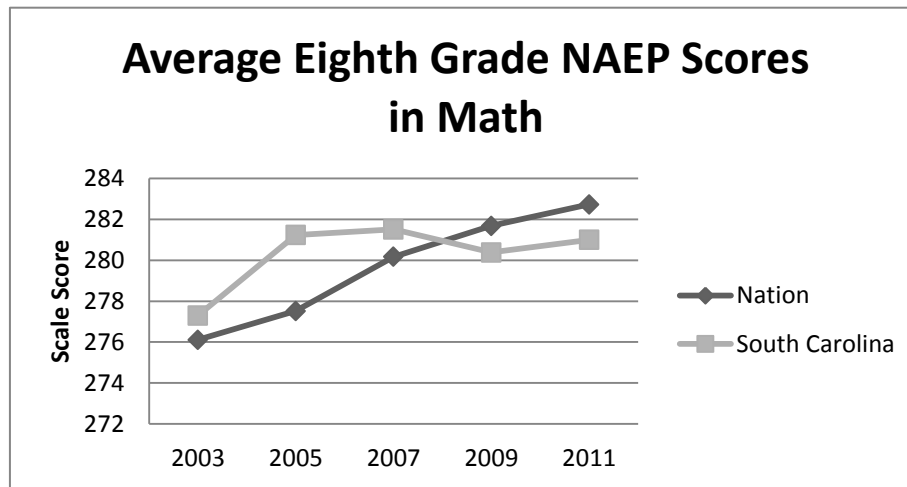


Relevance: The average eighth grade NAEP score in reading has improved significantly since 2005 and 2007. Despite this improvement, South Carolina consistently scores lower than the national average.

²¹² National Center for Education Statistics, <http://nces.ed.gov/nationsreportcard/> (last visited January 8, 2012).

²¹³ S.C. Department of Education, unpublished report, NAEP Scores generated December 2011.

3f. Average Eighth Grade NAEP Scores in Math: The National Assessment of Educational Progress reports comprehensive information about what fourth, eighth, and twelfth grades students have learned and can do in various subject areas.^{214 215}

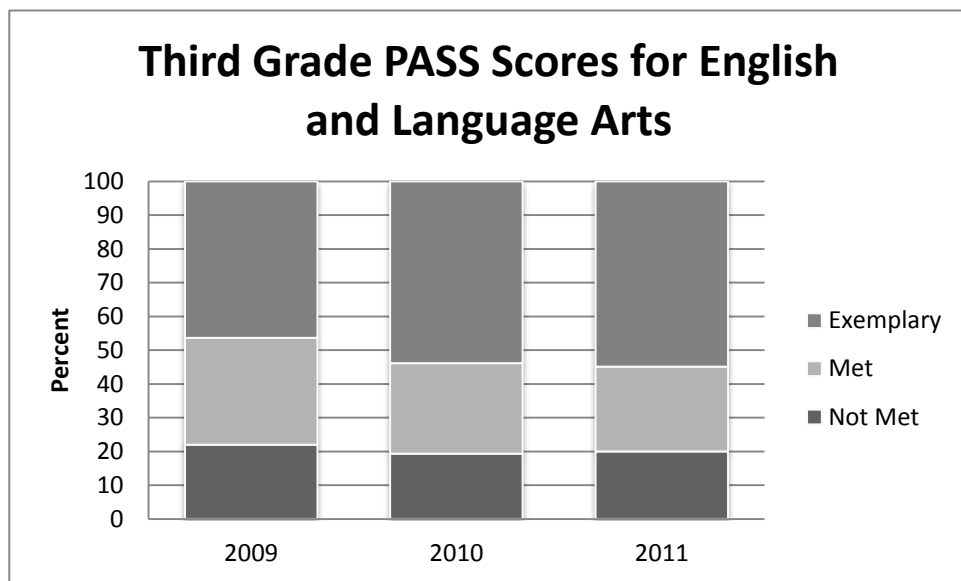
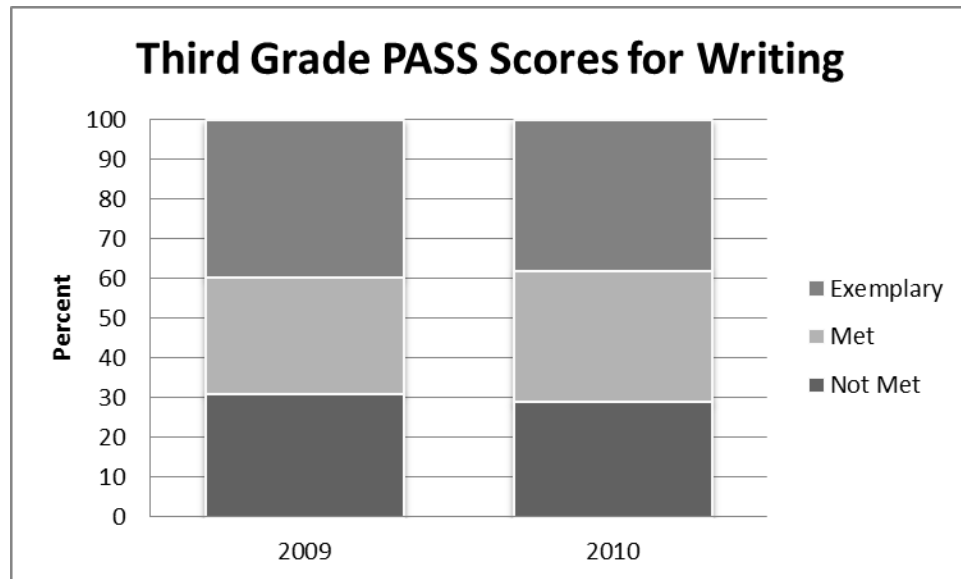


Relevance: From 2003 to 2011 the average eighth grade NAEP score in math in South Carolina statistically significant improved. Given this improvement, South Carolina is still below the national average. The national average has also consistently improved, while the South Carolina score declined slightly during the past two years.

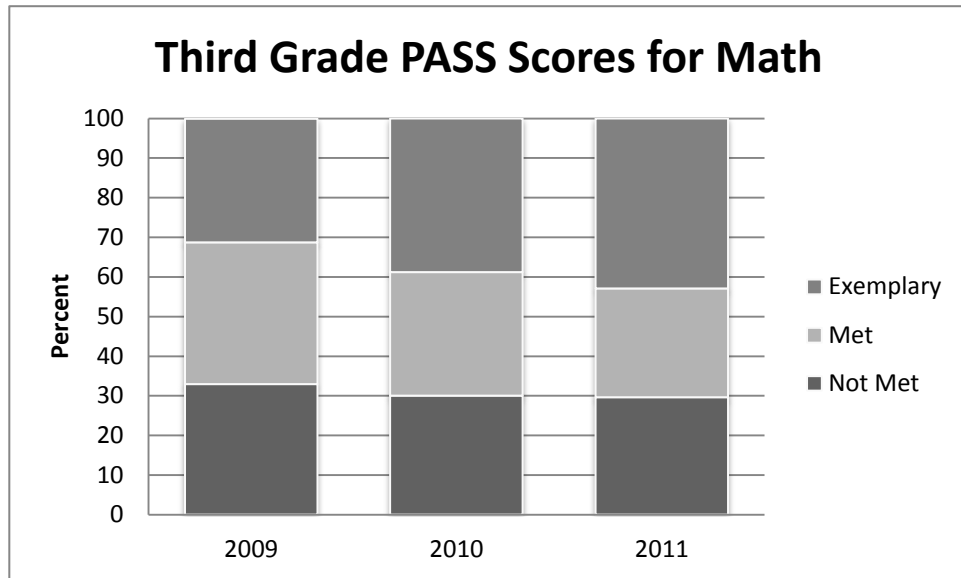
²¹⁴ National Center for Education Statistics, <http://nces.ed.gov/nationsreportcard/> (last visited January 8, 2012).

²¹⁵ S.C. Department of Education, unpublished report, NAEP Scores generated December 2011.

3g. Third Grade PASS Scores: The Palmetto Assessment of State Standards (PASS) is administered to students to assess knowledge and mastery of state standards. Categories are broken into three categories: met, unmet, and exemplary. This indicator is comprised of the writing, English and language arts, and math scores for third grade students. Writing Scores for the 2010-11 school year are not available.²¹⁶

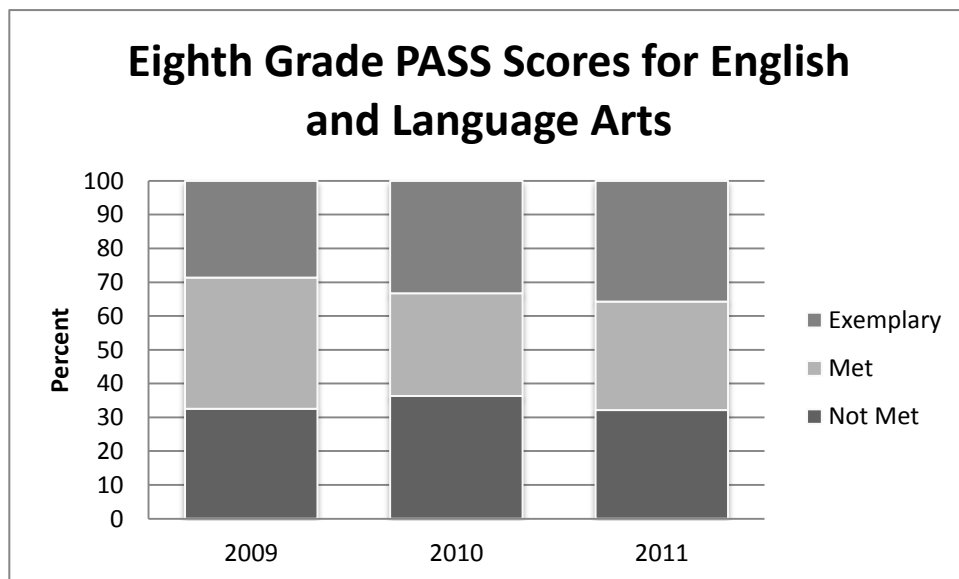
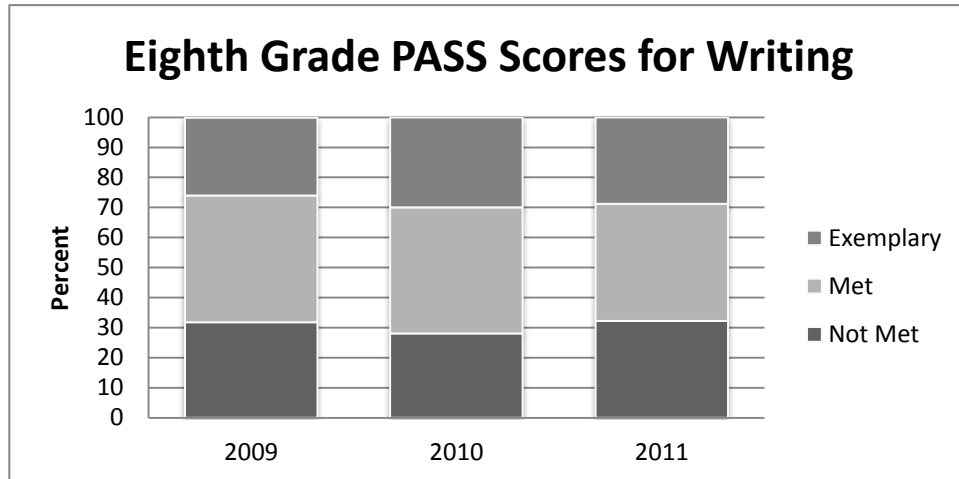


²¹⁶ S.C. Department of Education, unpublished report, PASS Scores generated December 2011.

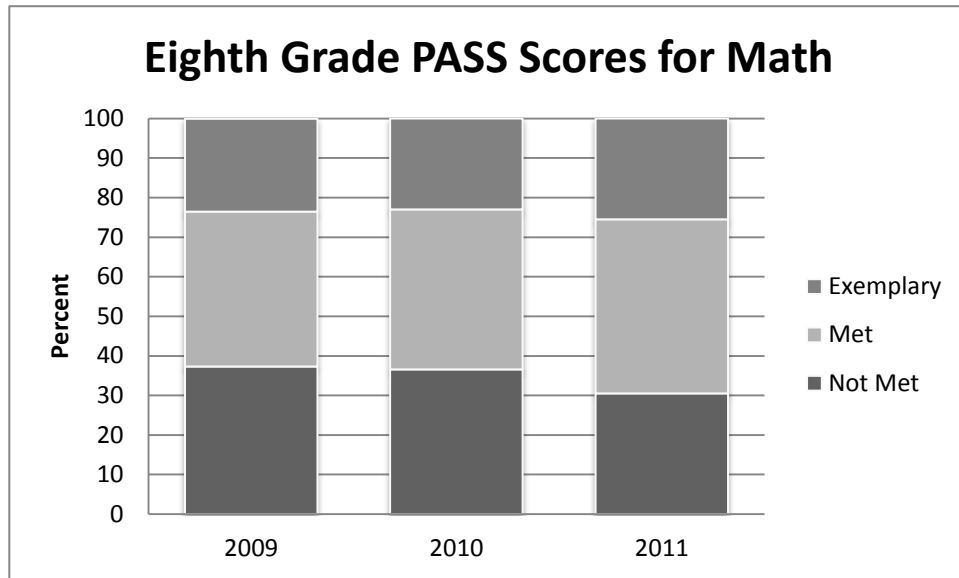


Relevance: Third grade PASS scores show that in math and English and language arts, the percentage of students scoring in the not met and met categories have decreased, while the percentage of exemplary scores has increased.

3h. Eighth Grade PASS Scores: The Palmetto Assessment of State Standards (PASS) is administered to students to assess knowledge and mastery of state standards. Categories are broken into three categories: met, unmet, and exemplary. This indicator is comprised of the writing, English and language arts, and math scores for eighth grade students.²¹⁷

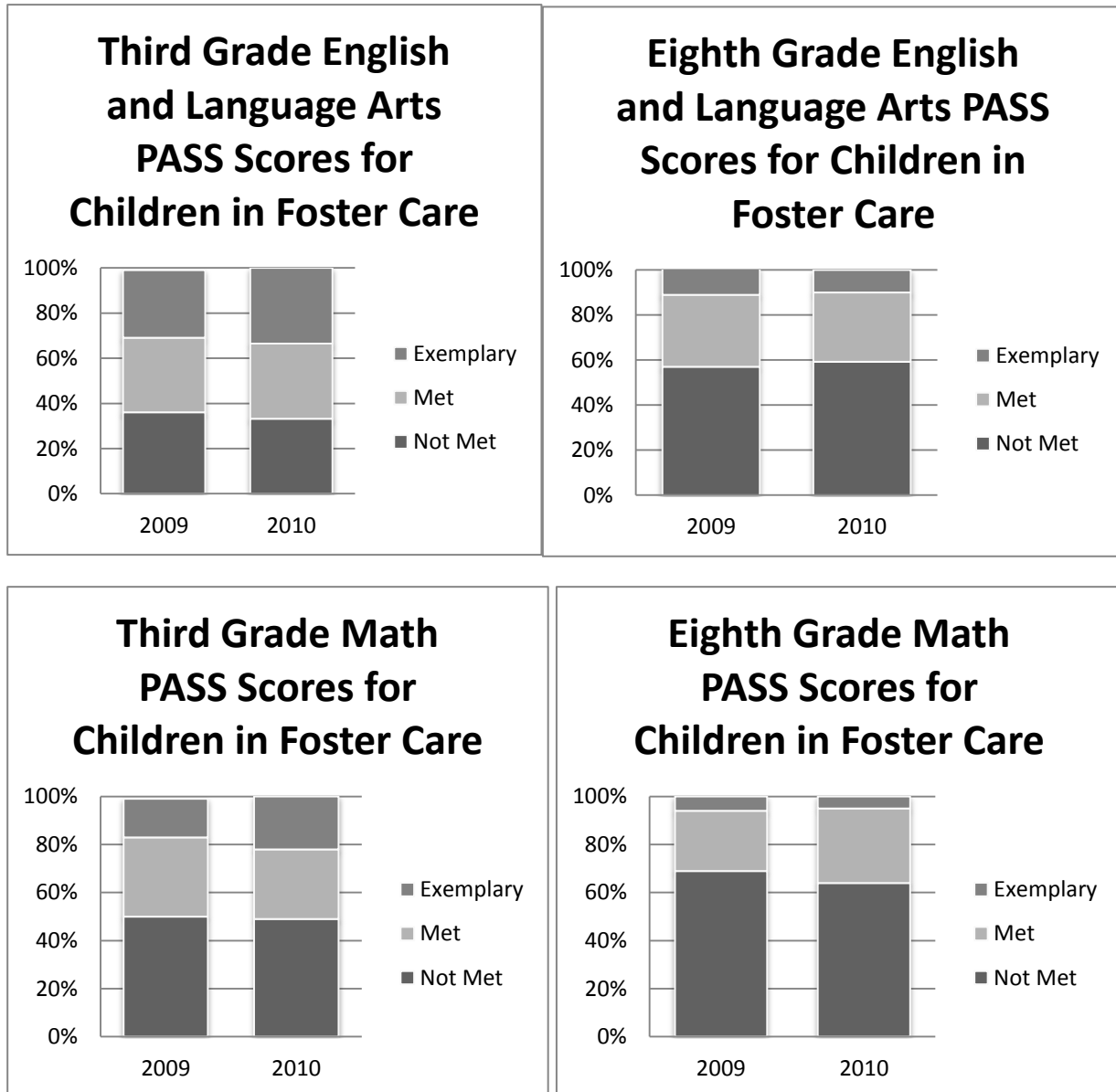


²¹⁷ S.C. Department of Education, unpublished report, PASS Scores generated December 2011.



Relevance: While there has not been a great deal of variance between 2009 and 2011 scores on the PASS test, there are some noteworthy changes. In writing, English and language arts, and math, the number of students who scored exemplary increased. In English and language arts, the number of students who scored in the not met category remained the same. In math, the percent of students who scored in the met and exemplary category increased, while the not met category shrank.

PASS Scores for Children in Foster Care: The Palmetto Assessment of State Standards Scores for children in foster care were collected from the Department of Social Services. These scores represent the percentage of students in three categories: not met, met, and exemplary for English and math. These estimates are used for comparison to total PASS Scores.²¹⁸

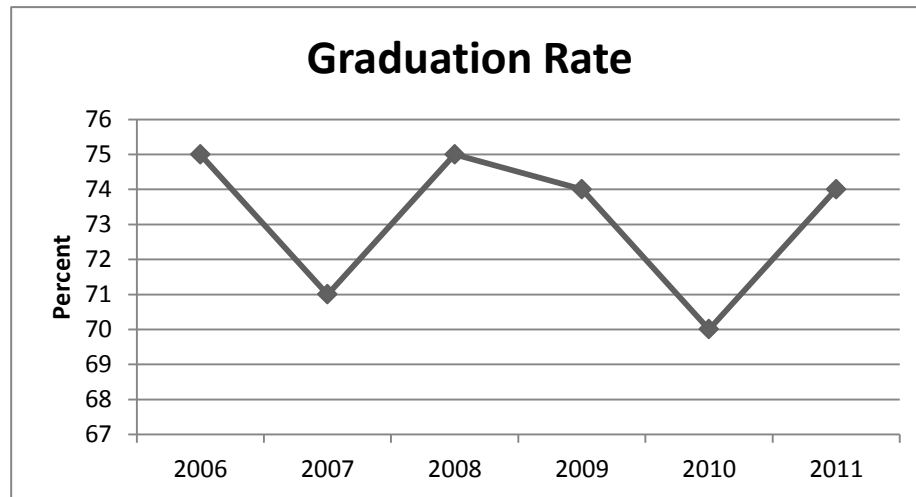


Relevance: Eighth grade students in foster care do consistently worse on the English and language arts and the math sections of the PASS than their peers who have not spent time in foster care. Similarly, third grade students also perform more poorly in these areas than peers who are not in foster care. The gap between children in foster care and all students is not as large for third graders as it is for eighth graders. Children in foster care face many challenges that

²¹⁸ S.C. Department of Social Services, unpublished report, PASS Scores for Children in Foster Care, generated December 2011.





can impact development across many areas for the entirety of their lives. Interventions to improve educational outcomes for children in foster care can mitigate these long term impacts.

3i. High School Graduation Rates: The graduation rate for South Carolina students in public schools was calculated using data from the Department of Education. This indicator reflects the percentage of eligible students who graduated within four years.²¹⁹



Relevance: The graduation rate for the past six years has fluctuated between 70% and 75% of eligible students graduating in four years. From 2006 to 2011, the graduation rate decreased overall by 1%. The rate has fluctuated in intervening years.

²¹⁹ S.C. Department of Education, unpublished report, Four Year High School Graduation Rate generated December 2011.

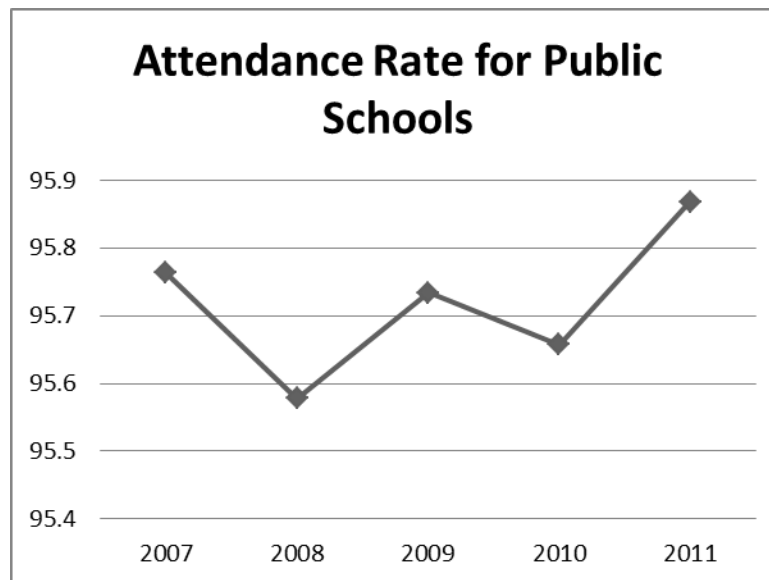
4. Index of Responsible Indicators			
Indicator	Data from Earliest Year^{220 221}	Data from Latest Available Year²²²	Percent Change from Earliest to Latest Available Year
4a. Attendance Rate in Public School	95.8%	95.9%	n/a
4b. Truancy	19,159	10,072	n/a
4c. Youth Employment	70,000	58,000	-17% 
4d. Youth Using Tobacco	30%	28%	n/a
4e. Youth Binge Drinking	24%	22%	n/a
4f. Youth Using Marijuana	19%	24%	n/a
4g. Number of Juveniles Charged with a Crime or Status Offense	19,115	13,680	-28% 
4h. Number of Juvenile Cases	24,699	18,114	-27% 
4i. Juvenile Recidivism	14%	15%	n/a
4j. Births to Teens	2,825	2,124	-25% 

²²⁰ Either four or five years of data is presented for each indicator. The earliest year of data collection is 2007 and the latest is 2011.

²²¹ Some data is better represented by a percentage of children in a specific population and is presented as such.

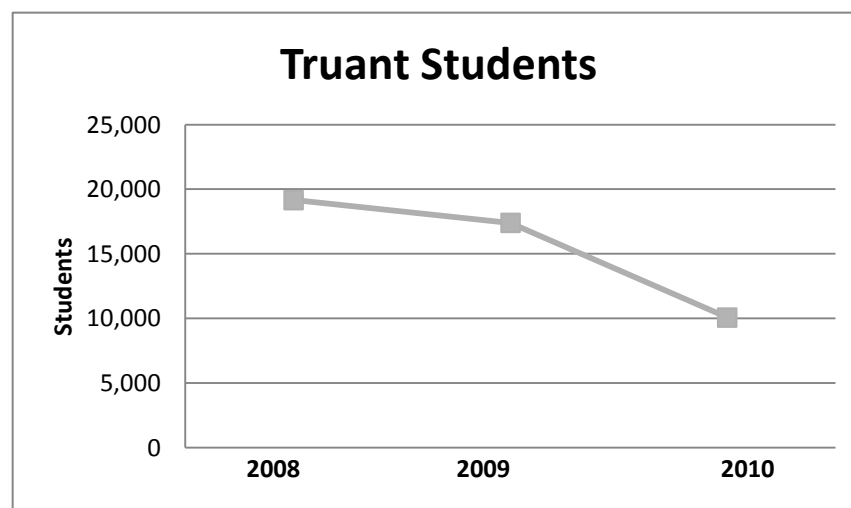
²²² Some data is better represented by a percentage of children in a specific population and is presented as such.

4a. School Attendance: School attendance is defined as the average percent attendance for children enrolled in public school settings.²²³ In addition to educating children, attending school gives children a network of peers and protective adults with which to connect.



Relevance: The attendance rate for students has remained consistently high over the past five school years, increasing in 2011.

4b. Truancy: Truant children are defined as those ages six through seventeen with three consecutive unexcused absences out of a minimum of five unexcused absences in a school year.²²⁴

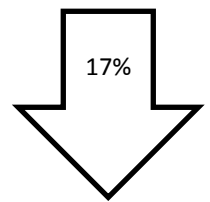
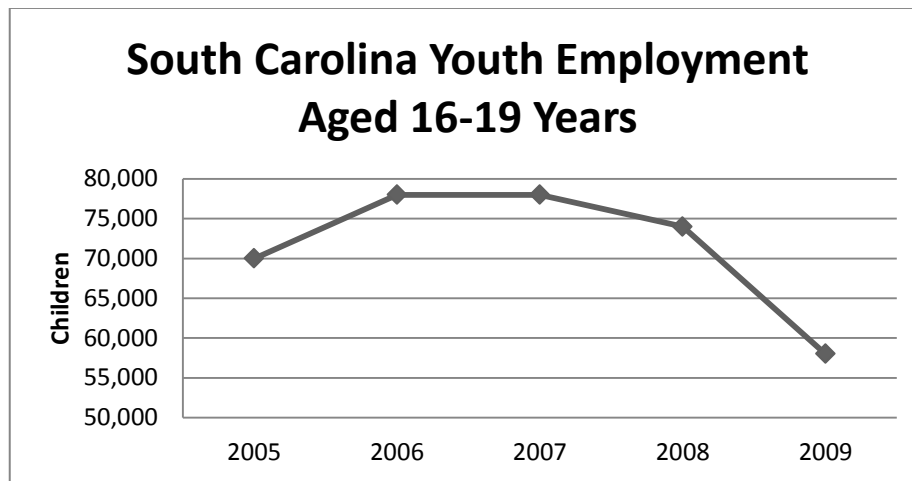


Relevance: Available data indicates the number of truant students across the state is decreasing.

²²³ S.C. Department of Education, unpublished report, Attendance Rate for Public School 2007-2011. Generated December 2012.

²²⁴ S.C. Department of Education, unpublished report, Truant Students for Public School 2008-2010. Generated December 2012.

4c. Youth Employment: The number of civilian youth aged sixteen through nineteen who are employed outside the home as in non-institutional settings as reported by the Bureau of Labor and Statistics.²²⁵

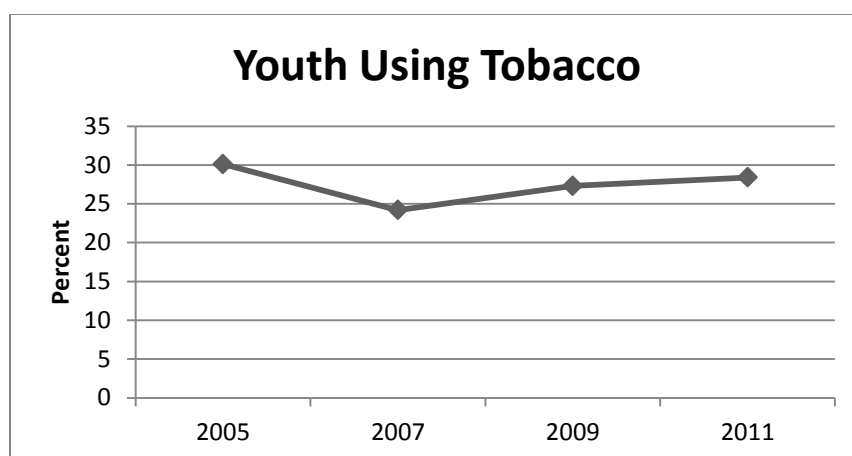


Relevance: The number of youth employed outside the home has decreased by 17% since 2005. The rate of unemployed youth tracks similarly with the rate of unemployed adults, and African American youth are more likely to be unemployed than white youth.²²⁶

²²⁵ Bureau of Labor and Statistics, Geographic Profiles of Employment and Unemployment by Year. <http://www.bls.gov/opub/gp/laugp.htm> (last visited January 19, 2012).

²²⁶Id.

4d. Youth Using Tobacco: The Youth Risk Behavior Survey (YRBS) surveys teens about their use of cigarette, cigar, chewing tobacco, dip or snuff within 30 days of survey administration.²²⁷



Relevance: From 2009 to 2011 there is no statistical difference in the percentage of children using some type of tobacco.²²⁸ Nationally, there has not been much improvement in reducing the number of youth who use tobacco use since the 1990s.²²⁹ The health effects of youth tobacco use are significant. Children who use tobacco products consistently at a young age are more likely to continue using them, and have an increased risk of several types of cancer.²³⁰

Continued efforts to reduce the number of youth who smoke or use smokeless tobacco will be important to reducing chronic adult health conditions. Objective data that captures the prevalence of tobacco without relying on youth to self-report is also important to measure progress on this indicator.

²²⁷ Per a t test conducted by the Office of Health and Nutrition South Carolina Department of Education, 2011 Youth Risk Behavior Survey Results: High School Student Trend Analysis Report. (not available online as of January 25, 2012).

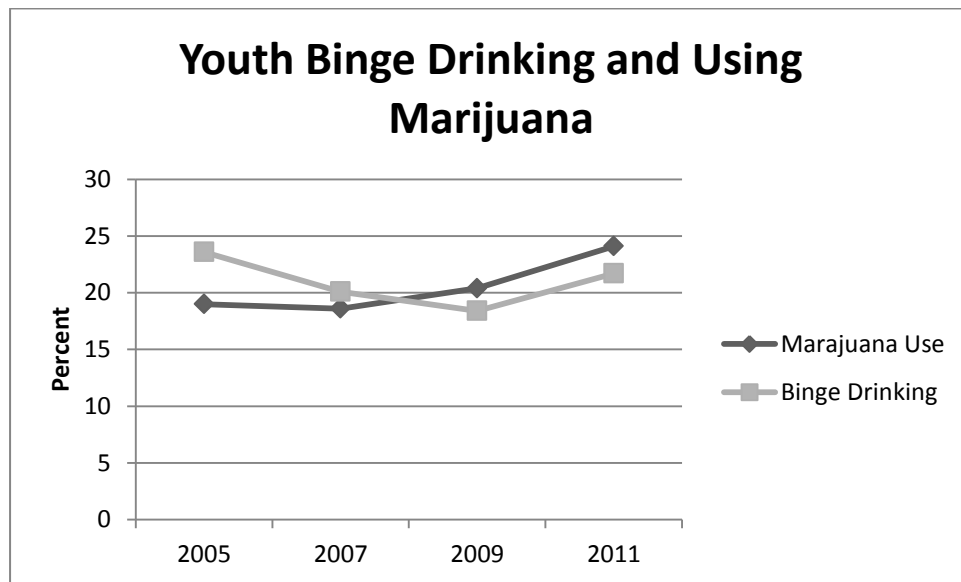
²²⁸ Id.

²²⁹ Centers for Disease Control, Youth Risk Behavior Survey Interactive Tables <http://www.cdc.gov/healthyyouth/yrbs/index.htm> (last visited January 7, 2012).

²³⁰ Centers for Disease Control, Healthy Youth, <http://www.cdc.gov/HealthyYouth/tobacco/facts.htm> (last visited January 18, 2012).

4e. High School Student Binge Drinking: High school students who report drinking five or more drinks of alcohol in a row (within a couple of hours) at least once in the past 30 days.²³¹

4f. High School Student Marijuana Use: High school students who report using marijuana one or more times in the past 30 days.²³²



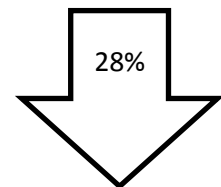
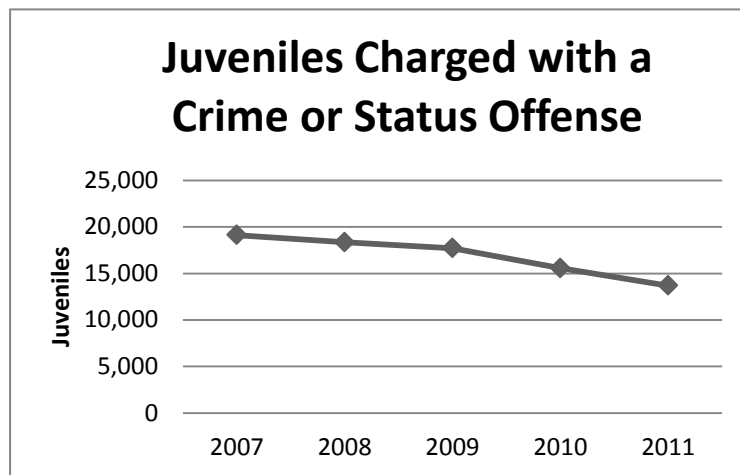
Relevance: The percentage of high school students binge drinking and using marijuana has remained between 18% and 24% since 2005. There has not been a significant change²³³ in either binge drinking or marijuana use from 2009 to 2011. From 2005 until 2007 the percentage of students using marijuana remained relatively constant, with an increase in 2008. Binge drinking decreased until 2009, and increased in 2011.

²³¹ Office of Health and Nutrition South Carolina Department of Education, 2011 Youth Risk Behavior Survey Results: High School Student Trend Analysis Report. (not available online as of January 25, 2012).

²³² Id.

²³³ Per a t test conducted by the Office of Health and Nutrition South Carolina Department of Education, 2011 Youth Risk Behavior Survey Results: High School Student Trend Analysis Report. (not available online as of January 25, 2012).

4g. Number of Juveniles Charged with a Crime or Status Offense: This indicator includes juveniles charged with crimes and status offenses. Status offenses are those offenses which, if committed by an adult, would not be a crime. Status offenses include offenses such as truancy, and underage drinking and tobacco use.²³⁴ The most frequently charged status offenses in South Carolina include truancy, incorrigibility and running away.²³⁵

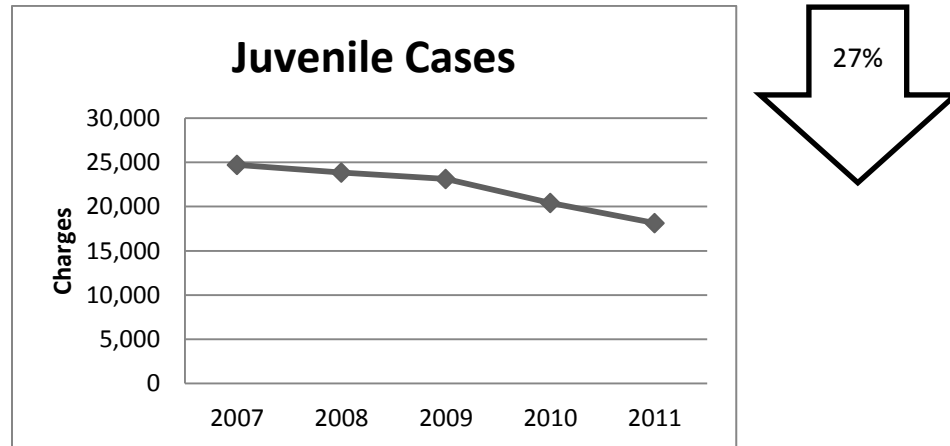


Relevance: The number of juveniles charged with a crime or status offense has steadily decreased since 2007.

²³⁴ S.C. Department of Juvenile Justice, unpublished report, Number of Juveniles Charged with a Crime FY 2007-2011. Generated December 2011.

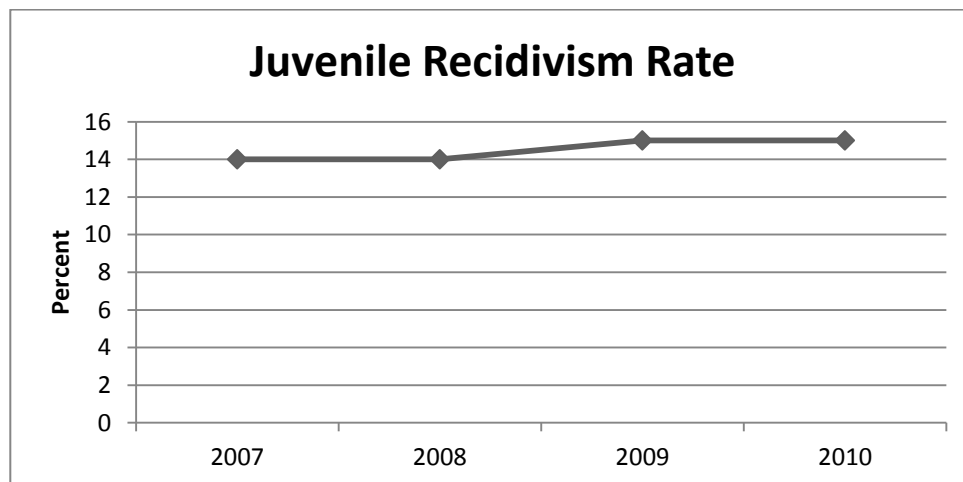
²³⁵ Id.

4h. Number of Juvenile Cases: The number of juvenile cases refers to the number of delinquency cases that come into the family court because of criminal or status offenses. An individual juvenile may be involved with more than one case over the course of an annual reporting period.²³⁶



Relevance: The number of juvenile cases has decreased in the past five years.

4i. Recidivism: Recidivism measures the rate at which juveniles offenders commit other crimes. The Department of Juvenile Justice defines juvenile recidivism as the rate of juveniles who reoffend while on probation, parole, or in arbitration programs.²³⁷

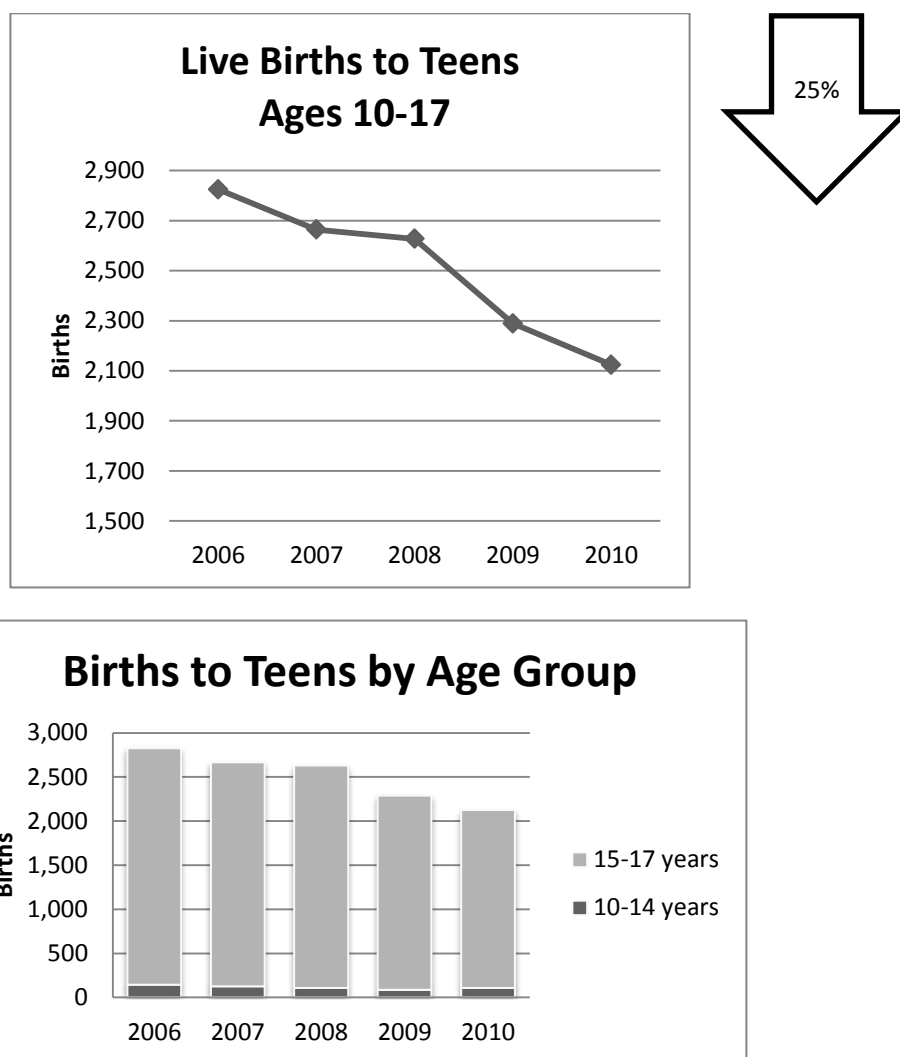


Relevance: The juvenile recidivism rate has remained relatively constant since the Department of Juvenile Justice began measuring recidivism for juveniles who reoffend while on probation, parole or in arbitration programs.

²³⁶ S.C. Department of Juvenile Justice, Juvenile Charges, <http://www.state.sc.us/djj/fact-sheets.php#Reports and Plans> (last visited, January 13, 2012).

²³⁷ S.C. Department of Juvenile Justice, Juvenile Recidivism Rate, <http://www.state.sc.us/djj/fact-sheets.php#Reports and Plans> (last visited, January 13, 2012).

5j. Births to Teens: This indicator reflects the number of live births to teens under the age of 18.²³⁸









Relevance: Births to teens in the state has decreased steadily since 2006. Births to teens may result in poor outcomes for both children and mothers. Children born to teen mothers are more likely to be premature, low birth weight, and die as infants than children born to women in their twenties and thirties.²³⁹ Compared with older mothers, teens who have children are less likely to finish high school or attend college.²⁴⁰ The concerted effort of public agencies and private non-profits to reduce teen births has contributed to this decline. Home visitation programs designed to support first time mothers, and in particular teens, have also likely contributed to the decline. Continued support of public agencies, private non-profits and home visitation programs will contribute to continued success in this measure.

²³⁸ S.C. Department of Health and Environmental Control, unpublished report, Births to Teens, generated December 2011.

²³⁹ Child Trends, Teen Births, <http://www.childtrendsdatabank.org/?q=node/52> (last visited January 19, 2012).

²⁴⁰Id.

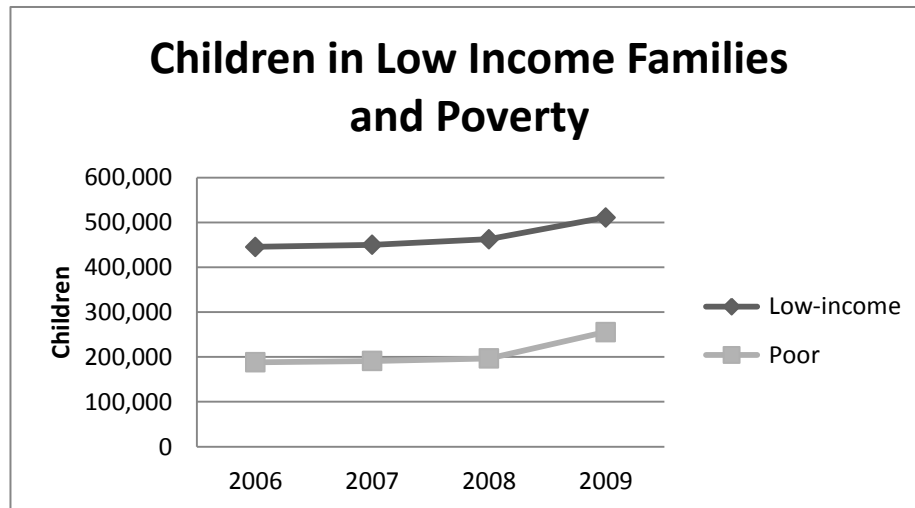
5. Index of Supported Indicators of Child Well-Being			
Indicator	Data from Earliest Year^{241 242}	Data from Latest Available Year²⁴³	Percent Change from Earliest to Latest Available Year
5a. Children living in Poverty	194,157	255,737	+32% 
5b. Children living in Low Income Families	436,940	511,162	+17% 
5c. Children Receiving Free and Reduced Lunch	52%	55%	n/a
5d. Children Participating in TANF	55,907	65,276	+17% 
5e. Children Participating in WIC	84,181	103,602	+23% 
5f. Children in Therapeutic Foster Care Placements	1,585	1,369	-14% 
5g. Child Support	212,085	223,218	+5% 

²⁴¹ Either four or five years of data is presented for each indicator. The earliest year of data collection is 2005 and the latest is 2011.

²⁴² For the indicator of Free and Reduced lunch, the measure is more informative by using the percent of children in school instead of a raw number.

²⁴³ For the indicator of Free and Reduced lunch, the measure is more informative by using the percent of children in school instead of a raw number.

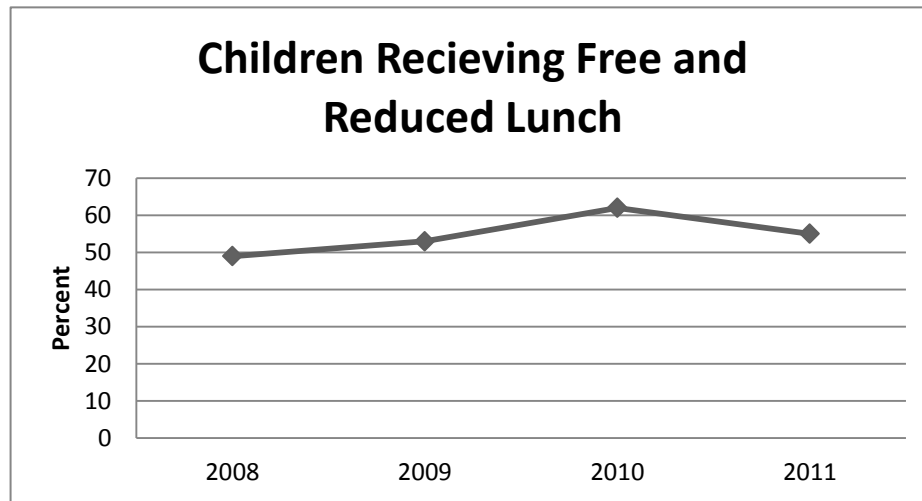
5a and b. Children in Poverty: Children living in families with an annual income less than 100% of the federal poverty level are categorized as being in poverty. Children living in families with an annual income less than 200% of the federal poverty level are categorized as being in low income families.²⁴⁴



Relevance: The recession has resulted in an increase of the number of children living in poverty and low income families. The number of children living in poverty has increased by 32% while the number of children living in low income families has increased 17% since 2007.

²⁴⁴ The National Center for Children in Poverty, South Carolina Children at 100% and 200% of the Federal Poverty Level. <http://nccp.org/topics/childpoverty.html> (last visited January 12, 2012).

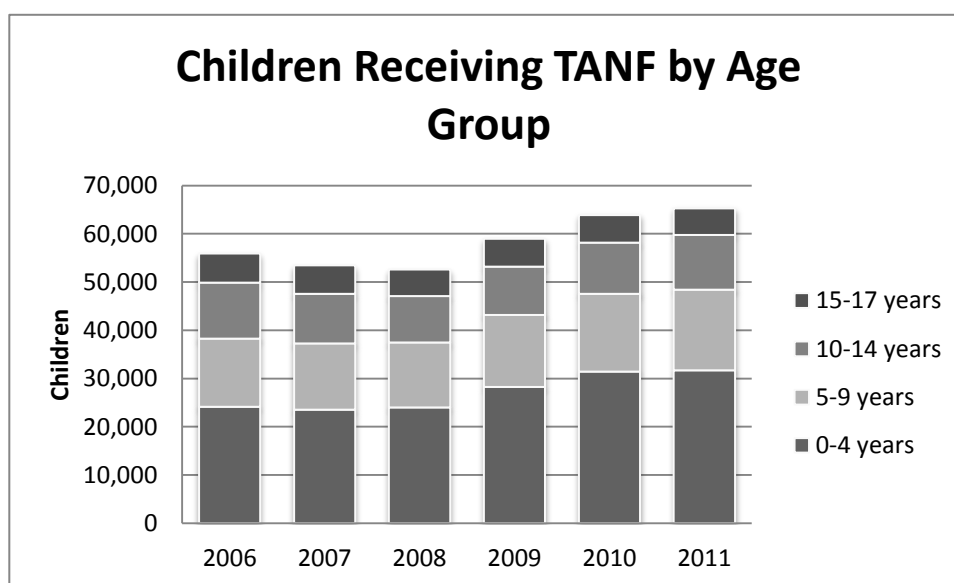
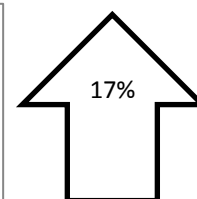
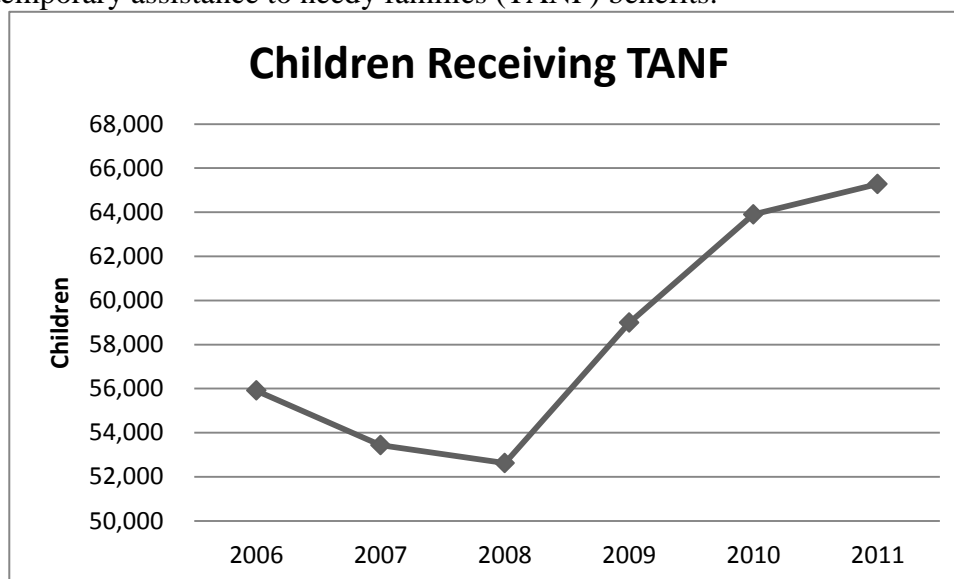
5c. Children Receiving Free and Reduced Lunch: The percent of students receiving free and reduced lunch was collected by the Department of Education.²⁴⁵



Relevance: The number of children participating in the free and reduced lunch programs increased as the recession impacted South Carolina. Since 2009, half of the students in public schools have participated in free and reduced lunch programs. Data for 2011 indicates recent decline.

²⁴⁵ S.C. Department of Education, Children Receiving Free and Reduced Lunch 2008-2011, generated December 2012 using e-rate data. <http://ed.sc.gov/data/erate/index.cfm> (last visited January 12, 2012), 2007 Children Receiving Free and Reduced Lunch, generated October 2011 using e-rate data. <http://ed.sc.gov/topics/researchandstats/reports/tech/erate/> (last visited October 2011).

5d. TANF Participants: This indicator presents number of children under the age of 18 receiving temporary assistance to needy families (TANF) benefits.²⁴⁶

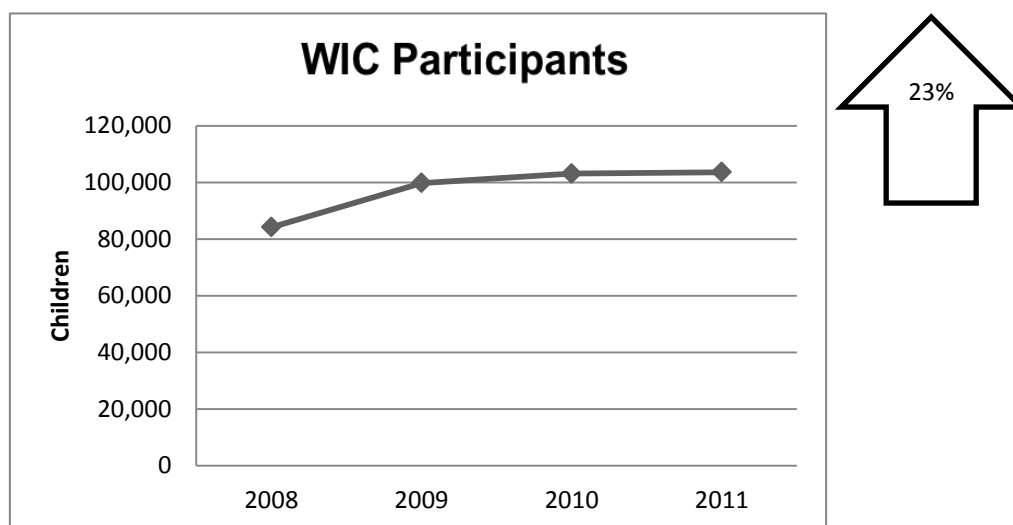


Relevance: As the number of children in poverty increases, the number eligible for assistance increases as well. Children five-years-old and under comprise the largest age group of children receiving TANF benefits each year. Children under five-years-old and under have also consistently increased annually. Research has shown that severe poverty in early childhood has serious effects on development.²⁴⁷ It is important that efforts are concentrated to reduce the impact of poverty on the young and most at risk.

²⁴⁶ S.C. Department of Social Services, unpublished report, Children Receiving TANF by Age Group, generated December 2011.

²⁴⁷ Center on the Developing Child, Harvard University, In Brief: The Impact of Early Adversity on Children's Development, http://developingchild.harvard.edu/resources/briefs/inbrief_series/ (last visited January 4, 2012).

5e. WIC Participants: This indicator reflects the number of children participating through the Department of Health and Environmental Control county offices in the Women, Infants and Children program. The WIC program is designed to support nutrition for a vulnerable population of at risk children.²⁴⁸



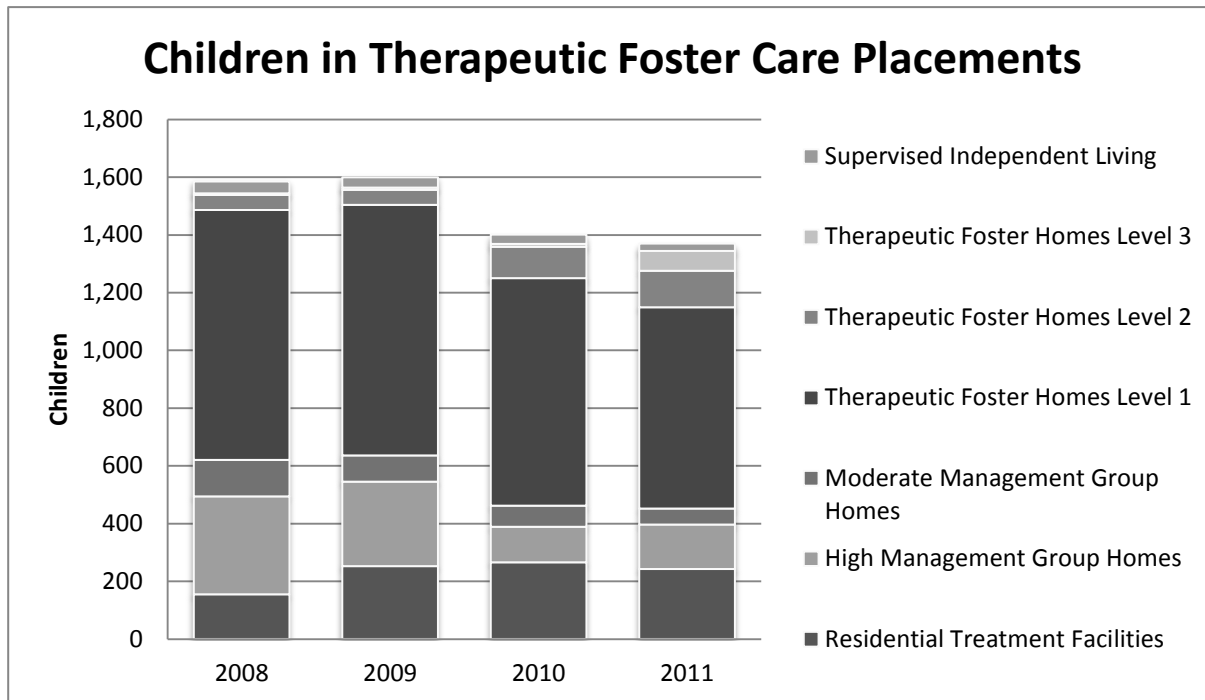
Relevance: A 23% increase in the number of child participants of the WIC program reflects the increasing number of poor and low income pregnant women, infants, and children.

Increased numbers of pregnant women, children, and infants who qualify for services are likely a reflection of the recession. According to the U.S.D.A. Food Nutrition Service, research has shown that WIC participation for women on Medicaid in five states resulted in longer pregnancies, fewer premature births, lower incidence of moderately low and very low birth weight babies and fewer infant deaths.²⁴⁹

²⁴⁸ Women are eligible during pregnancy, postpartum, and while breastfeeding. Infants are eligible up until the infant's first birthday and children are eligible up to the child's fifth birthday. Applicants must be classified by a health professional as a "nutrition risk." This means the individual must have a condition such as anemia, underweight, history of poor pregnancy outcomes, or a dietary based condition such as a poor diet. U.S. Department of Agriculture, Food and Nutrition Service, WIC Eligibility Requirements <http://www.fns.usda.gov/wic/howtoapply/eligibilityrequirements.htm> (last visited January 20, 2012).

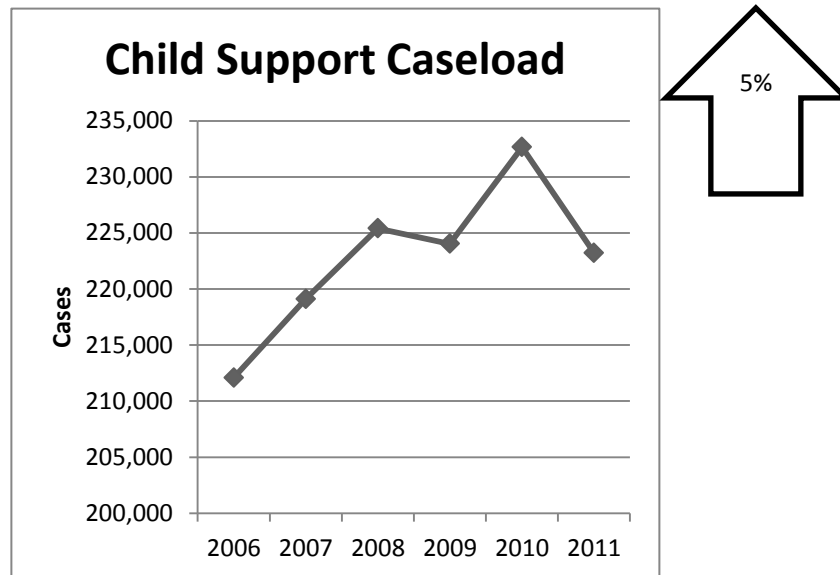
²⁴⁹ U.S. Department of Agriculture, Food and Nutrition Service, How WIC Helps, <http://www.fns.usda.gov/wic/howtoapply/eligibilityrequirements.htm> (last visited January 20, 2012).

5f. Children in Therapeutic Foster Care Placements: Children in therapeutic foster care placements including: supervised independent living, therapeutic foster homes level 3, therapeutic foster homes level 2, therapeutic foster homes level 1, moderate management group homes, high management group homes, and residential treatment facilities.



Relevance: Since 2008, the overall number of children in therapeutic foster care placements has decreased. This reduction may be attributed to changes in funding rules for certain categories of residential placements for children. During the same period, the number of children in residential treatment facilities increased. Level 1 therapeutic foster homes serve most of the children in therapeutic foster care.

5g. Child Support: This indicator reflects the caseload numbers for all DSS child support cases.
²⁵⁰ Approximately 70% are court ordered child support cases.²⁵¹



Relevance: The number of court ordered child support cases has increased since 2006, before the recession began, but decreased sharply from 2010 to 2011. This sharp decrease is the result of a diligent effort by the Department of Social Services to close cases that no longer needed assistance before the inception of a new computer system. Between February and December 2011 over 25,000 cases were closed in anticipation of the new computer system. Without this administrative change, the child support caseload would have increased to over 246,000 cases.²⁵²

²⁵⁰ S.C. Department of Social Services, Court Ordered Child Support Program Fact Sheets 2006-2010. Unpublished report, Court Ordered Child Support 2011. Generated December 2011.

²⁵¹ Id.

²⁵² Id. Follow up conversation with data expert on January 30, 2012.

Acknowledgements:

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