

STATE OF SOUTH CAROLINA
JOINT CITIZENS AND LEGISLATIVE COMMITTEE ON CHILDREN

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The Joint Citizens and Legislative Committee on Children is pleased to present its 2018 Annual Report. The Committee is charged with the important responsibility of identifying and studying key issues facing the children of South Carolina and making recommendations to the Governor and the General Assembly.

The 2018 Annual Report includes topics of concern identified by Committee members, by stakeholder partners, and by constituents. Public hearings conducted by the Committee around the state have also been an important source of information and insight on local concerns regarding our state's children. In this year's report, the Committee outlines ongoing and needed efforts to achieve four critical goals:

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

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

Senator Brad Hutto

Chair

Representative Shannon Erickson

Vice Chair

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Prior Annual Reports can be found at the Committee website:
www.sccommitteeonchildren.org

Executive Summary

This 2018 Annual Report of the Joint Citizens and Legislative Committee on Children provides information to the Governor and the General Assembly in the consideration of policy, funding, and legislation that affects children. The Committee looks forward to working with legislators and other elected officials, citizens, and all who serve or who are interested in promoting the well-being of children.

Based on input provided at the Committee's public hearings, and building on the Committee's previous work, this Annual Report gives attention to:

- **Child Victims of Human Trafficking**
- **Adverse Childhood Experiences and Resilience**

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

- **Child Hunger**
- **Tobacco Products Marketed to Children**
- **Children's Safety in Afterschool Programs and Summer Camps**
- **Driver's Insurance for Children in Foster Care**
- **Child Abuse Investigation Interviews of Children with Hearing Impairments**
- **Children Placed with Kinship Caregivers**
- **Incarceration of Status Offenders**
- **Placement of Children on the Sex Offender Registry**
- **Reform of the Disturbing Schools Law**
- **Teen Dating Violence Prevention**
- **Implementation of Local Child Fatality Review Teams**

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

Data Highlights

In 2017, South Carolina ranked 39th in the nation on overall child well-being by the Annie E. Casey Foundation in its 2017 *KIDS COUNT Data Book*.¹ There are more than 1.1 million children under age 18 living in South Carolina, which is 22% of the total population.² The most recent available data shows that:

- **57,337** children were born in South Carolina.³ (2016)
- **677** children died in South Carolina.⁴ (2016)
- **981** infants were born to girls under age 18.⁵ (2016)
- **102,978** non-fatal injuries to children required a hospital or emergency room visit, incurring a total cost of **\$258,081,880**.⁶ (2016)
- **636,645** or **58%** of children in South Carolina were enrolled in Medicaid.⁷ (2016)
- **40,240** children were the subject of a child abuse or neglect investigation.⁸ (2017)
- **4,020** children on average were in foster care each day.⁹ (2017)
- **13,591** juvenile delinquency cases were referred to the Department of Juvenile Justice.¹⁰ (2017)
- **98,424** children ages 3 to 17 were identified as having a disabling condition.¹¹ (2017)
- **28,744** infants and **44,819** children on average, participated in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).¹² (2017)

¹ The Annie E. Casey Foundation, *The 2017 KIDS COUNT Data Book*, <http://www.aecf.org/m/resourcedoc/aecf-2017kidscountdatabook.pdf> (last visited Jan. 2, 2018).

² S.C. Department of Health and Environment Control, <http://scangis.dhec.sc.gov/scan/bdp/tables/populationtable.aspx> (last visited Jan. 2, 2018).

³ S.C. Department of Health and Environment Control, <http://scangis.dhec.sc.gov/scan/bdp/tables/birthtable.aspx> (last visited Jan. 2, 2018).

⁴ S.C. Department of Health and Environment Control, Death Certificate Data, <http://scangis.dhec.sc.gov/scan/bdp/tables/death2table.aspx> (last visited Jan. 2, 2018).

⁵ S.C. Department of Health and Environment Control, Birth Certificate Data, <http://scangis.dhec.sc.gov/scan/bdp/tables/birthtable.aspx> (last visited Jan. 2, 2018).

⁶ S.C. Revenue and Fiscal Affairs Office. South Carolina Emergency Department Discharges (Ages 0-17 years). Unpublished report generated in Nov., 2017. Data includes inpatient admissions through the ED. SC residents for non-fatal injuries.

⁷ South Carolina eHealth Medicaid Statistics, Medicaid Enrollment, <http://www.schealthviz.sc.edu/medicaid-enrollment> (These data are preliminary and are current as of June 15, 2017; therefore, caution should be taken when comparing 2016 membership to prior years) (last visited Jan. 2, 2018).

⁸ Fostering Court Improvement, *Children Subject of Maltreatment Reports* (duplicated) During July 2016 through June 2017, http://www.fosteringcourtimprovement.org/state_websites.php (last visited Jan. 2, 2018).

⁹ Fostering Court Improvement, *Children in Foster Care During October 2016 through September 2017*, http://www.fosteringcourtimprovement.org/state_websites.php (last visited Jan. 2, 2018).

¹⁰ S.C. Department of Juvenile Justice, *FY 2016-2017 Annual Statistical Reports*, <http://www.state.sc.us/djj/pdfs/2016-17%20Annual%20Statistical%20Report.pdf> (last visited Jan. 2, 2018).

¹¹ S.C. Department of Education, *2016-2017 Child Count Data* (this data point is reflective of students with disabilities, ages 3-17, special education and related services through Individualized Education Programs under the coverage of the Individuals with Disabilities

Education Act, 2004. These counts would not include children with disabilities who do not have IEPs), <https://ed.sc.gov/districts-schools/special-education-services/data-and-technology-d-t/data-collection-and-reporting/sc-data-collection-history/idea-child-count-data/2016-2017-child-count-data/?startRow=1&nextNID=24A16826-B09F-6D5C-0EB3EF0CFE297922#> (last visited Jan. 2, 2018).

¹² U.S. Department of Agriculture, Food and Nutrition Service, WIC Program, Monthly Data – State Level Participation by Category and Program Costs, *WIC PROGRAM -- NUMBER OF INFANTS PARTICIPATING, FISCAL YEAR 2017*, Data as of December 8, 2017, <http://www.fns.usda.gov/pd/wisummary.htm> (last visited Jan. 2, 2018).

Updates on Committee Initiatives

The Committee on Children continues to work toward legislative and policy reforms that will improve protection for children and more effectively use limited public resources. In 2017, the Committee on Children sponsored or endorsed the following bills that ultimately passed:

- **Child Passenger Restraint (Act 78 of 2017)** brings South Carolina law into closer compliance with the recommendations of the American Academy of Pediatrics and the National Highway Transportation Safety Administration. The Act requires all drivers of a motor vehicle transporting a child under eight years of age upon public streets and highways to properly secure the child in the vehicle. A child under eight years of age may be transported in the front seat of the motor vehicle if all rear seating positions are occupied by other children under eight years of age and if they are secured properly in an appropriate child passenger seat for their size.
- **Driver's Licenses for Minors (Act 2 of 2017)** allows a responsible adult to sign for and assume liability and obligation for a driver's license or beginner's permit for a minor not in his or her legal custody and expands the list of individuals able to sign for minors on driver's licenses or beginner's permits.

Resolutions:

- **Child Hunger (S 701/ H 4237)** recognizes the devastating impact of child hunger and encourages eligible schools to maximize access to breakfast and lunch at no cost to children in poverty by adopting the Community Eligibility Provision of the Healthy, Hunger-Free Kids Act.

Other 2017 Committee on Children legislation and initiatives received hearings and prompted important discussion, public debate, and study. During 2017, the Committee convened informational sessions that included stakeholder presentations and discussions on issues of youth in transition, youth suicide, childcare safety, and Children's Advocacy Centers. Additional Committee on Children legislative priorities include:

Child Health and Safety

- **S 41 (School Breakfast and Lunch):** The health of children has been a long-standing priority of the Committee. **S 41** requires school districts to provide nutritious and well-balanced breakfasts and lunches to all students at no cost to the student by the 2018-2019 school year. **S 41** also removes the availability of waiver exceptions, which allow districts to opt out of the requirement. These measures will help to ensure that all children are able to have healthy and nutritious meals and children from being hungry during the school day.

- **S 575/H 3664 (Tobacco):** The Committee on Children supports amending South Carolina Code § 12-21-625, so as to revise the weight limitation on cigarettes from three pounds or less per one thousand cigarettes to four and one-half pounds or less per one thousand cigarettes, to exempt those wrapped totally in tobacco leaf with no filter, and to define “cigarette” to include 0.325 ounces of tobacco likely intended to be purchased to roll your own cigarettes. This measure could deter youth tobacco use.
- **S 569/H 4044 (Childcare Licensure):** The Committee on Children continually supports keeping South Carolina’s children safe. S 569 and H 4044 redefine the parameters of childcare facilities that are required to be licensed through the Department of Social Services (DSS) to include after school and summer camp programs. If passed, childcare facilities and programs will have more oversight and will be held to higher safety standards.

Child Welfare

- **S 541/H 4094 (Child Victims of Human Trafficking):** These companion bills provide that child victims of human trafficking can be served by DSS, bringing South Carolina into compliance with federal law by amending the definition of “child abuse and neglect” to include children who are victims of human trafficking, regardless of whether their trafficker was a parent or caregiver.
- **H 3322 (Driver’s Insurance for Foster Youth):** This bill reflects the need for normalcy for children in foster care and assists youth in transition. **H 3322** requires DSS to create a program to pay for certain expenses incidental to becoming legally authorized to drive for children age 15 or older who reside in out-of-home care. This measure would facilitate young people in foster care achieving an important skill—driving—that will help them become successful adults just like their non-foster care counterparts.
- **S 220 (Interpreters for Hearing-Impaired Children):** The Committee on Children is dedicated to connecting children who have been abused or neglected with needed services. **S 220** provides that children who are deaf or hard of hearing must have non-relative interpreters for interviews during investigations of child abuse or neglect.
- **H 3125 (Safety Plans):** This legislation brings clarity to the procedure leading to a child’s temporary placement with a relative or alternative caregiver, which is the circumstance that most often leads to long-term kinship care. **H 3125** also establishes time limits for safety plans and family preservation cases.

Juvenile Justice

- **S 580/H 3946 (Status Offenders):** The Committee on Children continues to support limiting the detention and incarceration of juveniles for status offenses and considering all possible alternatives before prosecuting status offenses. **S 580** and **H 3946** amend the Children's Code to remove the valid court order exception and to reflect federal law, which prohibits the detention of status offenders unless they are in violation of a valid court order.
- **S 560/H 3948 (Juvenile Sex Offender Registry Reform):** The Committee on Children supports holding juvenile offenders appropriately accountable for their actions while preparing them for successful reentry into society. **S 560** and **H 3948** provide family court judges with the discretion whether to require a juvenile aged 14 or older adjudicated delinquent for a sex offense in the family court to be placed on the sex offender registry and prohibit placement on the sex offender registry for juveniles aged 13 and younger at the time of the offense. The legislation also provides persons 21 years of age and older who were adjudicated in family court and required to register a process of petitioning for removal from the registry.
- **S 131/H 3794 (Disturbing Schools):** The Committee supports reforming South Carolina's Disturbing Schools law as described in **S 131** and **H 3794** to keep schools safe without criminalizing typical adolescent conduct. The legislation amends the law to exclude currently enrolled students and lists specifically prohibited actions.

Crimes Against Children

- **S 169 (Teen Dating Violence):** The Committee is dedicated to promoting healthy and safe relationships for youth in South Carolina. **S 169** requires age-appropriate instruction on sexual abuse and assault awareness and prevention for children in kindergarten through twelfth grade. Further, at least one time in the four years of high school, instruction must be given on teen dating violence education.
- **S 170 (Child Fatality Review Teams/Coroners):** The Committee is dedicated to promoting initiatives that can reduce avoidable child fatalities, including review by professionals of the circumstances around child deaths as they occur. **S 170** provides that the coroner of each county shall schedule a local child fatality review team to perform a review of a case where a child under the age of 18 dies in that county, and if available, would provide additional funds to assist counties in employing a full-time coroner and providing equipment and training to them.

Improving Child Well-Being in South Carolina

Although South Carolina's Kids Count ranking of 39th in the nation represents a slight improvement from its previous rank of 41st, significant challenges still persist and must be addressed on behalf of our state's children. Almost a quarter of the more than one million children in South Carolina live in poverty.¹³ When measuring by Medicaid eligibility, nearly two-thirds of the children in this state are living in poverty.¹⁴ Children in South Carolina also face a range of significant and complex challenges including mental health needs, abuse and neglect, family instability, lack of healthcare, and educational problems.

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

Since its inception, the Committee on Children has led a number of successful efforts to improve outcomes for children in our state, including developing a data- and research- driven model for annual evaluation of child well-being in the state, and important legislative and policy initiatives, including supporting trauma-informed care training for child-serving professionals to encourage the detection and treatment of childhood trauma, increasing safety measures for children cared for in family childcare homes, and promoting healthy food in South Carolina public schools.

The Committee has conducted statewide public hearings annually to seek citizen and stakeholder insight on how well our children are faring. During the fall of 2017, a number of speakers presented information to the Committee, and the members are grateful for having had this important opportunity to receive these insights. Testimony received at the hearings as well as written testimony raised many pressing issues including trauma and toxic stress in children, teen dating violence, the inability of Dreamers to access higher education or achieve professional licensure, and the need for firearm safety around children, among others. These hearings have informed the work the Committee has undertaken this year.

¹³ United States Census Bureau, *Small Area Income and Poverty Estimates*, <https://www.census.gov/data/datasets/2016/demo/saipa/2016-state-and-county.html> (last visited Jan. 23, 2018).

¹⁴ SC HealthViz, *South Carolina eHealth Medicaid Statistics*, <http://www.schealthviz.sc.edu/medicaid-enrollment> (last visited Jan. 23, 2018).

Protecting Children from Abuse and Neglect

The most vulnerable children in South Carolina are those whom the state has taken into custody due to maltreatment, and meeting their myriad needs is critical. Improving the multisystem processes and community supports that impact children in need of protection is a task that many in our state have undertaken, and the Committee commends those interdisciplinary efforts. The Children's Policy of South Carolina¹⁵ charges the Committee with cooperatively identifying strategies that maximize all available resources to protect children. Providing support for children who have been abused or neglected has been a priority concern for the Committee since its formation and is the reason the Committee undertakes this new focus initiative on the **Commercial Sexual Exploitation of Children**.

Child Victims of Human Trafficking / Victims of Commercial Sexual Exploitation of Children

Human trafficking is a form of modern-day slavery occurring in every state, including South Carolina,¹⁶ and children are at a particular risk of being affected.¹⁷ The inherent vulnerabilities of children facilitate exploitation by traffickers and demand a specialized, victim-centered approach focusing on the victim's rehabilitation rather than criminalization.¹⁸ In short, child victims of human trafficking need to be treated as victims of abuse and violence, rather than as offenders or witnesses. In 2017, the Committee began researching the state's response to child victims of human trafficking and meeting with stakeholders from around the state who are leading and contributing to local efforts. The Committee is in continued conversation and collaboration with the South Carolina Office of the Attorney General's Anti-Human Trafficking Task Force, regional human trafficking task forces, healthcare providers, victims' advocates, state agencies, and community organizations to achieve several shared goals: identifying the unique needs of child victims of trafficking in our state; identifying the best practices and evidence-based approaches to meet those needs; and promoting effective, efficient coordination of services for children.

Background

The commercial sexual exploitation of children (CSEC) includes sex trafficking, child pornography, and all forms of transactional sex where a child engages in sexual

¹⁵ S.C. Code Ann. § 63-1-20.

¹⁶ South Carolina Human Trafficking Task Force, *2017 Annual Report*, <http://humantrafficking.scag.gov/wp-content/uploads/2018/01/01559920.pdf>.

¹⁷ U.S. Department of Health and Human Services, *Administration for Children, Youth and Families, Guidance to States and Services on Addressing Human Trafficking of Children and Youth in the United States*, <https://goo.gl/JBQjpe>.

¹⁸ See generally Michigan Department of Health and Human Services, *Human Trafficking of Children Protocol 4* (2007), http://www.michigan.gov/documents/dhs/HumanTraffickingProtocol_440356_7.pdf.

activities in exchange for basic necessities such as food, shelter, or access to education.¹⁹ System-involved youth, persons with disabilities, LGBTQ+ youth, immigrant children, and runaway and homeless youth are at an even greater risk of being exploited.²⁰ Runaway and homeless youth are at a greater risk of being forced to engage in survival sex by trading sexual acts for money, shelter, or other basic needs.²¹ Children may be victimized by a trafficker who is a family member, intimate partner, acquaintance, or stranger. Exploited children suffer immediate and long-term health effects associated with their trauma including violence-inflicted injuries, depression, and substance or alcohol use.²²



National Center for Missing and Exploited Children²³

Despite their victimization, exploited children have historically been regarded as criminal perpetrators, which has resulted in re-traumatization and decreased trust in law enforcement.²⁴ However, in 2015 the Child Abuse Prevention and Treatment Act (CAPTA) was amended to recognize these children as victims of child abuse and neglect,²⁵ and in 2017, members of the Committee on Children introduced legislation in South Carolina to bring these children under the purview of DSS care.²⁶ As the lead agency serving these children, DSS already embodies the core principles of care for CSEC victims: individualized assessments, placement decisions, and services designed to begin healing and recovery. It is important to acknowledge that no single agency can meet every need of this specialized population, and CAPTA also requires coordination with other agencies.

¹⁹ The Stockholm Declaration and Agenda for Action, adopted at First World Congress Against Commercial Sexual Exploitation of Children, Stockholm, Sweden (Aug. 1996); 22 U.S.C. § 7102 (The term “sex trafficking” means the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act, defined as any act on account of which anything of value is given to or received by any person); S.C. Code Ann. § 16-3-2010(7) (Force, fraud, or coercion is not required to prove sex trafficking when the victim is under the age of eighteen years and anything of value is given).

²⁰ U.S. Department of State, *Trafficking in Persons Report* 428 (June 2017), <https://www.state.gov/documents/organization/271339.pdf>.

²¹ Homelessness, Survival Sex and Human Trafficking: As Experienced by the Youth of Covenant House New York, <https://humantraffickinghotline.org/sites/default/files/Homelessness%2C%20Survival%20Sex%2C%20and%20Human%20Trafficking%20-%20Covenant%20House%20NY.pdf>.

²² Guidance to States, *supra* note 17.

²³ National Center for Missing and Exploited Children, CHILD SEX TRAFFICKING, <http://www.missingkids.com/CSTT> (last visited Feb 9, 2018).

²⁴ Trafficking in Persons Report, *supra* note 20.

²⁵ Justice for Victims of Trafficking Act of 2015, Pub. L. 114-22, § 178, 129 Stat 227, 264 (2015).

²⁶ H. 4094, 2017 Leg., 122nd Sess. (S.C. 2017), S. 541, 2017 Leg., 122nd Sess. (S.C. 2017).

Essential Elements of a CSEC Response

Currently, South Carolina does not have a coordinated, uniform response to provide CSEC victims with immediate and long-term care.²⁷ A strategic, collective approach to CSEC can improve awareness and cooperation among professions likely to engage with victims, increase access to services and improve outcomes for victims, and facilitate data collection and research to support evidence-based victim services.²⁸ Statewide consistency can better ensure victim-centered and trauma-informed approaches in all phases of victim identification, assistance, recovery, and participation in the criminal justice process.²⁹ A comprehensive and coordinated CSEC response offers professional training and validated resources; uses local multidisciplinary teams to meet victim needs; provides safe and appropriate placement options; collects, tracks, and shares data on CSEC cases; and facilitates victim-centered care and services.

Training and Education

Training law enforcement officers, healthcare professionals, and others likely to serve as first points of contact for trafficking victims is crucial to an effective response.³⁰ Victim identification and access to trauma-informed services and legal remedies increase when more trusted adults are aware of trafficking red flags, trained in administering screening tools, and familiar with protocols for reporting and responding to CSEC.^{31 32} In South Carolina, evidence-based trainings and materials are made available by local agencies, faith-based organizations, and task forces.³³ In 2017, thousands of people in our state were trained to recognize, report, and respond to CSEC.³⁴ The Committee applauds the continued efforts of the South Carolina Office of the Attorney General's Anti-Human Trafficking Task Force, local human trafficking task forces, child-serving agencies and nonprofits, and citizens dedicated to increasing public awareness about human trafficking in our state.

²⁷ The Committee recognizes the Office of the Attorney General's Anti-Human Trafficking Task Force and their work to improve access to services for all victims of human trafficking.

²⁸ See U.S. Department of Justice, Office of Justice Programs, *Human Trafficking Task Force e-Guide*, <https://www.ovcttac.gov/taskforceguide/eguide/> (last visited Jan. 20, 2018) ("The multidisciplinary task force response model (agencies from various disciplines working together) is encouraged by the U.S. Department of Justice and is considered worldwide as a "best practice" in the response to human trafficking").

²⁹ *Id.*

³⁰ See Trafficking in Persons Report, 423, *supra* note 17; Center for the Human Rights for Children, Loyola University and International Organization for Adolescents, *Building Child Welfare Response to Child Trafficking* 14 (2011), <https://www.luc.edu/media/lucedu/chrc/pdfs/BCWRHandbook2011.pdf>.

³¹ *Id.* at 13; U.S. Dep't of Health and Human Services, Office on Trafficking in Persons, National Human Trafficking Training and Assistance Center, <https://www.acf.hhs.gov/otip/training/nhttac> (last visited Jan. 20, 2018).

³² Likely first points of contact are law enforcement officers, healthcare professionals, social workers, DJJ workers, hotel/motel proprietors, emergency response teams, educators and coaches, bus drivers, childcare employees, guardians ad litem/caregivers working with children or other vulnerable populations, and legal professionals.

³³ Many offer trainings for specific service providers like law enforcement, healthcare, and legal professions; The S.C. Human Trafficking Task Force has compiled a list of available on-line training materials, available at <http://humantrafficking.scag.gov/resources/>.

³⁴ Lighthouse for Life, *January 2018 Newsletter*, <https://www.lighthouseforlife.org/our-news-new/january-2018-newsletter>.

Educating young people on CSEC and trafficking can empower youth to recognize red flags in their or a friend's situation. In some states, public school nurses, teachers, counselors, school psychologists, and administrators receive human trafficking awareness training, and teen sex trafficking information is included in middle and high school health education curriculums.³⁵ In response to a 2012 Virginia General Assembly mandate, Prince Williams County initiated a trafficking prevention program to educate parents and school employees along with students. The program partners with several local service providers and allows students to indicate if they would like to speak further with a trusted adult.³⁶

Screening Tools

Youth should be screened for sexual exploitation upon entry into any child-serving system.³⁷ Screening tools elicit information to better identify CSEC victims, understand individual service needs, monitor progress toward recovery, improve well-being over time, and compare and analyze data collected from victims. Standardized screening tools can be incorporated into existing protocols and initial processing across systems and facilitate collaborative victim-centered services.³⁸ States have adopted a variety of screening tools for juvenile justice and child welfare systems. For example, Washington, Connecticut, and Ohio have created and implemented system-specific screening tools for children.³⁹ In 2015, pursuant to Florida House Bill 7141 (2014), Florida's Departments of Children and Families and Juvenile Justice developed a Human Trafficking Screening Tool designed to help professionals in both agencies screen for possible CSEC victims.⁴⁰ Shortly after training staff in both agencies on using the identification tool, additional entities began receiving training to administer the tool.⁴¹ Other states rely on published validated resources, such as Shared Hope International's INTERVENE⁴² and Vera Institute of Justice's Trafficking Victim Identification Tool,⁴³ which are not system-specific and can be utilized by many agencies. The Committee encourages child serving agencies to work proactively towards adopting a cross-system standardized screening tool to provide opportunities for a variety of individuals who work with young people to identify victims.

³⁵ Ohio Revised Code § 3301-073, et. al; Tex. Code Ann. § 402.035 (requiring the Texas Human Trafficking Prevention Task Force to work with TEA to develop a standardized curriculum and train school personnel to identify and assist victims of human trafficking).

³⁶ Jim Barnes, *Prince William Schools Educate Staff, Students and Parents on Human Trafficking*, The Washington Post (Jan. 2015), https://www.washingtonpost.com/local/prince-william-schools-educate-staff-students-and-parents-on-human-trafficking/2015/01/09/493651d4-9755-11e4-8005-1924ede3e54a_story.html?utm_term=.a162bb1c8f6c (in one year, the program had 100 students come forward with 41 identified as at risk)

³⁷ Human Trafficking Task Force e-Guide, *supra* note 28.

³⁸ See Center for Children & Youth Justice, Washington State Model Protocol for Commercially Sexually Exploited Children, 22 (Nov. 2012), <http://csec-response.org/wp-content/uploads/2016/05/Washington-State-Model-Protocol-for-CSEC-2012.pdf>.

³⁹ See *Id.* at 24; CONNECTICUT STATE DEPARTMENT OF CHILDREN AND FAMILIES HART (HUMAN ANTI-TRAFFICKING RESPONSE TEAM) (last visited Feb. 11, 2018) available at <http://www.portal.ct.gov/DCF/HART/Home>; Washington State Model Protocol, *supra* note 38, at 61 (providing the Portland State University CSEC Screening Interview). OHIO HUMAN TRAFFICKING TASK FORCE, HUMAN TRAFFICKING SCREENING TOOL, 10 (June 2013), <http://humantrafficking.ohio.gov/links/Screening-Tool.pdf> (providing the Screening Protocol Tailored for the Ohio Department of Rehabilitation and Corrections and the Ohio Department of Youth Services)

⁴⁰ Services and Resources Committee of the Statewide Council on Human Trafficking, *2016 Human Trafficking Response in Florida* 48 (2016), [http://myfloridalegal.com/webfiles.nsf/WF/MNOS-AF9P43/\\$file/2016HumanTraffickingAnnualReportSupplemt.pdf](http://myfloridalegal.com/webfiles.nsf/WF/MNOS-AF9P43/$file/2016HumanTraffickingAnnualReportSupplemt.pdf).

⁴¹ *Id.*

⁴² This tool is available at <https://sharedhope.org/product/intervene-identifying-and-responding-to-americas-prostituted-youth/>.

⁴³ LAURA SIMICH ET AL., OUT OF THE SHADOWS: A TOOL FOR THE IDENTIFICATION OF VICTIMS OF HUMAN TRAFFICKING (2014), <https://www.vera.org/publications/out-of-the-shadows-identification-of-victims-of-human-trafficking> (last visited Feb 8, 2018).

Multidisciplinary Teams

No single system can successfully meet the unique and complex needs of CSEC victims and the various legal proceedings that may be involved.⁴⁴ The coordinated and collaborative work of local multidisciplinary teams (MDTs)⁴⁵ is central to providing critical support to CSEC victims. These teams may typically consist of professionals from a range of sectors including law enforcement, legal agencies, social services, schools and Children’s Advocacy Centers (CACs); medical professionals; and guardians ad litem. While a rapid response is effective for identifying and intervening on behalf of CSEC victims, MDTs also address the long-term and continued needs of CSEC victims while keeping victim safety and well-being as the primary concern.⁴⁶ MDTs can be used to coordinate the investigation and prosecution of CSEC cases and to ensure that CSEC victims are accessing all available appropriate resources and services. To optimize efficiency and facilitate relationships between victims and local service providers, MDTs should be flexible to meet the needs of the victims they serve.⁴⁷ Local teams can inform local decisions about placements and providers’ needs or other aspects of the provision of care to best provide for the local population.⁴⁸ MDTs can assist with assessments of the child’s safety, advocacy and support, coordination of medical care and treatment of mental health or substance abuse disorders, case investigation, and placement planning.

As legislative, policy, and practice changes occur that enable all CSEC victims to receive care and placement through DSS, caseworkers specifically trained to work with CSEC youth will be best suited to lead local MDTs.⁴⁹ The network of CACs across the state have existing relationships with prosecutors, DSS, victim advocates, and medical providers and could serve as a convener as well as a contributor to MDTs. The Committee supports continued research and review of existing state resources that can be leveraged to support the development of local MDTs to coordinate children’s care management.

Placement and Services

The lack of residential placement options for CSEC victims in our state is a significant deficit. Trafficked youth should be treated as victims, not criminals; but in far too many cases, they are being detained in our state in the name of “protecting” children. For many CSEC victims, secure placements and confinement only exacerbate their trauma

⁴⁴ Guidance to States, *supra* note 17.

⁴⁵ U.S. Department of Justice, Office for Victims of Crime, Training and Technical Assistance Center, Human Trafficking Resource Paper (2012) (“Working with multiple systems can be overwhelming for victims ... and in order to coordinate victim-centered service delivery, collaboration is essential”).

⁴⁶ Compared to Rapid Response Teams (RRTs) that only assist in the first 24 to 72 hours of an identified victim’s recovery and rehabilitation; Human Trafficking Task Force e-Guide, *supra* note 13; *see* Rhode Island’s Uniform Response Protocol for the Commercial Sexual Exploitation of Children 12 (Jan. 2016), <https://www.justice.gov/usao-ri/file/883361/download>.

⁴⁷ Human Trafficking Task Force e-Guide, *supra* note 28.

⁴⁸ *Id.*

⁴⁹ The Center for the Human Rights for Children at Loyola University Chicago recommends child welfare agencies use multidisciplinary case staffing and referrals for child victims of trafficking, Building Child Welfare Response to Child Trafficking, *supra* note 30.

and should be avoided if possible. Ideally, a wide array of placement options should be accessible to CSEC victims depending on their individual needs, not on placement availability.⁵⁰ Placements should be staff-secure, not hardware-secure, so that child victims are not further traumatized by being placed in de facto jails. A diverse continuum of placement options provides the ability to respond to an individual's needs and can include specialized residential foster care, kinship care, therapeutic placements, transitional housing, and both locked and unlocked residential treatment centers.⁵¹ Placements should be locations that are trusted by law enforcement and provide triage and shelter, and they should be able to accept children 24 hours a day. At least one protective placement should be accessible to each region of the state.

The safety of trafficked youth must be an important consideration. A victim's perception of safety is central to determining which placement is appropriate, and having a variety of placements provides the ability to respond to fluctuating perceptions and needs.⁵² The National Council of Juvenile and Family Court Judges recommends developing "non-detention triage facilities and specialized placement options that are equipped to effectively address the unique trauma suffered by victims of human trafficking."⁵³

Acute medical examination and stabilization may be needed for youth with physical injuries, acute substance withdrawal, or recent sexual assault. Children's hospitals around the state are already addressing these acute needs. Other care such as additional medical treatment, dental care, and drug and alcohol treatment is likely to be needed. CSEC victims are eligible for services such as Medicaid once in foster care, state and federal victims' assistance funds, Substance Abuse and Mental Health Services Administration (SAMHSA) Programs, Supplemental Nutrition Assistance Program, and public housing programs.⁵⁴ Collaboration among essential agency partners is required to provide victims and survivors with these services and assistance in accessing them.

Data

Data collection is important for identifying service needs and system gaps, adapting responses to local environments, and crafting private and government grant applications to fund further CSEC response development. The Committee supports the ongoing collaboration of the Office of the Attorney General's Anti-Human Trafficking Task Force with the Children's Law Center on the Child Sex Trafficking Data Project.⁵⁵

⁵⁰ Human Trafficking Task Force e-Guide, *supra* note 17.

⁵¹ *Id.*; *supra* note 39 at 38.

⁵² Washington State Model Protocol, *supra* note 28.

⁵³ The National Council of Juvenile and Family Court Judges, *Resolution Regarding Domestic Child Sex Trafficking and Commercial Sexual Exploitation of Children* (March 2016), http://www.ncjfcj.org/sites/default/files/SexTrafficking_Resolution%20REVISED2016V3.pdf.

⁵⁴ The Victims of Crime Act of 1984, Pub. L. No. 93-473, 98 Stat. 2170 (1984); S.C. Code Ann. § 16-3-1210, et al.

⁵⁵ South Carolina Human Trafficking Task Force, 2017 Annual Report, available at <http://humantrafficking.scag.gov/data-reports/>.

In order to better identify risk factors of child sex trafficking, the South Carolina Attorney General's Office is working with the Children's Law Center, University of South Carolina School of Law, to conduct a data analysis on 561 runaway and incorrigible incident reports in 2016 using data provided by the Richland County Sheriff's Department. The drafted data report is currently under review by the Richland County Sheriff's Department. Orangeburg County has also submitted 2016 incident report data for analysis, and Greenville County is working on gathering incident report data for analysis. No reliable statewide estimate exists to measure the number of child victims and survivors. Data collection and analysis are essential to understanding human trafficking victimization and service needs and to inform prevention, intervention, and policy-making on human trafficking.

Victim-Centered Approach

The prosecution of traffickers must be an important consideration but should not override an approach that places the child as the focus of our state response. This population of children has elevated needs which cannot be met solely in court. Victim-centered approaches prioritize a victim's wishes, safety, and well-being in all matters and focus on the needs and concerns of victims to ensure the compassionate and sensitive delivery of services in a nonjudgmental manner.⁵⁶ Victim-centered approaches incorporate trauma-informed care which allows providers to gain an understanding of a victim's trauma and an awareness of the impact it can have across settings and services.⁵⁷ A trauma-informed approach to the delivery of services has four key elements: (1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; (3) responding by putting this knowledge to practice; and (4) resisting re-traumatization, and creating opportunities for survivors to rebuild a sense of control and empowerment.⁵⁸ Services, placements, and providers should be flexible when accommodating a victim's fluctuating perception of safety and must do no further harm to any child or adolescent victim or survivor.

Recommendations

The development of a coordinated response to CSEC in our state is an urgent need, but must be deliberately informed by experts on child development and local needs and resources. The Committee on Children commits to further study of this issue to determine the best policy and practice solutions to benefit South Carolina's youngest victims of CSEC. Committee staff will identify next steps in partnership with child-serving agencies and other stakeholders to support adoption of a cross-system standardized screening tool

⁵⁶ Human Trafficking Task Force e-Guide, *supra* note 17.

⁵⁷ Substance Abuse and Mental Health Services Administration, *Trauma-Informed Care, Key Terms: Definitions*, https://www.samhsa.gov/samhsaNewsLetter/Volume_22_Number_2/trauma_tip/key_terms.html (last visited Jan. 21, 2017).

⁵⁸ *Id.*

to better ensure victim-centered and trauma-informed approaches in all phases of victim identification, assistance, recovery, and participation in the criminal justice process; and development of a statewide uniform data collection system to better identify risk factors of CSEC and service needs of child victims. Committee staff will also continue its research and state resource review to support the development of local MDTs to coordinate children's care management. Finally, the Committee encourages passage of the needed definitional change for DSS to serve child victims of human trafficking, and will continue to consider other needed legislation to strengthen the legal response to CSEC, to support DSS as the lead agency in this critical task, as well as support the other child-serving agencies who will work with this population of young victims.

Promoting Children’s Physical and Mental Health and Well-Being

Children in South Carolina are suffering from a variety of negative factors impacting their mental health and well-being. Trauma, toxic stress, and inadequate supports can lead to immediate and long-term mental and physical health impacts. Trauma can be examined using the 3 Es: to truly understand childhood trauma, one must look at the traumatic *event*, the child’s *experience* during that event, and the *effects* of the event on the child.⁵⁹ Toxic stress is a response to trauma resulting from the absence of protections.⁶⁰ Prevention of trauma whenever possible is crucial, as are early identification and intervention for children who have been exposed to adverse childhood experiences. The Committee has a long-standing commitment to the use of data and evidence-based practices to guide policies, as demonstrated in its initiatives focusing on obesity, child passenger safety, and immunizations. The Committee continues its commitment to the use of best practices to protect children’s physical and mental health and well-being by focusing on **Adverse Childhood Experiences (ACEs) and Resilience**.

Adverse Childhood Experiences (ACEs) and Resilience

Adverse Childhood Experiences (ACEs) are events involving psychological abuse, physical abuse, sexual abuse, or household dysfunction experienced during childhood.⁶¹ They are a subset of childhood traumatic experiences. Children are exceptionally vulnerable to the experience and effects of maltreatment.⁶² ACEs impact a child’s health and development in a variety of ways. While the experiences themselves or the outward symptoms of distress shown by a child may be temporary, the effects of ACEs and toxic stress can be permanent. Simply put, these experiences can change the architecture of a child’s developing brain by creating “a weak foundation for later learning, behavior, and health.”⁶³ This disrupted foundation impacts adult behavior.⁶⁴ ACEs also have intergenerational impacts, as “adults in this high-risk group who become parents themselves are less likely to be able to provide the kind of stable and supportive relationships that are needed to protect their children from the damages of toxic stress.”⁶⁵

⁵⁹ SAMHSA’S TRAUMA AND JUSTICE STRATEGIC INITIATIVE, SAMHSA’S CONCEPT OF TRAUMA AND GUIDANCE FOR A TRAUMA-INFORMED APPROACH (2014), <https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf> (last visited Feb 8, 2018).

“Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”

⁶⁰ Jack P. Shonkoff, MD & Andrew S. Garner, MD, PhD, *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, 129 PEDIATRICS e232–e246, 236 (2012). “The third and most dangerous form of stress response, toxic stress, can result from strong, frequent, or prolonged activation of the body’s stress response systems in the absence of the buffering protection of a supportive, adult relationship... The essential characteristic of this phenomenon is the postulated disruption of brain circuitry and other organ and metabolic systems during sensitive developmental periods.”

⁶¹ See generally Vincent Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, 14 AM. J. PREV. MED. 245–258 (1998).

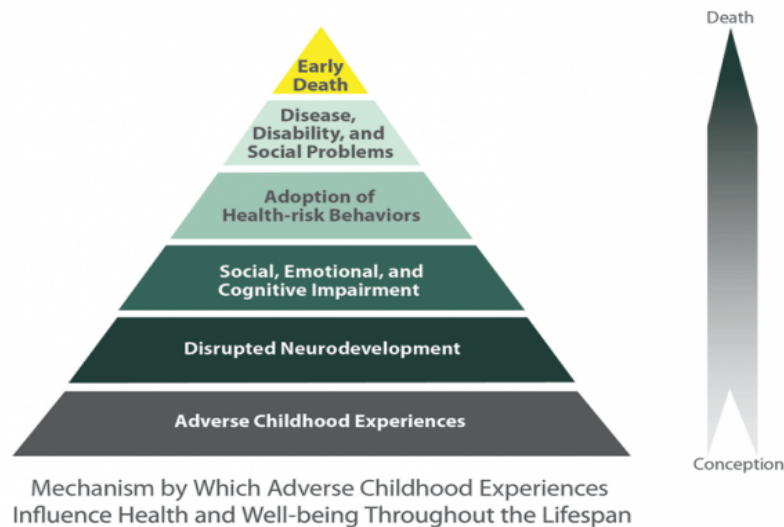
⁶² Center for the Study of Social Policy, *STRENGTHENING FAMILIES: A PROTECTIVE FACTORS FRAMEWORK 3*, <https://www.cssp.org/young-children-their-families/strengtheningfamilies/about>.

⁶³ Jack P. Shonkoff, MD and Andrew S. Garner, MD, PhD, *supra* note 60 at 236.

⁶⁴ Shanta R. Dube et al., *Adverse childhood experiences and personal alcohol abuse as an adult*, 27 ADDICT. BEHAV. 713–725, 723 (2002).

⁶⁵ Jack P. Shonkoff, MD and Andrew S. Garner, MD, PhD, *supra* note 60 at 237.

The Center for Disease Control and Prevention summarized these impacts over an individual's lifespan:



*Center for Disease Control and Prevention*⁶⁶

The impacts of ACEs can be mitigated through positive experiences, improvement of protective factors, and encouragement of resilience.⁶⁷ These interventions can lessen the potentially life-long suffering of survivors of ACEs and toxic stress and reduce future public health costs that correlate with ACEs.⁶⁸ The science of child and adolescent brain development is advancing rapidly, and public policy needs to catch up to reflect “the early childhood roots of adult disease and to examine the compelling implications of this growing knowledge base for the future of pediatric practice.”⁶⁹

⁶⁶ Center for Disease Control and Prevention, *The ACE Pyramid About the CDC-Kaiser ACE Study*, <https://www.cdc.gov/violenceprevention/acestudy/about.html>.

⁶⁷ See, e.g., Center for Disease Control and Prevention, *ACE Prevention Strategies Violence Prevention*, https://www.cdc.gov/violenceprevention/ace/prevention_strategies.html; Judy Hall et al., *Reducing Adverse Childhood Experiences (ACE) by Building Community Capacity: A Summary of Washington Family Policy Council Research Findings*, 40 J. PREV. INTERV. COMMUNITY 325–334 (2012); Robert Sege, MD, PhD et al., *Balancing Adverse Childhood Experiences (ACEs) With HOPE*: New Insights into the Role of Positive Experience on Child and Family Development* (2017), <https://www.cssp.org/publications/documents/Balancing-ACEs-with-HOPE-FINAL.pdf>.

⁶⁸ ACEs correlate with a number of public health harms that will be discussed later in this chapter, but the cost of chronic diseases correlated with ACEs is substantial. See, e.g., Mary Ann Priester, MSW et al., *Adverse Childhood Experiences in South Carolina: Preventable Chronic Diseases* 6 (2017), https://scchildren.org/public/files/docs/Prevention_Learning_Center/ACE-Research-Brief-SC-Chronic-Diseases.pdf. “In 2014, the chronic diseases correlated with ACEs were estimated to have an economic burden of \$1.3 trillion in lost productivity and healthcare costs. By 2023, costs related to these chronic diseases are predicted to increase to \$4.1 trillion annually.”

⁶⁹ Jack P. Shonkoff, MD and Andrew S. Garner, MD, PhD, *supra* note 60 at 237.

Understanding ACEs

In 1998, researchers first developed a tool to survey primary care patients to measure the impact of exposure to child trauma and household dysfunction on disease risk factors and incidence, health care utilization, mortality, and quality of life in adults.⁷⁰ The survey involved the following questions, which participants answered with yes or no.⁷¹

Psychological Abuse

(Did a parent or other adult in the household ...)

Often or very often swear at, insult, or put you down?

Often or very often act in a way that made you afraid that you would be physically hurt?

Physical Abuse

(Did a parent or other adult in the household ...)

Often or very often push, grab, shove, or slap you?

Often or very often hit you so hard that you had marks or were injured?

Sexual Abuse

(Did an adult or person at least 5 years older ever ...)

Touch or fondle you in a sexual way?

Have you touch their body in a sexual way?

Attempt oral, anal, or vaginal intercourse with you?

Actually have oral, anal, or vaginal intercourse with you?

Household dysfunction by category

Substance abuse

Live with anyone who was a problem drinker or alcoholic?

Live with anyone who used street drugs?

Mental illness

Was a household member depressed or mentally ill?

Did a household member attempt suicide?

Mother treated violently

Was your mother (or stepmother)

Sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at her?

Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?

Ever repeatedly hit over at least a few minutes?

Ever threatened with, or hurt by, a knife or gun?

Criminal behavior in household

Did a household member go to prison?

⁷⁰ Felitti et al., *supra* note 58. The study included two cohorts of 19,000 respondents and 15,000 respondents, respectively.

⁷¹ *Id.* at 248.

For each “yes” response, participants were given a point. The total number of points for all questions is a patient’s ACE score.

Table 3. Prevalence of categories of adverse childhood exposures by demographic characteristics

Characteristic	Sample size (N)	Number of categories (%) ^a				
		0	1	2	3	4
Age group (years)						
19–34	807	35.4	25.4	17.2	11.0	10.9
35–49	2,063	39.3	25.1	15.6	9.1	10.9
50–64	2,577	46.5	25.2	13.9	7.9	6.6
≥65	2,610	60.0	24.5	8.9	4.2	2.4
Gender ^b						
Women	4,197	45.4	24.0	13.4	8.7	8.5
Men	3,859	53.7	25.8	11.6	5.0	3.9
Race ^b						
White	6,432	49.7	25.3	12.4	6.7	6.0
Black	385	38.8	25.7	16.3	12.3	7.0
Hispanic	431	42.9	24.9	13.7	7.4	11.2
Asian	508	66.0	19.0	9.9	3.4	1.7
Other	300	41.0	23.5	13.9	9.5	12.1
Education ^b						
No HS diploma	480	56.5	21.5	8.4	6.5	7.2
HS graduate	1,536	51.6	24.5	11.3	7.4	5.2
Any college	2,541	44.1	25.5	14.8	7.8	7.8
College graduate	3,499	51.4	25.1	12.1	6.1	5.3
All participants	8,056	49.5	24.9	12.5	6.9	6.2

Vincent Felitti *et al*⁷²

The researchers then looked at the correlation between exposure to ACEs and ten risk factors that were leading contributors to morbidity and mortality in the United States, including smoking, drug abuse, and a number of chronic diseases.⁷³ Some of the correlation between ACEs and adult health risk factors appears to result from the use of unhealthy behaviors as coping mechanisms for childhood trauma.⁷⁴ However, there are also links between exposure to ACEs and adult health problems independent of genetic history and problem behaviors, demonstrating that the link goes far beyond poor coping mechanisms and unhealthy behaviors.

ACEs in South Carolina

South Carolina is distinct from the rest of the country, “with higher rates of minorities (27.9% African-American residents in SC versus 12.6% nationwide, $p < 0.01$) and lower rates of college-educated citizens (25.8% in SC versus 29.8% nationwide, $p < 0.01$), both characteristics that may influence ACEs exposure.”⁷⁵ ACE data for South Carolina was collected for 2014-2015 through the Centers for Disease Control’s Behavioral Risk Factor Surveillance System (BRFSS), which is managed by the Department of Health and Environmental Control.⁷⁶ A total of 62% of participants surveyed reported having

⁷² *Id.* at 251; used with permission.

⁷³ Felitti *et al.*, *supra* note 61.

⁷⁴ *Id.* at 253.

⁷⁵ Elizabeth Crouch *et al.*, *Assessing the interrelatedness of multiple types of adverse childhood experiences and odds for poor health in South Carolina adults*, 65 CHILD ABUSE NEGL. 204–211, 206 (2017).

⁷⁶ Adverse Childhood Experiences: South Carolina Data 2014-2015 (2017), https://scchildren.org/public/files/docs/Prevention_Learning_Center/ACE-Data-Packages/ACE-State-Data-2014-15.pdf.

experienced at least one ACE factor, and 16% reported having an ACE score of four or more.⁷⁷ The most common ACEs based on the surveyed results included parental divorce/separation (30%), emotional abuse (30%), and household substance use (28%).⁷⁸ Notably, South Carolina’s prevalence of emotional abuse is twice as high as the original study.⁷⁹

Demographic Variation of ACEs in South Carolina

DEMOGRAPHICS

	Demographic Variables	All	No ACE	ACE	4+ ACE
Sex	Male	48%	40%	60%	14%
	Female	52%	37%	63%	18%
Age	18-29	20%	27%	73%	21%
	30-39	15%	29%	71%	22%
	40-49	17%	32%	68%	21%
	50-59	18%	43%	57%	14%
	60-69	17%	43%	57%	13%
	70+	13%	58%	42%	5%
Race/Ethnicity	American Indian	1%	29%	71%	24%
	Asian	1%	53%	47%	5%
	Black	25%	35%	65%	14%
	Hispanic	4%	21%	79%	16%
	White	68%	41%	59%	17%
	Other	2%	21%	79%	35%
Annual Household Income	\$0-\$9,999	6%	30%	70%	23%
	\$10,000-\$14,999	6%	32%	68%	24%
	\$15,000-\$19,999	9%	31%	69%	22%
	\$20,000-\$24,999	9%	32%	68%	20%
	\$25,000 - \$34,999	11%	35%	65%	17%
	\$35,000 - \$49,999	14%	37%	63%	17%
	\$50,000 - \$74,999	14%	43%	57%	14%
	\$75,000 or more	23%	43%	57%	12%
Educational Attainment	Some high school	15%	32%	68%	21%
	Graduated high school	30%	37%	63%	16%
	Some college or trade	32%	37%	63%	18%
	Graduated college or trade	23%	47%	53%	11%

*Children’s Trust of South Carolina*⁸⁰

The disparities between rural and urban communities are also important, with rural residents reporting less ACE exposure than their urban counterparts.⁸¹ Despite this, the difficulties in dealing with ACEs in rural communities should not be underestimated: “In

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ Felitti et al., *supra* note 61.

⁸⁰ ADVERSE CHILDHOOD EXPERIENCES: SOUTH CAROLINA DATA 2014-2015, *supra* note 76; used with permission.

⁸¹ B Radcliff, E Crouch & M Stropolis, *Rural-urban differences in adverse childhood experiences in South Carolina adults*, Rural Remote Health (2017).

contrast to urban residents, rural residents may experience more social connections within their families and communities, which may influence ACE exposure; however, care coordination, social support services, and access to health care are limited in rural areas. Thus, families in rural areas may be less equipped to mitigate and manage the effects of ACEs.”⁸²

Health Risks That Correlate with ACEs

Understanding ACEs is important for reasons that go beyond compassion: exposure to ACEs has been shown to correlate with a number of health problems. Because of exposure to adverse childhood experiences, a survivor of childhood trauma may have challenges finding appropriate coping mechanisms,⁸³ and may turn to substance use.⁸⁴ For the purposes of prevention, identification, and intervention, it is important to examine and identify these behaviors and also to identify cases where a link between childhood exposure to ACEs and adult health problems exists even in the absence of those behaviors.

Alcohol Use Disorders

There is a strong correlation between exposure to ACEs and adult alcohol use disorders.⁸⁵ Alcohol use disorders may result from a number of factors and are often attributed to genetic factors or familial patterns—if a parent abuses alcohol, their child is more likely to abuse alcohol as an adult.⁸⁶ However, the correlation between exposure to ACEs and adult alcohol use disorders is strong even in individuals with no history of parental alcohol use disorders - individuals with ACE scores of four or above have a fourfold increase in self-reported alcohol use disorders even without parental history of alcohol use disorders,⁸⁷ regardless of their sociodemographic characteristics⁸⁸ and gender.⁸⁹ The strength of the association varied between the genders, as did which ACEs correlated with adult alcohol use disorders.⁹⁰ It is worth noting that these findings are likely

⁸² *Id.*

⁸³ Shanta R. Dube, MPH et al., *supra* note 61 at 723.

⁸⁴ Shanta R. Dube, MPH et al., *Childhood Abuse, Neglect, and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experiences Study*, 111 PEDIATRICS 564–572, 570 (2003).

⁸⁵ For a discussion of this relationship in South Carolina, see Elizabeth Crouch et al., *Adverse Childhood Experiences (ACEs) and Alcohol Abuse among South Carolina Adults*, SUBST. USE MISUSE (2017).

⁸⁶ See, e.g., a Rebecca Gilbertson, Robert Prather & Sara Jo Nixon, PhD, *The Role of Selected Factors in the Development and Consequences of Alcohol Dependence*, 31 ALCOHOL RES. HEALTH 389–399 (2008). See also Shanta R. Dube et al., *supra* note 64 at 714.

⁸⁷ Shanta R. Dube et al., *supra* note 64 at 722. “An ACE score of at least four, in contrast to a zero ACE score, was associated with fourfold risk of self-reported alcoholism among adults with no history of parental alcoholism and threefold risk of alcoholism among those with at least one alcoholic parent. [...] Adults with an ACE score of at least four and a history of parental alcoholism also had the highest risk of self-reported alcoholism (21.4%) and marrying an alcoholic (38.6%) than other adults in the study.”

⁸⁸ Tara W. Strine, PhD, MPH et al., *Associations Between Adverse Childhood Experiences, Psychological Distress, and Adult Alcohol Problems*, 36 AM. J. HEALTH BEHAV. 408–423, 415 (2012).

⁸⁹ *Id.* at 418.

⁹⁰ *Id.* at 418. “Among women, our results confirmed previous suggesting that a variety of ACEs including abuse (emotional, physical, sexual), neglect (emotional, physical), and household dysfunction (parental separation or divorce, drug use in household, and mental illness in household) were related to self-reported alcohol problems. Among men, we found that, in addition to sexual abuse, self-reported alcohol problems may also be related to physical abuse, emotional neglect, and various types of household dysfunction (drug use in household, mental illness in household, and incarcerated household member).”

an undercount, as people tend to underreport alcohol use disorders and underreport being married to people who misuse alcohol.⁹¹

Drug Abuse

Individuals who have experienced ACEs are also more likely to use drugs and initiate drug use earlier than their peers who have not been exposed to ACEs. Given the trauma of ACEs, individuals who have been exposed to the associated toxic stress may utilize drugs to escape or dissociate.⁹² Every type of ACE increases the likelihood of drug use prior to the age of 14 two- to four-fold.⁹³ For every increase in the number of ACEs, the likelihood of this early drug use increases by 40%.⁹⁴ Illicit drug use has substantial economic costs, including lost productivity, crime, and burdens on health care systems.⁹⁵

Smoking

Individuals who have experienced ACEs are more likely to begin smoking earlier and more likely to die from lung cancer at an earlier age.⁹⁶ Exposure to ACEs appears to actually cause individuals to begin smoking earlier.⁹⁷ This may be attributable to the desire for mood regulation through the psychoactive effects of nicotine.⁹⁸ In 2015, 12% of youth in high school and 20% of adults in South Carolina smoked cigarettes.⁹⁹ Smoking is extremely harmful and is responsible for 30% of all cancer deaths and nearly 80% of deaths from chronic obstructive pulmonary disease.¹⁰⁰ Identification of ACEs and appropriate early treatments or interventions may reduce early smoking initiation.¹⁰¹

Health Risks that Exceed Unhealthy Behaviors

As noted above, exposure to ACEs may lead to a number of unhealthy behaviors that are known risk factors for many chronic diseases.¹⁰² Notably, there is also evidence of a correlation between ACEs and chronic diseases even after controlling for those behaviors and adjusting for traditional risk factors for those diseases. For example, a high ACE score

⁹¹ Shanta R. Dube, MPH et al., *supra* note 61 at 724.

⁹² Shanta R. Dube, MPH et al., *supra* note 84 at 568.

⁹³ *Id.* at 567.

⁹⁴ *Id.* at 567.

⁹⁵ National Drug Threat Assessment 1–64 (2011), <https://www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf>. “The estimated economic cost of illicit drug use to society for 2007 was more than \$193 billion. This estimate reflects direct and indirect public costs related to crime (\$61.4 billion), health (\$11.4 billion), and lost productivity (\$120.3 billion).”

⁹⁶ David W Brown et al., *Adverse childhood experiences are associated with the risk of lung cancer: a prospective cohort study*, 10 BMC PUBLIC HEALTH (2010), <https://bmcpublihealth.biomedcentral.com/articles/10.1186/1471-2458-10-20>.

⁹⁷ Robert F. Anda et al., *Adverse Childhood Experiences and Smoking During Adolescence and Adulthood*, 282 J. AM. MED. ASSOC. 1652–1658, 1657 (1999).

⁹⁸ *Id.* at 1657.

⁹⁹ Center for Disease Control and Prevention, *State Tobacco Activities Tracking and Evaluation (STATE) System: South Carolina*, https://nccd.cdc.gov/STATE/System/rdPage.aspx?rdReport=OSH_STATE.Highlights&rdRequestForwarding=Form.

¹⁰⁰ David W Brown et al., *supra* note 96 at 12.

¹⁰¹ Robert F. Anda et al., *supra* note 97 at 1657.

¹⁰² Maxia Dong et al., *Adverse Childhood Experiences and Self-Reported Liver Disease: New Insights Into the Causal Pathway*, 163 ARCH. INTERN. MED. 1949–1956, 1953 (2003). “[T]he effects of childhood trauma on occurrence of liver disease may operate through resultant behaviors such as alcohol consumption, drug abuse, and sexual promiscuity, which, in turn, may be attempts to cope with unpleasant affective states and alterations in brain function that likely result from ACEs.”

correlates to a higher rate of death from lung cancer at younger ages even where individuals did not smoke more or begin smoking earlier, which “suggests other mechanisms by which childhood traumatic stressors negatively affect health.”¹⁰³ Further, for every increase in an individual’s ACE score (except for parental marital discord), the likelihood of reporting Ischemic Heart Disease (IHD) increased by 10% even after controlling for traditional and psychological risk factors, leading researchers to conclude, “it appears that there may be unmeasured or as yet unidentified pathways by which ACEs affect the risk of IHD.”¹⁰⁴ Therefore, it is crucial to identify individuals who have been exposed to ACEs and offer effective interventions to attempt to control these risks.

Protective Factors and Resilience

The presence of protective factors in childhood has been shown to help mitigate and lessen the impact of ACEs. Protective factors are the positive individual, family, and community conditions and interactions that help a child feel safe after experiencing the trauma and stress associated with ACEs.¹⁰⁵ They include parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children.¹⁰⁶ Additionally, these protective factors can also include a child’s own biological, developmental, and educational characteristics, like problem solving skills and agency.¹⁰⁷ The greatest protective impact shown came from childhood feelings of familial support during hard times and the ability to talk to someone about difficult feelings.¹⁰⁸

Protective factors can also serve to prevent exposure to ACEs, particularly when the ACEs stem from intergenerational trauma or abuse. With protective factors, parents can mitigate the impact of their own responses to trauma on their parenting by managing clinical symptoms and reactions, protecting children from adversity and trauma, and providing more nurturing care and secure attachment to their children.¹⁰⁹

According to the Center for the Study of Social Policy, protective factors can contribute to optimal child and youth development, while also strengthening family relationships. The presence of these protective factors within families increases the chances

¹⁰³ David W Brown et al., *supra* note 96 at 10.

¹⁰⁴ Maxia Dong et al., *Insights into Causal Pathways for Ischemic Heart Disease: Adverse Childhood Experiences Study*, CIRCULATION, 1765 (2004).

¹⁰⁵ Minnesota Department of Health, *Resilience to ACEs*, <http://www.health.state.mn.us/divs/cfh/program/ace/resilience.cfm>.

¹⁰⁶ Center for the Study of Social Policy, *Core Meanings of the Strengthening Families Protective Factors*, <https://www.cssp.org/reform/strengtheningfamilies/2015/Core-Meanings-of-the-SF-Protective-Factors-2015.pdf>.

¹⁰⁷ Minnesota Department of Health, *supra* note 97.

¹⁰⁸ Sege, R., Bethell, C., et al. Balancing adverse childhood experiences with HOPE: New insights into the role of positive experience on child and family development 13-14 (2017) <https://www.cssp.org/publications/documents/Balancing-ACEs-with-HOPE-FINAL.pdf>.

¹⁰⁹ Center for the Study of Social Policy, *Parental Resilience*, https://www.cssp.org/reform/strengthening-families/2013/SF_Parental-Resilience.pdf.

that a child will achieve positive outcomes later in life.¹¹⁰ Data from the Wisconsin Behavioral Risk Factor Survey showed that positive childhood experiences, including protective factors, have long-lasting effects into adulthood, like fewer negative health and behavioral outcomes.

The presence of protective factors during childhood helps children to develop resilience. Resilience is the ability to recover or to cope effectively with adverse events or traumas.¹¹¹ In the case of ACEs, resilience is the ability to utilize protective factors to stem the long-term negative impacts of exposure to ACEs.¹¹² This interaction helps to determine and shape the behavioral and health outcomes later in life.¹¹³ Analysis of the 2011-12 National Survey of Children's Health data showed a strong correlation between childhood resilience and mitigating the negative effects of ACEs, especially when it came to having better school outcomes.¹¹⁴

Some children may be naturally more resilient to ACEs by way of their own characteristics and experiences; however, the presence of protective factors, especially nurturing and stable relationships, can significantly impact a child's resilience to the stress and trauma associated with ACEs and provide long term positive outcomes into adulthood.¹¹⁵ Building resilience gives every child the skills to live a healthy and productive adult life.

South Carolina Initiatives

A number of promising programs exist to address ACEs in South Carolina. Children's Trust has been studying ACEs and, with funding from DSS and the Duke Endowment, supports programs such as the Strengthening Families Program,¹¹⁶ Community Support for Young Parents,¹¹⁷ Triple P,¹¹⁸ and Maternal Infant Early

¹¹⁰ Protective/Promotive Factors Across Development. Center for the Study of Social Policy. <https://cssp.org/reform/strengtheningfamilies/practice/body/HO1.3-Protective-and-Promotive-Factor-Infographic.pdf>

¹¹¹ CENTER FOR THE STUDY OF SOCIAL POLICY, YOUTH RESILIENCE, https://www.cssp.org/reform/strengtheningfamilies/practice/body/HO-3.1e-YT_Youth-Resilience.pdf, p. 1.

¹¹² *Supra* note 101.

¹¹³ *Id.*

¹¹⁴ Robert Sege, MD, PhD et al., Balancing Adverse Childhood Experiences (ACEs) With HOPE, <https://www.cssp.org/publications/documents/Balancing-ACEs-with-HOPE-FINAL.pdf>, at 13.

¹¹⁵ *Supra* note 101.

¹¹⁶ Children's Trust of South Carolina, *Children's Trust Strengthening Families Program*, <https://scchildren.org/local-partners/strengthening-families-program/>. The Strengthening Families Program (SFP) serves families with children ages 6 to 11 through local partners in settings that include community centers, schools, and churches. SFP is designed to help families develop positive discipline practices, stay resilient in tough times, reduce conflict, improve parenting skills, and assist children with social skills, relationships, and school performance. All of these factors play an important role in keeping families strong while protecting against potential neglect or abuse. Participants complete a 14-session program graduate. The sessions, which always begin with a family meal, typically last 2½ hours and include parents and children meeting separately to work with group leaders before coming together for shared activities to finish.

¹¹⁷ Children's Trust of South Carolina, *Community Support for Young Parents*, <https://scchildren.org/local-partners/community-support-for-young-parents/>.

¹¹⁸ As a national and international parenting program, the Triple P support system helps parents address behavioral and emotional issues in children and teenagers. Triple P offers five different levels of services, so that organizations can offer help to every parent depending on the help they need. It offers single-visit consultations, public seminars and group courses, and private sessions. The 5 Core Principles of Triple P are 1) Ensuring a safe and engaging environment; 2) creating a positive learning environment that helps

Childhood Home Visiting¹¹⁹ to help families build resilience and prevent exposure to ACEs. The Department of Mental Health, in partnership with Children’s Trust, has developed the Pee Dee Resiliency Project, which provides wraparound school-based services to children and families in the Pee Dee to focus on building family and community resilience to combat ACEs and mental health issues.¹²⁰ The Pee Dee Resiliency Project is a community-based partnership for students and their families to prevent or cope with and recover from adversity or to address emotional and behavioral challenges that interfere with a student’s success. With schools serving as the gateway to community support and services, the project will focus on increasing understanding of adversity, updating school policies to better support students and their families, and improving school connections to community resources. By supporting student well-being, the project encourages positive child behaviors and academic achievement, reduces child maltreatment and exposure to other toxic stressors, increases family well-being and achievement, promotes quality caregiving, and ensures that children live in safe and supportive neighborhoods. These programs are limited in size and scope, and many of them are new; however, they show promising results for children and families in South Carolina.

Recommendations

The Committee on Children makes the following recommendations related to this priority issue:

1. Support and promote programs in South Carolina and around the nation that prevent ACEs and promote protective factors.
2. Improve screening for exposure to ACEs. Some of the pathways between ACEs and health problems are not yet clearly understood, but practitioners should nonetheless begin screening for ACEs to allow for earlier identification and treatment.¹²¹
3. Family court cases for delinquency or child abuse should include an assessment for childhood trauma and address services to mitigate the consequences of toxic stress.
4. State child-serving agencies should coordinate and expand the collection of uniform and standardized data regarding the number and type of ACEs children experience and share data to effectively identify needs and provide services.

children learn to solve problems; 3) using assertive, consistent discipline that teaches children to accept responsibility for their behavior; 4) having realistic expectations about children’s behavior; and 5) taking care of yourself as a parent to find balance in life.

¹¹⁹ Children’s Trust of South Carolina, CHILDREN’S TRUST HOME VISITING, <https://scchildren.org/local-partners/home-visiting-is-locked-home-visiting/>. Home visiting is a service delivery strategy that has existed for many years in a number of fields to serve clients in a way that best meets their needs and eliminates barriers that would otherwise inhibit access to services. Home visiting has become an especially significant intervention in the context of early childhood, given its proven effectiveness at achieving improved outcomes around the health and well-being of children and families as well as its ability reach at-risk populations most in need of these services. Programs target improved outcomes related to health, development, early learning, family support, and prevention of child abuse and neglect. The research shows that home visits by a nurse, social worker, or early childhood educator during pregnancy and in the first years of life make a real difference, from the promotion of maternal and infant health to increased positive parenting to stronger school readiness. Services pair new, volunteer families with home visitors who provide family-focused services throughout the critical first few years of the child’s development. Programs offer services to expectant and post-partum parents and families with new babies and children and continue to serve families throughout the child’s first five years of life.

¹²⁰ Pee Dee Resiliency Project, <https://peedeeresiliencytemporary.blog/>.

¹²¹ Maxia Dong et al., *supra* note 102 at 1955.

5. A multi-agency group, such as the Joint Council on Children and Adolescents, which promotes and facilitates collaborative activities to improve access to quality, responsive, and cost-effective services for children, adolescents, and their families, should examine the efforts of its member agencies regarding identification and prevention of ACEs and building protective factors and should report to the Committee regarding any available data, limitations on available data, and promising programs.

Acknowledgments

The 2018 Annual Report of the Joint Citizens and Legislative Committee on Children is the result of countless hours of hard work and the cooperation of many agencies and individuals. Much assistance was provided to the Committee with its data collection, analysis, research, policy review, and editing to ensure that issues affecting children in South Carolina are accurately and clearly presented.

The Committee thanks the many South Carolina residents who took time to attend the public hearings and present testimony to the Committee. The Committee relies heavily on the concerns and recommendations offered by those who confront children's issues on a daily basis.

Staff to the Committee met with stakeholders throughout the state to discuss the critical issues surrounding the youngest victims of human trafficking in South Carolina, including child welfare professionals, juvenile justice professionals, substance disorder professionals, community- and faith-based organizations, law enforcement personnel, attorneys in juvenile and criminal courts, judges in juvenile and criminal courts, mental health professionals, social workers, educators, physicians and other health care providers, and survivors. The Committee is thankful to each of those stakeholders for their time, expertise, and ongoing commitment to protect South Carolina's children.

The Committee also expresses its appreciation to the many stakeholders and agency staff whose work contributed indirectly to this 2018 Annual Report. The members of the Committee are especially grateful for the contributions and efforts of the following individuals who assisted in its preparation: Allison Farrell, Department of Mental Health; and Dr. Melissa Stropolis, Children's Trust of South Carolina.

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