2016 Data Reference Book
Joint Citizens and Legislative
Committee on Children

Joint Citizens and Legislative Committee on Children

Membership

Appointed by the President Pro Tempore of the Senate:

Senator Michael L. Fair, Greenville, Chair
Senator C. Bradley Hutto, Orangeburg
Senator Darrell Jackson, Columbia

Appointed by the Speaker of the House:

Representative Shannon S. Erickson, Beaufort, Vice Chair
Representative Mia S. McLeod, Columbia
Representative Neal A. Collins, Pickens

Appointed by the Governor:

Ms. Marie M. Land, Manning
Mr. W. Derek Lewis, Greenville

Ex Officio:

Director, Department of Disabilities and Special Needs... Beverly A. H. Buscemi, Columbia
State Superintendent of Education ..... Molly M. Spearman, Columbia
Director, Department of Juvenile Justice..... Sylvia Murray, Columbia
Director, Department of Mental Health ..... John H. Magill, Columbia
Director, Department of Social Services..... V. Susan Alford, Columbia

Committee website: sccommitteeonchildren.org

Committee Staff:

Children's Law Center, University of South Carolina School of Law

Harry W. Davis, Jr., Director ..... hwdavis@sc.edu
Carolyn S. Morris, Assistant Director ..... carolynmorris@sc.edu
Amanda Adler, Senior Resource Attorney ..... amandaadler@sc.edu

1600 Hampton Street, Suite 502
Columbia, South Carolina 29208
(803) 777-1646
http://childlaw.sc.edu

STATE OF SOUTH CAROLINA

JOINT CITIZENS AND LEGISLATIVE COMMITTEE ON CHILDREN

Fellow South Carolinians:

On behalf of the Joint Citizens and Legislative Committee on Children and its staff from the Children's Law Center of the USC School of Law, we are pleased to provide you with this 2016 Child Well-being Data Reference Book as a supplement to the 2016 Annual Report, which contains findings and recommendations for action on a variety of issues impacting the well-being of South Carolina's children. This document will supply you with much of the research to support the annual report.

The Committee on Children studies issues and makes legislative and policy recommendations designed to improve the well-being of children in South Carolina. Annually, the Committee on Children conducts public hearings and collects data to support its policy and legislative work. The data are reported in this child well-being data reference book.

The data contained herein indicates that the children of our state face challenges to their safety, health, and education.

We urge you to put this information to good use as you consider the implications of the data and contemplate policy recommendations for future study and action.

Our thanks to all those who contributed to compiling this report. May it serve our children well.

Michael L. Fair

Mike Fair

Chair

Shannon S. Erickson

Shannon S. Erickson

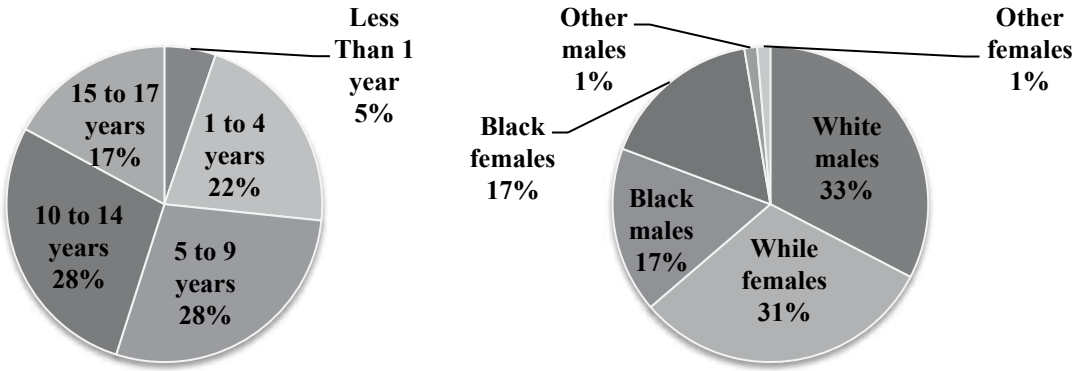
Vice Chair

2016 CHILD WELL-BEING DATA REFERENCE BOOK
TABLE OF CONTENTS

Demographics

Child Population

- There were 4,832,482 people in South Carolina, and **1,089,749** or **23%** of the population were children under 18 years.[1] (2014)
- **57,631** children were born in South Carolina with a birth rate of 11.9 per 1,000 population.[2] (2014)
- **93,374** or **8.6%** of children in South Carolina were Hispanic in 2014.[3]



Family and Parents

- **432,000** or **43%** of children in South Carolina were living in single-parent families.[4] (2014)
- **110,000** or **10%** of children were in immigrant families.[5] (2014)
- **27%** of children were in family that household head had a bachelor's or higher degree.[6] (2014)
- **356,000** or **33%** of children whose parents lack secure employment.[7] (2014)

[1] S.C. Department of Health and Environment Control, **http://scangis.dhec.sc.gov/scan/bdp/tables/populationtable.aspx** (Last visited, November 23, 2015).
[2] S.C. Department of Health and Environment Control, **http://scangis.dhec.sc.gov/scan/bdp/tables/birthtable.aspx** (Last visited, November 23, 2015).
[3] S.C. Department of Health and Environment Control, **http://scangis.dhec.sc.gov/scan/bdp/tables/populationtable.aspx** (Last visited, November 23, 2015).
[4] KIDS COUNT data center. Indicator: Children in single-parent families, **http://www.datacenter.kidscount.org/topics** (Last visited, March 28, 2016).
[5] KIDS COUNT data center. Indicator: Children in immigrant families, **http://www.datacenter.kidscount.org/topics** (Last visited, January 7, 2016).
[6] KIDS COUNT data center. Indicator: Children by household head's educational attainment, **http://www.datacenter.kidscount.org/topics** (Last visited, January 7, 2016).
[7] KIDS COUNT data center. Indicator: Children whose parents lack secure employment, **http://www.datacenter.kidscount.org/topics** (Last visited, January 7, 2016).

Highlights

In 2014, South Carolina was ranked 42nd in the nation on overall child well-being by the Annie E. Casey Foundation in its annual *KIDS COUNT Data Book*.[8] The most recent available data showed that:

- **619** children died in South Carolina.[9] (2014)
- **1,235** infants were born to female teenagers under 18 years old.[10] (2014)
- **101,529** children suffered non-fatal injuries requiring a hospital or emergency room visit.[11] (2014)
- **281,738** children lived in poverty, which was 26.4% of the child population.[12] (2014)
- **721,198** or **66%** of children in South Carolina were enrolled in Medicaid.[13] (2015)
- **58%** of all students received subsidized school meals to have access to adequate nutrition.[14] (2015)
- **30,512** children were the subject of a child abuse or neglect investigation.[15] (2015)
- **3,752** children lived in foster care for some period of time.[16] (2015)
- **15,697** juvenile delinquency cases were referred to the Department of Juvenile Justice.[17] (2015)
- **25,731** children received mental health treatment.[18] (2015)
- **13%** of children in public schools have diagnosed disabilities.[19] (2015)
- **20%** of all students who started school did not graduate with their peers.[20] (2014)
- **22,614** children experienced homelessness in 2013.[21] (2013)
- **553,318** or more than half of the children (52.3%) had experienced at least one Adverse Child Experience (ACE).[22] (2012)
- **3,476** children were in treatment of drug and alcohol abuse.[23] (2015)

---

[8] The Annie E. Casey Foundation. The 2015 KIDS COUNT Data Book, **http://www.aecf.org/m/resourcedoc/aecf-2015kidscountdatabook-2015.pdf** (Last visited, November 23, 2015).
[9] S.C. Department of Health and Environment Control, Death Certificate Data, **http://scangis.dhec.sc.gov/scan/bdp/tables/death2table.aspx** (Last visited, November 23, 2015).
[10] S.C. Department of Health and Environment Control, Birth Certificate Data, http://scangis.dhec.sc.gov/scan/bdp/tables/birthtable.aspx (Last visited, January 5, 2016).
[11] S.C. Revenue and Fiscal Affairs Office. South Carolina Emergency Department Discharges (Ages 0-17 years). Unpublished report generated in October, 2015. Data included those admitted as inpatients.
[12] U.S. Census, Small Area Income and Poverty Estimates, **http://www.census.gov/did/www/saipe/data/index.html** (Last visited, January 6, 2016).
[13] South Carolina eHealth Medicaid Statistics, Medicaid Enrollment, http://www.schealthviz.sc.edu/medicaid-enrollment (Last visited, January 6, 2016).
[14] S.C. Department of Education, E-Rate - Free and Reduced Meal Eligibility Data 2014-15, **http://ed.sc.gov/data/erate/** (Last visited January 6, 2016).
[15] Fostering Court Improvement, **http://www.fosteringcourtimprovement.org/state_websites.php** (Last visited February 29 , 2015).
[16] Fostering Court Improvement, data as of March 31, 2015. **http://www.fosteringcourtimprovement.org/state_websites.php** (Last visited November 25, 2015).
[17] S.C. Department of Juvenile Justice, Report Card for 2015, **http://www.state.sc.us/djj/pdfs/2015-report-card.pdf** (Last visited, January 7, 2016).
[18] S.C. Department of Mental Health. Children Receiving Mental Health Services. Number of Children (Ages 0-17) Clients Served by County. Unpublished report generated in March, 2016.
[19] S.C. Department of Education, 2015 State Report Cards, http://ed.sc.gov/data/report-cards/state-report-cards/2015/ (Last visited, March 16, 2016).
[20] S.C. Department of Education, unpublished report, Four Year High School Graduation Rate generated February 2015.
[21] The National Center on Family Homelessness at American Institutes for Research, **http://www.homelesschildrenamerica.org/pdfs/2014/SC.pdf http://www.homelesschildrenamerica.org/mediadocs/282.pdf** (Last visited, January 7, 2016).
[22] Data Resource Center for Child & Adolescent, **http://www.childhealthdata.org/browse/survey/results?q=2257&r=42&r2=1** (Last visited, January 7, 2016).
[23] S.C. Department of Alcohol and Other Drug Addiction Services, unpublished reports generated in December 2015.

How to Use This Data Reference Book

A number of indicators were selected for inclusion in this report to enhance understanding of the well-being of children in the categories of safety, health, education, responsibility, and support. These indicators were selected based on an extensive review of literature and discussion with leaders of child-serving state agencies to comprehensively address priority areas and measure progress across childhood lifespan. Each year the Data Reference Book evolves to inform child welfare professionals in their efforts to keep children **safe**, **healthy**, **educated**, **responsible**, and **supported**.

Definitions: Data are presented in counts, percentages, or rates.

Count: the number of cases identified that year. This measure is most useful for determining the impact, or burden, that a condition places on communities or institutions.

Example: In 2012, 101,938 children sustained non-fatal injuries.

Percent: a proportion multiplied by 100. This is a standardized measure that is most useful for comparing across populations, such as other states or at the national level.

Example: In 2011, 70% of children in South Carolina were immunized with the 4313314 vaccination series; or 70 out of every 100 children were vaccinated.

Rate: a proportion multiplied by a relevant constant typically between 1,000 and 100,000. Like a percentage, this is another standardized measure that is most useful for comparing to other states or national level data. A rate is more useful for comparing less-common conditions or when more precise estimates are desired.

Example: In 2010, for every 10,000 individuals in South Carolina, 36.9 of them were victims of family violence.

Tables: There are five summary tables, one for each set of indicators: **safety**, **health**, **education**, **responsibility**, and **support**. Data from early years are presented in column 1 and 2, and are within the range from 2003 – 2013 depending on the particular indicator. Data from the most recent year are presented in column 3, and are within the range of 2011 to 2015, depending on the indicator. A dash "-" in the summary tables indicates the unavailability of the data point.

Graphs: Indicators with data from at least three consecutive years are also presented as line graphs, which are useful for observing trends over time. Bar graphs were used to visualize data with multiple subgroups, such as age-groups. In each graph, the year is on the horizontal axis (x-axis) and the count, percent, or rate is on the vertical axis (y-axis).

A brief interpretation of the observed trend in South Carolina, and a comparison with national levels are also included for each child well-being indicator in this book.

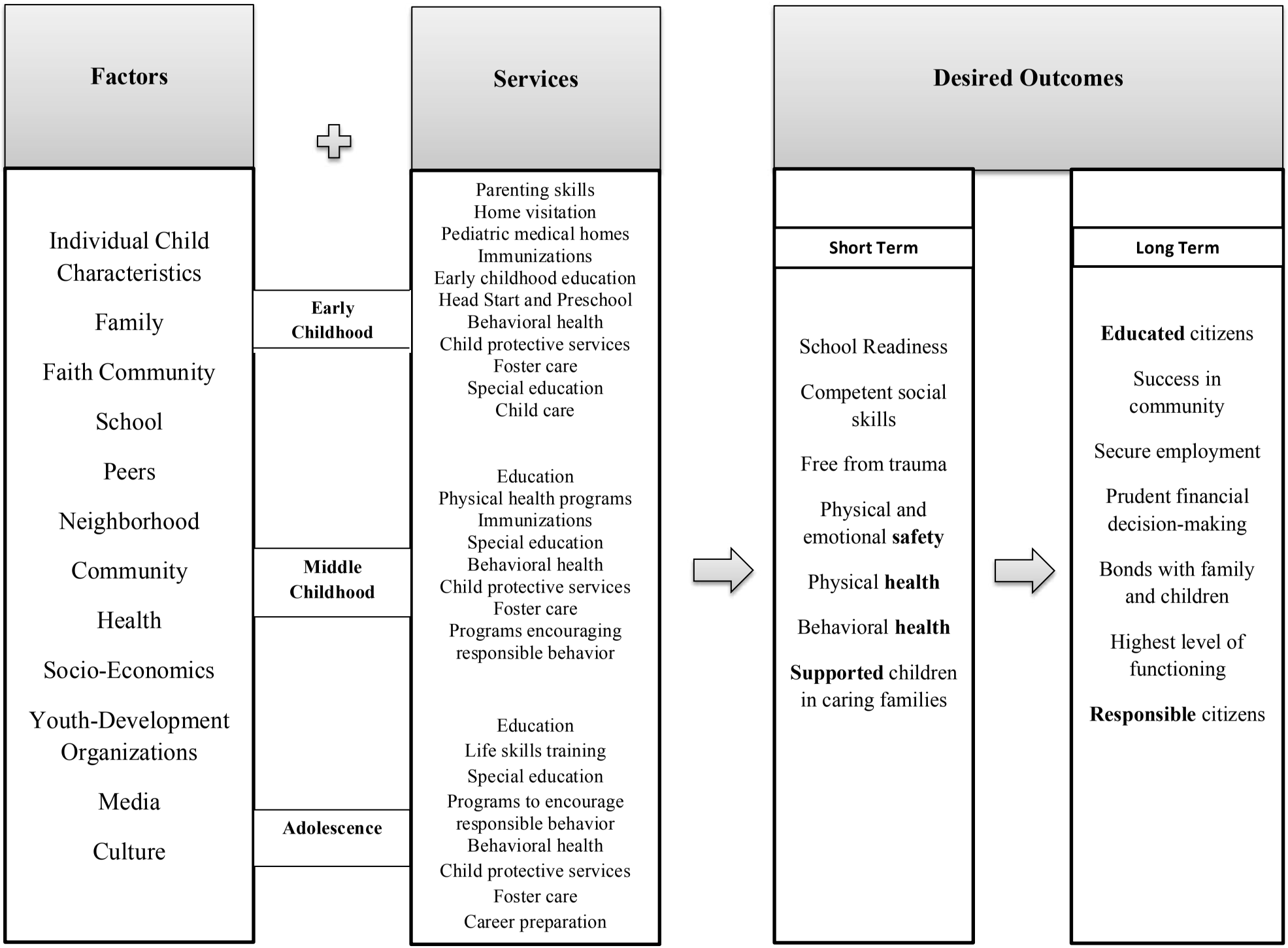
Logic Model of Child Development

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 and an extensive review of research on child development. The logic model on the next page presents various 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. Factors may be negative or positive influences and may commence even before birth. Some factors that influence a child throughout life include:

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

Child well-being requires favorable influence from these diverse and powerful arenas. Because these 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. 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.


Factors
Services
Desired Outcomes
Individual Child Characteristics
Family
Faith Community
School
Peers
Neighborhood
Community
Health
Socio-Economics
Youth-Development Organizations
Media
Culture
Early Childhood
Middle Childhood
Adolescence
Parenting skills
Home visitation
Pediatric medical homes
Immunizations
Early childhood education
Head Start and Preschool
Behavioral health
Child protective services
Foster care
Special education
Child care
Education
Physical health programs
Immunizations
Special education
Behavioral health
Child protective services
Foster care
Programs encouraging responsible behavior
Education
Life skills training
Special education
Programs to encourage responsible behavior
Behavioral health
Child protective services
Foster care
Career preparation
Short Term
School Readiness
Competent social skills
Free from trauma
Physical and emotional safety
Physical health
Behavioral health
Supported children in caring families
Long Term
Educated citizens
Success in community
Secure employment
Prudent financial decision-making
Bonds with family and children
Highest level of functioning
Responsible citizens

Safety Indicators of Child Well-Being

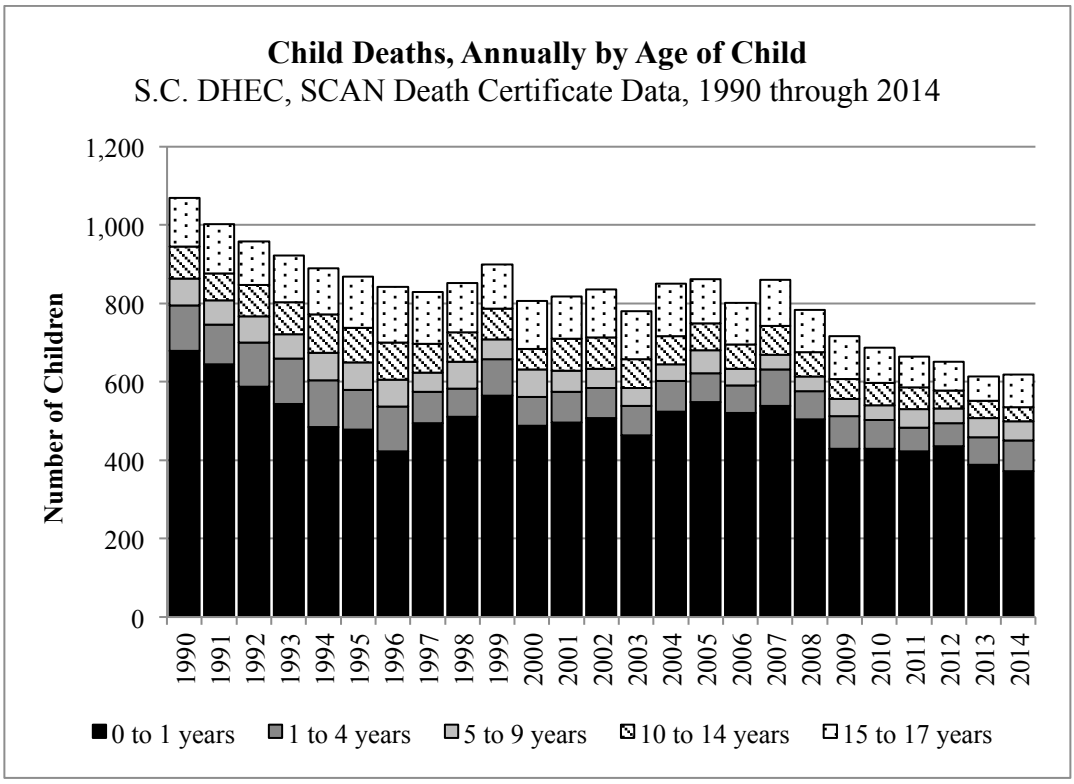
Keeping children safe from physical harm is essential to preventing, or mitigating the effects of traumatic experiences that can negatively impact a child's transition to adulthood. Safety indicators include measurements about child death, injury, child suicide attempts, neighborhood safety, bullying, child abuse and neglect.

Indicators	2011	2013	2015	Trend
A. Child Deaths	665	614	619 (2014)	*No trend*
B. Non-fatal Injuries	100,171	98,180	101,529 (2014)	*No trend*
C. High School Students Attempting Suicide	10.8% (2009)	11% (2011)	9.4% (2013)	*No trend*
D. Children Feeling Unsafe in Their Neighborhood	16.7% (2003)	13.3% (2007)	13.3% (2012)	*Decreasing*
E. High School Students Being Bullied	34%	34%	-	*No trend*
F. Child Abuse & Neglect				
Children Investigated for Abuse or Neglect	28,327	20,586	30,512	*No trend*
Children Subject of an Indicated Report (Child Victims)	11,757	10,822	13,509	*No trend*
Children Referred to a Community Based Prevention Services Organization	23,699 (2013)	19,828 (2014)	11,675	*Decreasing*
Child Victims Re-victimized within 6 Months of Initial Report of Abuse or Neglect	3.2%	2.9%	3.4%	*No trend*
G. Children in Foster Care	3,811	3,209	3,752	*No trend*
H. Children Leaving Foster Care to Live with a Family	90%	92%	94%	*Increasing*

A. Child Deaths

Child deaths include the number of children who die due to illness, accident, or maltreatment. In South Carolina, there were 619 child deaths in 2014, which remained close to the number in the previous year of 2013 (i.e., n=614), but a 42% decrease from 1990.[24] As the chart below reflects, infants (i.e., children from birth to age one) represent the largest number of child fatalities (i.e., 60%), consistently comprising over half of all child fatalities. The overall infant mortality rate for 2014 was 6.5 deaths per 1,000 live births. This includes a more than 30% drop in deaths among South Carolina infants between 2005 and 2014, reaching a historic low for the second consecutive year.[25]

[24] S.C. Department of Health and Environment Control, Death Certificate Data, **http://scangis.dhec.sc.gov/scan/bdp/tables/death2table.aspx** (Last visited, November 23, 2015).
[25] S.C. Department of Health and Environment Control, **http://www.scdhec.gov/Agency/NewsReleases/2015/nr20150411-01/** (Last visited, November 23, 2015).



In 2014, the primary causes of death for infants were a result of conditions originating in the prenatal period, congenital malformations, deformations and chromosomal abnormalities and unintentional injuries. For all other children, **motor vehicle accidents**, **homicides**, **suicides** and **cancers** were the leading causes of deaths.[26] Nationally, there were 42,328 child deaths (ages 0 to 19 years) in 2013, which was a 2% decrease from 2012 and a 29% decrease from 1999.[27]

Many children died in South Carolina from **preventable causes**. Of unexpected infant deaths, the majority of the deaths were related to unsafe sleeping practices.[28] For children ages 1 to 17 years, half of the child deaths were due to accidents or homicides.[29] Any child's death is a tragedy that has a profound effect on families and communities. More efforts and resources should be used to recognize the child death risk factors and to create new practices to protect our children.[30]

[26] S.C. Department of Health and Environment Control, Death Certificate Data, **http://scangis.dhec.sc.gov/scan/bdp/tables/death2table.aspx** (Last visited, November 23, 2015).
[27] Centers for Disease Control and Prevention, National Vital Statistics Report, **http://www.cdc.gov/nchs/products/nvsr.htm** (Last visited January 7, 2016).
[28] The State Child Fatality Advisory Committee (SCFAC), 2015 report, **https://www.childdeathreview.org/wp-content/uploads/State-Docs/SC_2014Report.pdf** (Last visited, February 15, 2016).
[29] S.C. Department of Health and Environment Control, Death Certificate Data, **http://scangis.dhec.sc.gov/scan/bdp/tables/death2table.aspx** (Last visited, February 15, 2016).
[30] The State Child Fatality Advisory Committee (SCFAC), 2015 report, **https://www.childdeathreview.org/wp-content/uploads/State-Docs/SC_2014Report.pdf** (Last visited, February 26, 2016).

Three Leading Causes of Child Death by Age Group, South Carolina, 2014[31]					
Rank	0 to 1 Years n=372	1 to 4 Years n=78	5 to 9 Years n=50	10 to 14 Years n=36	15 to 17 Years n=83
1	Certain conditions originating in the perinatal period n=192 (52%)	Motor vehicle accidents n=11 (14%)	Motor vehicle accidents n=10 (20%)	Suicide n=9 (25%)	Motor vehicle accidents n=34 (41%)
2	Congenital malformations, deformations and chromosomal abnormalities n=56 (15%)	Homicide (Assault) n=10 (13%)	Cancer n=9 (18%)	Diseases of heart n=5 (14%)	Suicide n=17 (20%)
3	Other and unspecified non-transport accidents and their sequelae n=34 (9%)	Cancer n=4 (5%)	Homicide (Assault) n=5 (10%)	Motor vehicle accidents n=4 (11%) Cancer n=4 (11%)	Homicide (Assault) n=11 (13%)
Total % of deaths (top 3 causes)	**76%**	**32%**	**48%**	**61%**	**74%**

B. Non-Fatal Injuries

Non-fatal injuries include accidental and intentional injuries that do not result in death, but require a hospital or emergency room visit. In 2014, there were 101,529 non-fatal injuries to children in South Carolina, a 3% increase from 2013 and a 3% decrease from 2006.[32]

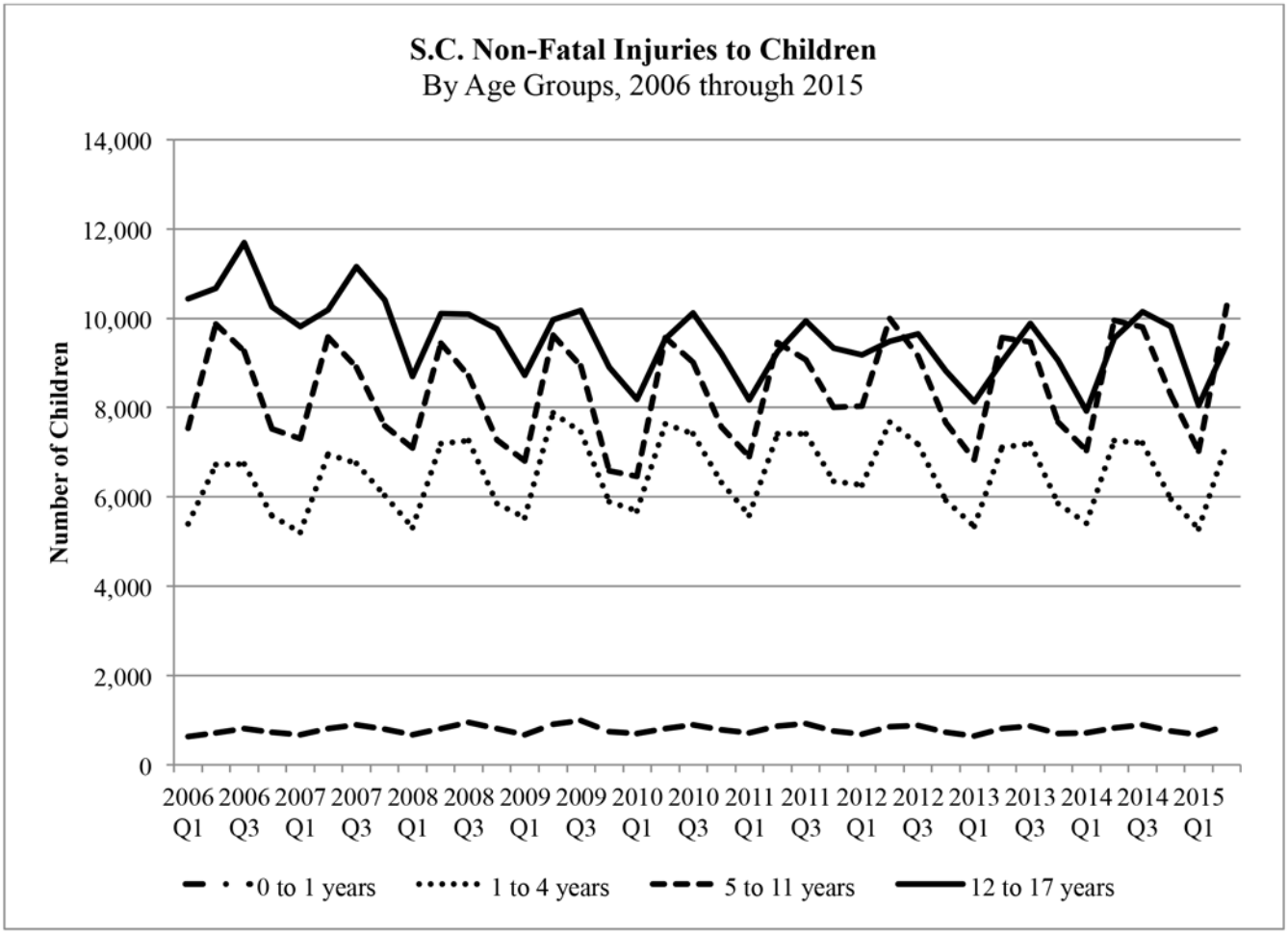
In 2014, children between ages 12 and 17 years experienced the highest number of non-fatal injuries, followed by children ages 5 to11 years (34%), and 1 to 4 years (25%). Infants had the least non-fatal injuries (3%). There appears to be a consistent seasonal trend in non-fatal childhood injuries requiring hospitalization or emergency room visits, with slightly more children experiencing injuries during the summer months.

From January 2012 to June 2015, a total of 258,612 children were injured accumulating approximately $715,531,654 hospital charges with an average of $2,767 per child. The top five most common non-fatal injuries were contusion (bruises) of the face, scalp, and neck, head injury, sprain of ankle, open wound of forehead and sprain of neck.

Nationally, there were 7,647,559 non-fatal injuries to children ages 0 to 17 years in 2013, which was an 8% decrease from 2012 and a 15% decrease from 2001.[33] In 2013, the three

[31] Note: Causes of other and unspecified non-transport accidents and their sequelae were not included in the ranking (i.e., ICD 10 Codes of W20-W31, W35-W64, W75-W99, X10-X39, X50-X59, Y86).
[32] S.C. Revenue and Fiscal Affairs Office. South Carolina Emergency Department Discharges (Ages 0-17). Unpublished report generated in October, 2015. Data included those admitted as inpatients.
[33] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, WISQARS

leading causes of child injuries nationwide were falls, being struck by/against person or object or caught in or between objects,[34] and overexertion.[35,36]



C. High School Students Attempting Suicide

This indicator reports the percent of high school students in South Carolina who attempted suicide one or more times during the 12 months before the 2013 High School Youth Risk Behavior Survey (YRBS). In South Carolina, 9.4% of high school students attempted suicide one or more times during the 12 months before the YRBS survey. This is a 1.6%

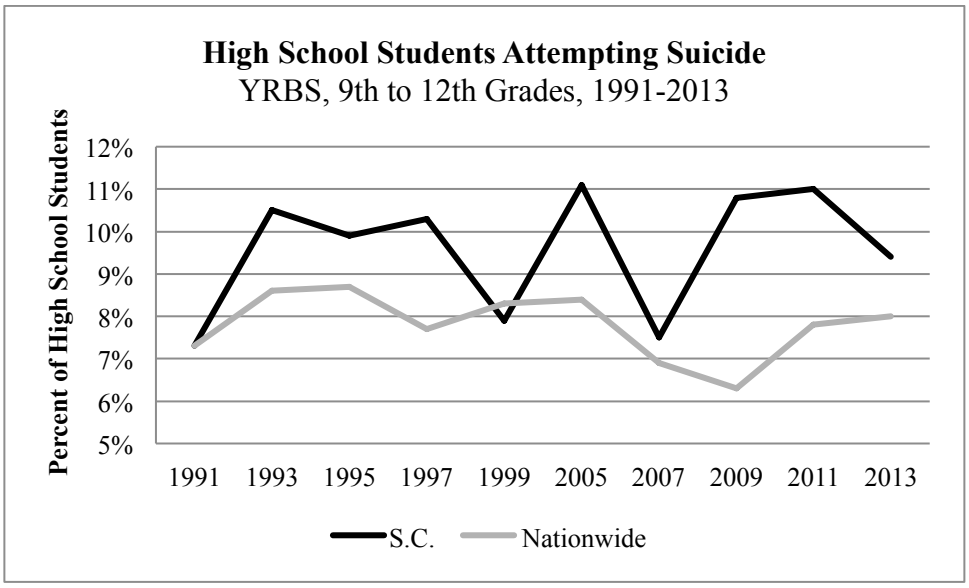
online, non-fatal injury reports, **http://www.cdc.gov/injury/wisqars/nonfatal.html** (Last visited January 7, 2016).

[34] Struck by / against or crushed includes Injury resulting from being struck by (hit) or crushed by a human, animal, or inanimate object or force other than a vehicle or machinery; injury caused by striking (hitting) against a human, animal, or inanimate object or force other than a vehicle or machinery.

[35] Overexertion refers to working the body or a body part too hard, causing damage to muscle, tendon, ligament, cartilage, joint, or peripheral nerve (e.g., common cause of strains, sprains, and twisted ankles). This category includes overexertion from lifting, pushing, or pulling or from excessive force.

[36] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, WISQARS online, non-fatal injury reports, **http://www.cdc.gov/injury/wisqars/nonfatal.html** (last visited February 6, 2015).

decrease from the previous survey of 2011. Nationally, the percent of high school students attempting suicides was 8% in 2013, slightly lower than South Carolina.[37,38]

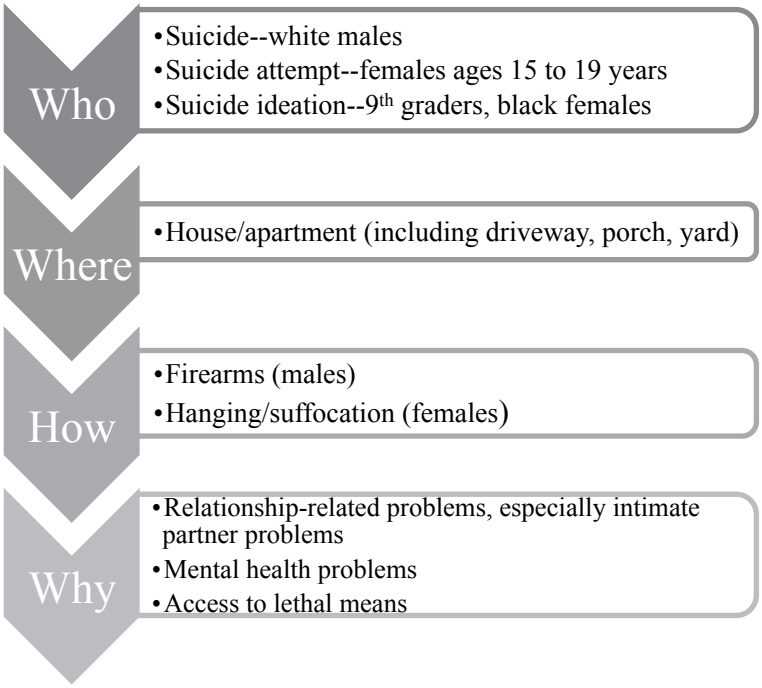


Suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities in South Carolina. On average, a resident of South Carolina kills themselves every 16.8 hours, and there are five suicide attempts per day resulting in hospital stays and total charges of nearly $35,000,000 per year in South Carolina.[39] Between 1999 and 2014, a total of 438 children and youth ages 0 to 19 years died by suicide in South Carolina. Approximately 53% of the suicide deaths were related to intentional discharge of firearms. Suicide is the third leading cause of death for children ages 0 to 19 years.[40] More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.[41]

Centers for Disease Control and Prevention defined suicide as death caused by self-directed injurious behavior with any intent to die as a result of the behavior. Suicide attempt refers to a non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury. Suicidal ideation means thinking about, considering, or planning for suicide. Data suggested that there were significant differences among South Carolina children regarding suicides, suicide attempts and suicide ideations. Females, especially black females, were more often than males to have thoughts about

[37] Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS), **https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=SC** (Last visited, January 20, 2016).
[38] Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS), **https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=XX** (Last visited, January 20, 2016).
[39] South Carolina Suicide Prevention Coalition. The South Carolina Suicide Prevention Plan (Revised October, 2010), **http://www.sprc.org/sites/sprc.org/files/SC%20Suicide%20Prevention%20Plan.pdf** (Last visited, March 30, 2016)
[40] S.C. Department of Health and Environment Control, Death Certificate Data, **http://scangis.dhec.sc.gov/scan/bdp/tables/death2table.aspx** (Last visited, March 30, 2016).
[41] American Society for the Positive Care of Children, About Teen Suicide & Depression, **http://americanspcc.org/facts-teen-suicide/** (Last visited, March 30, 2016)

suicide and to attempt suicide, but more males died by suicide. Suicide methods also differ. Males, especially white males, were more likely to use firearms in a suicide; whereas females were more likely to commit suicide by hanging or suffocation. High school students from 9th grade were among high-risk groups for suicide ideation.[42] Actions should be taken to screen those child groups who are at risk for suicide.[43]



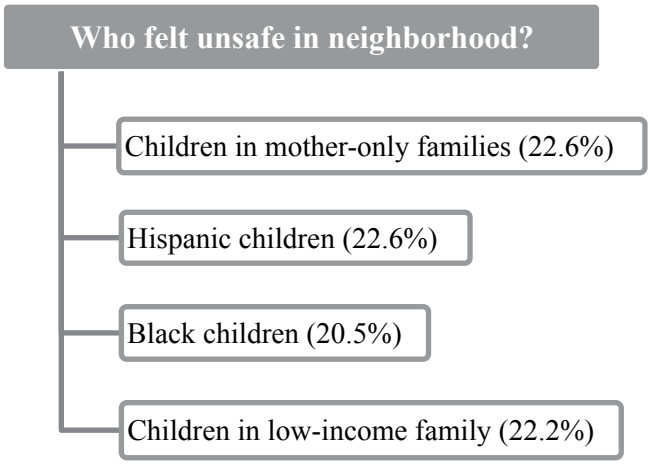
D. Children Feeling Unsafe in Their Neighborhood[44]

This indicator reports the percent of children in South Carolina ages 0 to 17 years whose parents reported that their neighborhoods or communities were unsafe for children. In 2012, 13.3% of children ages 0 to 17 years whose parents reported that their neighborhoods or communities were unsafe for children, which remained the same as 2007 and a 3.4% decrease from 2003.

More children in mother-only families (22.6%) in South Carolina reported feeling unsafe in their neighborhoods compared to children in two-parent families (9.4%). Hispanic children (22.6%) reported feeling more unsafe in their neighborhoods compared to black children

[42] Note that these high-risk groups were detected after the analysis of data from National Violent Death Reporting System of CDC, S.C. Death Certificate Data, and Youth Risk Behavior Surveillance System (YRBSS) of CDC.
[43] In 2016, the SC Department of Mental Health (SCDMH) was awarded the Garrett Lee Smith Suicide Prevention Grant. The grant will fund the implementation of the SC Youth Suicide Prevention Initiative (SCYSPI) to reduce deaths by suicide and nonfatal suicide attempts among SC youth and young adults age 10-24. The initiative will focus on increasing access to screening and mental health services, raising awareness through social media marketing, and increasing protective factors through training across community domains, supporting clinicians and educators in implementing evidenced-based interventions, utilizing safety plans in emergency departments, and strengthening our statewide infrastructure.
[44] Data Resource Center for Child & Adolescent Health.2011/12 National Survey of Children's Health, **http://childhealthdata.org/browse/survey/results?q=2524&r=1&r2=42** Note that higher ranking indicated larger percent of children feeling unsafe in neighborhood (Last visited, January 7, 2016).

(20.5%), white children (7.6%) and other non-Hispanic children (14.7%). Children in low-income family (22.2%) reported having more unsafe feelings in neighborhoods compared to high-income family (2.2%). Nationally, 13.4% of parents reported that their neighborhoods or communities were unsafe for children, which was a 0.6% decrease from 2007 and a 2.8% decrease from 2003. South Carolina was ranked the 39th nationwide on this indicator.

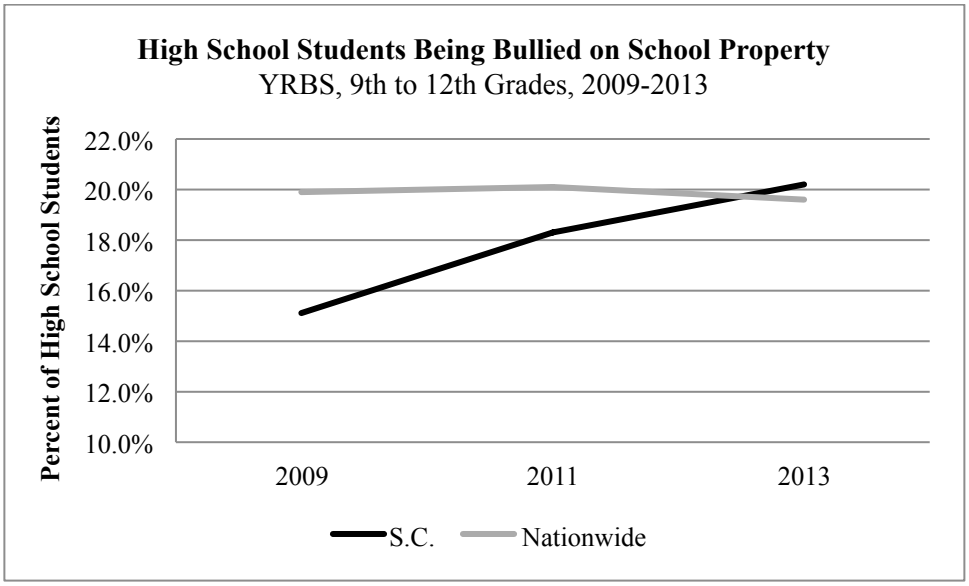


E. High School Students Being Bullied

This indicator reports the percent of high school students who reported being electronically bullied and being bullied on school property during the 12 months before the 2013 High School Youth Risk Behavior Survey. Electronic bullying included children who were in 9th to 12th grades being bullied through e-mail, chat rooms, instant messaging, websites, or texting. In South Carolina, 13.8% of high school students reported that they were electronically bullied during the 12 months before the YRBS survey in 2013, a 1.8% decrease from 2011. Approximately 20.2% of high school students reported that they were bullied on school property during the 12 months before the YRBS survey in 2013, which was a 5.1% increase from 2009.[45,46] Nationally, 14.8% of high school students reported being electronically bullied and 19.6% were bullied on school property during the 12 months before the survey in 2013.[47]

Students' reports of being bullied at school varied by student characteristics. According to National Center for Educational Statistics, in 2013, a higher percent of female adolescents than male adolescents reported that they were made fun of, called names, or insulted; were the subject of rumors; and were excluded from activities on purpose. In contrast, a higher percent of male adolescents than of females reported being pushed, shoved, tripped, or spit on.[48]

[45] Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS), **https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=SC** (Last visited January 20, 2016).
[46] Note: The collection of data on high school students who were electronically bullied started in 2011 YRBS survey.
[47] Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS), **https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=XX** (Last visited January 20, 2016).
[48] National Center for Educational Statistics, Bullying, **http://nces.ed.gov/fastfacts/display.asp?id=719** (Last visited, March 2, 2016).



F. Children Experiencing Abuse or Neglect [49]

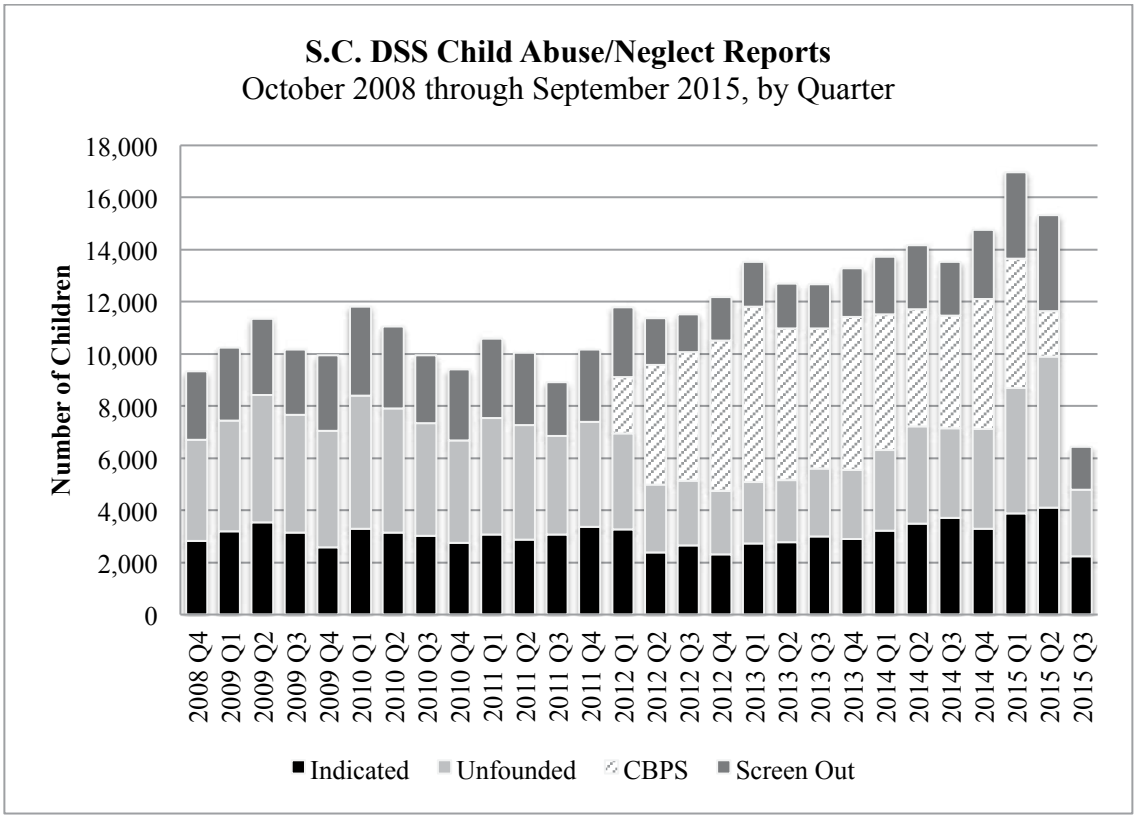
When DSS receives a report of suspected child abuse or neglect, intake staff conducts a safety and risk assessment to determine whether a formal investigation is required, a referral to a Community Based Prevention Service (CBPS) organization is appropriate, or if no abuse is alleged, legally the report should be screened out.[50] If investigated, Child Protective Services staff at DSS will conclude the report is "indicated" whenever the evidence supports a decision that it is more likely than not that a child has been abused or neglected; otherwise, the report is "unfounded."[51]

In South Carolina, DSS received nearly 53,639 reports of suspected child abuse or neglect from October 2014 through September 2015. According to analysis of those reports:

- Of the 30,512 children who were investigated,
  - 13,509 of the investigated cases were indicated
  - 17,003 of the investigations were unfounded
- 11,675 were referred to Community Based Prevention Services, an intake response implemented in South Carolina in 2012 to comply with federal law.

The graph below reflects the number of child abuse or neglect reports by quarter, broken down by the type of DSS intake response or disposition.[52]

[49] A Fostering Court Improvement, **http://www.fosteringcourtimprovement.org/state_websites.php** (Last visited, March 1, 2016). Abuse or Neglect includes harm that children experience at the hands of a parent, guardian, or other person responsible for the child's welfare.
[50] DSS investigates all reports that identify either actual harm or risk factors that place the child at substantial risk of abuse or neglect. Referrals to Community Based Prevention Services are appropriate when the report does not allege actual harm, but the safety and risk assessments raise a moderate or low risk of abuse or neglect. All other reports are screened out, with no further action taken.
[51] See S.C. Code Ann. § 63-7-20.
[52] Note that the data on the third quarter of 2015 is not complete.

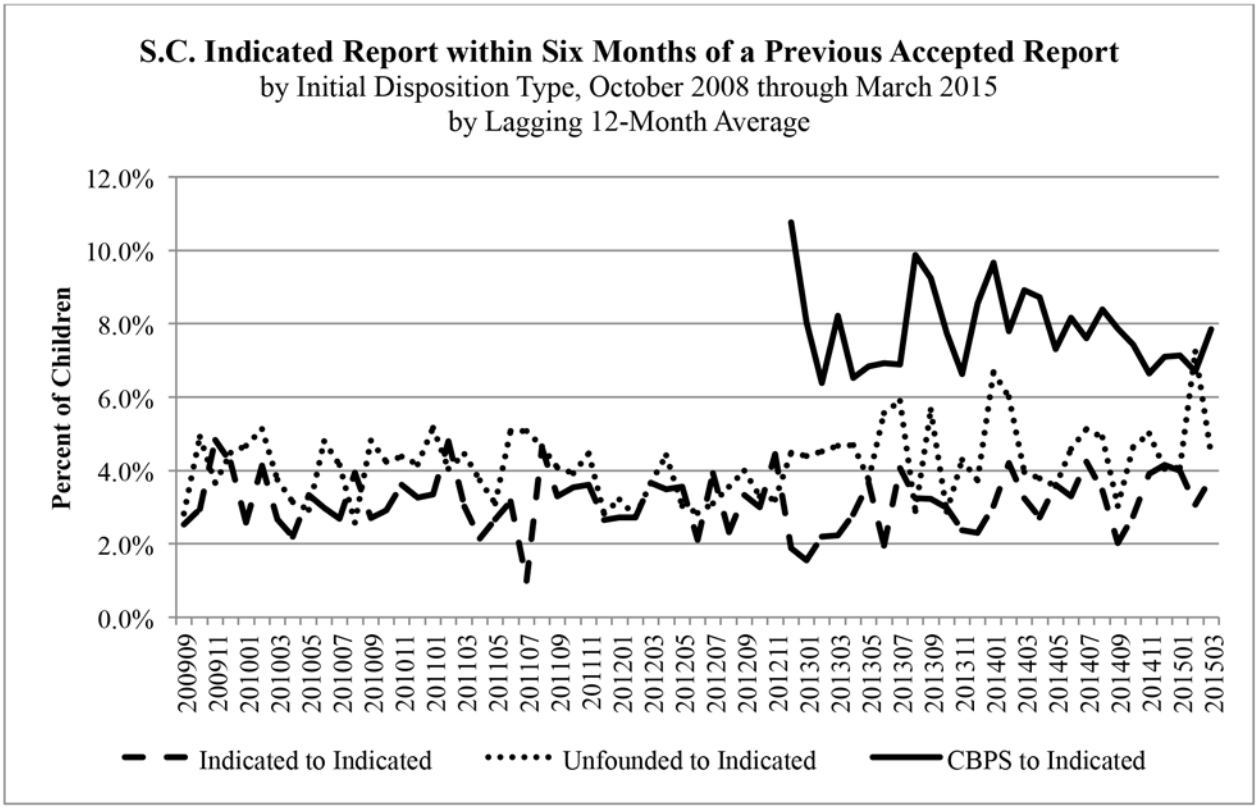


The most commonly accepted indicator of our state's ability to protect children from abuse or neglect is the recurrence rate. This indicator examines the number of children who are the subject of an indicated report within six months of a previously accepted report to DSS. The prior report may have been either investigated or referred to Community Based Prevention Services (CBPS), but the subsequent report is indicated. Children who are the subject of an indicated report within six months of a previous accepted report are experiencing ongoing abuse or neglect, and are at increased risk for poor outcomes as they transition to adulthood.[53]

In South Carolina, from April 2014 to March 2015:

- 3.4% of children who were the subject of an indicated report of abuse or neglect had been the subject of a previous *indicated* report of abuse or neglect during the past six months;
- 4.5% of children who were the subject of an indicated report of abuse or neglect had been the subject of a *unfounded* report of abuse or neglect during the past six months; and
- 7.6% of children who were the subject of an indicated report of abuse or neglect had been the subject of a referral to *Community Based Prevention Services* within the past six months.

[53] Centers for Disease Control and Prevention, Understanding Child Maltreatment: Fact Sheet. **http://www.cdc.gov/violenceprevention/pub/CM_factsheet.html** (last visited January 13, 2015).



G. Children in Foster Care

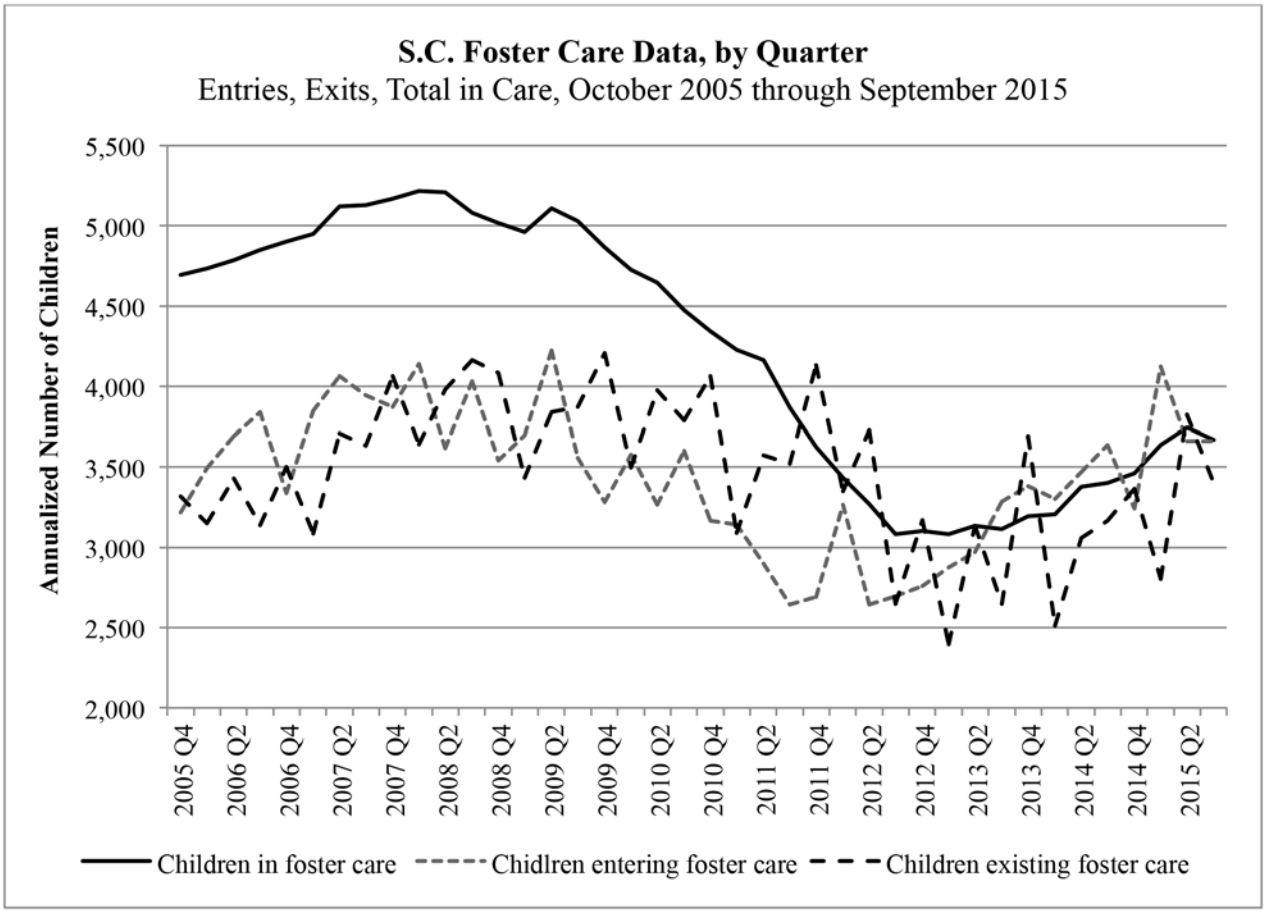
Ordinarily, children who are victims of abuse or neglect receive services in their home, with their family. However, when children are unable to safely remain in their home, they may be removed from the physical custody of their caretaker, and placed in foster care.

The number of children in foster care represents the number of children in the legal custody of DSS who have been removed from the custody of parents or guardians and placed outside the home. The solid line (shown in the graph next page) represents the number of children in foster care on the last day of the reporting period. These children may be placed with foster care families, in group homes, with relatives, or other placements. The dotted line in the graph represents the annualized number of children entering care during the reporting period. The dashed line represents the annualized number of children exiting care during the reporting period.

On September 30, 2015, there were 3,752 children in foster care in South Carolina with a rate of 33 per 10,000 children, which was an 8% increase from the number of children in care on September 30, 2014. The graph reflects a 26% decrease in the number of children in care from September 30, 2007. The median length of stay in foster care was 11.8 months. As of

September 30, 2015, 34% of children were in foster care over 18 months and 24% of children were in foster care over 24 months.[54]

Nationally, there were 415,129 children in foster care during the 2014 federal fiscal year, a 10 % decrease from 2008. As of September 30, 2014, the median age of children in foster care was 8 years old. A total of 52% were boys, 48% were girls. In terms of race/ethnicity, 42% of children were white, 24% were black, 22% were Hispanic (of any race), 7% were two or more races, 2% were American Indian/Alaskan Native and 1% were Asian. The median length of stay in foster care was 12.6 months. A total of 24% of children entered foster care when they were one year's old or less than one year. For children in foster care waiting to be adopted, the median age was 6.8 years old.[55]

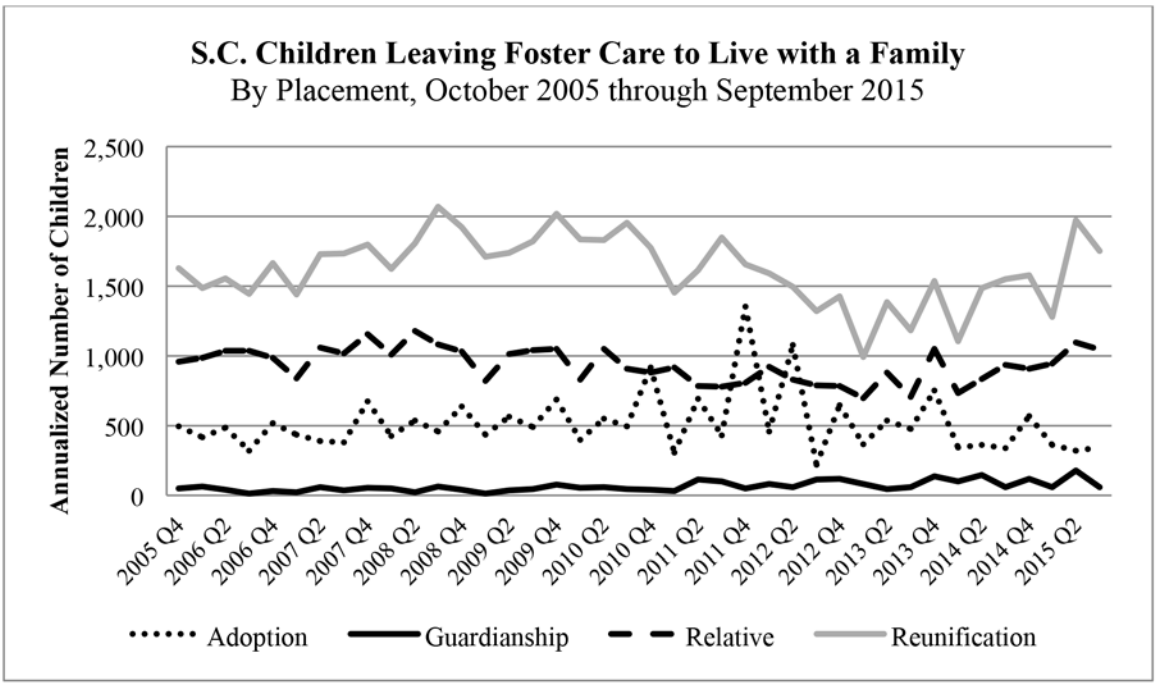


H. Children Leaving Foster Care to Live with a Family

When a child cannot safely remain in their home because of abuse or neglect, DSS is given legal custody, and the child is placed in foster care. Foster care is meant to be a temporary

[54] Fostering Court Improvement, **http://www.fosteringcourtimprovement.org/state_websites.php** (Last visited, March 1, 2016).
[55] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. The AFCARS Report, Preliminary FY 2014 Estimates as of July 2015.
http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport22.pdf
https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport20.pdf (Last visited November 25, 2015).

placement, lasting only until the child can safely return to their parent/caretaker or, in some instances, until a new family can be found. This indicator represents the percent of children who leave DSS custody and who are either returned to their original caregiver or are adopted, appointed a guardian, or placed permanently with a relative.[56] On September 30, 2015, 94% of children who left foster care were either reunified with their family or placed with a new family through adoption or guardianship.[57] According to the most recent data available, the national percent was 87% on September 30, 2014.[58]



[56] S.C. Department of Social Services, unpublished report generated March 2013. Children Leaving Foster Care for Positive Closure Reason.
[57] Fostering Court Improvement, **http://www.fosteringcourtimprovement.org/state_websites.php** (Last visited, February 17, 2016).
[58] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. The AFCARS Report, Preliminary FY'2014 Estimates as of July 2015.
http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport22.pdf (Last visited, January 5, 2016).

Health Indicators of Well-Being

Healthy children generally miss fewer days of school, exhibit good eating and exercise habits, and live free from chronic conditions such as diabetes, cancer, and heart disease. Early and effective health interventions help children and their families avoid or lessen expensive medical costs. Health indicators include information on low birth weight babies, immunization, mental health diagnoses and treatment, Adverse Childhood Experiences (ACEs), percent of students having breakfast, child obese and overweight, physical activities and children's time spent on video games.

Indicators	2010	2012	2014	Trend
A. Children Born with Moderately Low Birth Weight	4,678	4,430	4,418	*Decreasing*
Children Born with Very Low Birth Weight	1,104	1,023	1,026	*No trend*
B. Immunizations of Children 19-35 Months	73.6%	71.9%	72.6%	*No trend*
C. Children Receiving Mental Health Services	27,447	23,745	25,731 (2015)	*No trend*
D. Children Needing but Not Receiving Mental Health Services	37.3% (2007)	49.9%	-	*Increasing*
E. Prevalence of Adverse Childhood Experiences (ACEs)	-	52.3%	-	*No trend*
F. Third Grade Students with Tooth Decay	57.9% (2002)	54.3% (2008)	47.3% (2013)	*Decreasing*
G. High School Students Obese and Overweight	31.5 (2009)	29.6% (2011)	30.7% (2013)	*No trend*
H. High School Students Not Eating Fruits or Vegetables	20.0% (2009)	20.5% (2011)	17.4% (2013)	*No trend*
I. High School Students Not Attending Physical Education Classes	76.9% (2007)	83.2% (2009)	75.8% (2011)	*No trend*
J. High School Students Playing Video or Computer Games	22.7% (2009)	28.9% (2011)	37.7% (2013)	*Increasing*
K. High School Students Not Eating Breakfast	-	-	67.2% (2013)	*No trend*

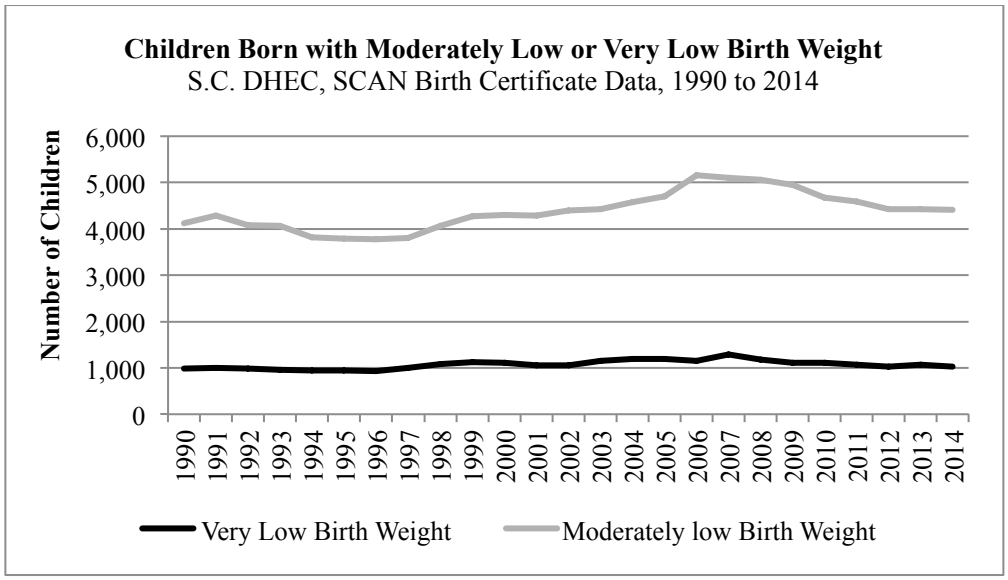
A. Moderately Low and Low Birth Weight Babies

Low birth weight is divided into two categories: moderately low and very low. Moderately 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.[59] This indicator represents the moderately low and very low birth weight babies born to women in South Carolina hospitals.

[59] U.S. Department of Health and Human Services, Health Resources and Services Administration, Child Health USA 2013, Low Birth Weight, **http://mchb.hrsa.gov/chusa13/perinatal-health-status-indicators/p/low-birth-weight.html** (Last visited, February 2, 2015).

In South Carolina, 4,418 or 7.7% of children were born in 2014 with a moderately low birth weight, which showed no significant data difference from the previous year of 2013 but a 7% increase from 1990. There were 1,026 or 1.8% of children born in South Carolina with a very low birth weight in 2014, a 4% decrease from 2013, and a 3% increase from 1990.[60] Nationally, the 2014 very low birthweight rate was stable at 1.4%, which was slightly down from the high of 1.5% reported for 2005-2007. The percent of moderately low birth-weight infants was 6.6% in 2014, which remained unchanged from 2013, but lower than the 2006 peak of 6.8%.

Weight at birth is closely associated with gestational age and can be an important and independent predictor of short-and long-term outcomes.[61] The infant mortality rate for very low birth weight infants was more than 100 times the rate for infants with birth weights of 2,500 grams or more.[62] Very low birth weight babies who survive are also more likely to experience long-range physical difficulties, developmental health problems and learning disabilities.[63]

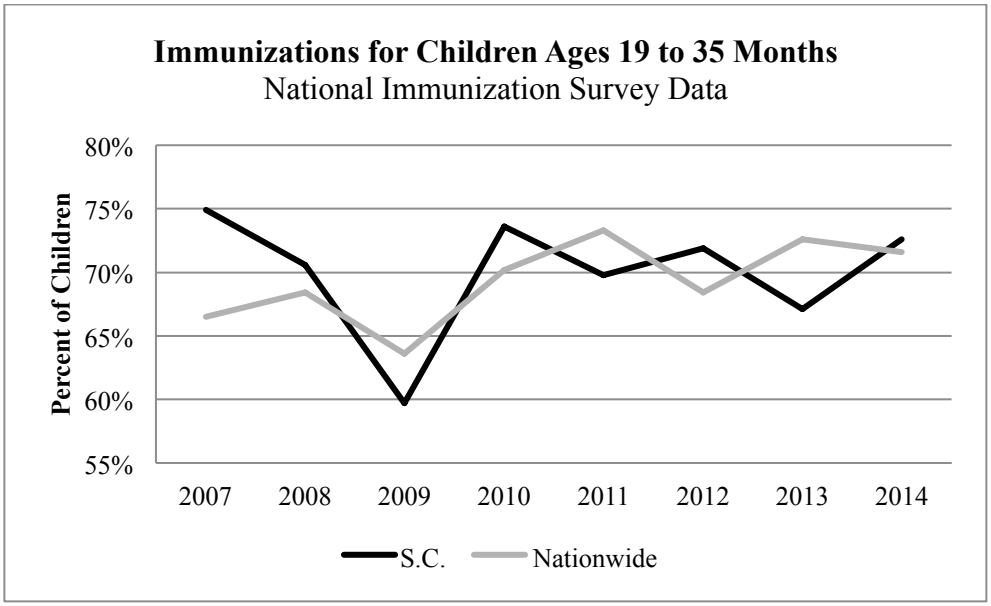


B. Immunizations of Children 19 to 35 Months

The Centers for Disease Control and Prevention (CDC) provides a thorough immunization schedule for children, beginning at birth and continuing into early adolescence.[64] The National Immunization Survey estimated that in 2014, approximately 72.6% of children in

[60] S.C. Department of Health and Environmental Control, SCAN Birth Certificate Data, **http://scangis.dhec.sc.gov/scan/bdp/tables/birthtable.aspx** (Last visited, January 7, 2016).
[61] National Vital Statistics Reports. Births: Final Data for 2014. **http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_12.pdf** (Last visited, January 7, 2016).
[62] Mathews, T. J., MacDorman, M. F. (2012). Infant mortality statistics from the 2008 period: linked birth/infant death data set. National Vital Statistics Reports, 60(5). Hyattsville, Maryland: National Center for Health Statistics. **http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_05.pdf** (Last visited, February 10, 2015).
[63] U.S. Department of Health and Human Services, Health Resources and Services Administration, Child Health USA 2008-2009, Very Low Birth Weight, **http://mchb.hrsa.gov/chusa08/hstat/hsi/pages/203vlbw.html** (Last visited, February 2, 2015).
[64] Centers for Disease Control and Prevention, Immunization Schedules, **http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html** (Last visited January 8, 2015).

South Carolina between ages 19 and 35 months were on schedule with the recommended immunizations, which was a 5.5% increase from 2013 and 2.3% decrease from 2007. The national percent was 71.6% in 2014.[65] Children living in families with incomes below the federal poverty level had lower percent of coverage than children living in families at or above the poverty level in some types of vaccination.[66] Vaccination coverage varies across states. Recent budget cuts to state and local health departments, differences between immunization program activities, vaccination requirements for child-care centers, and vaccine financing policies by states contributed to the variances.[67]



C. Children Receiving Mental Health Services

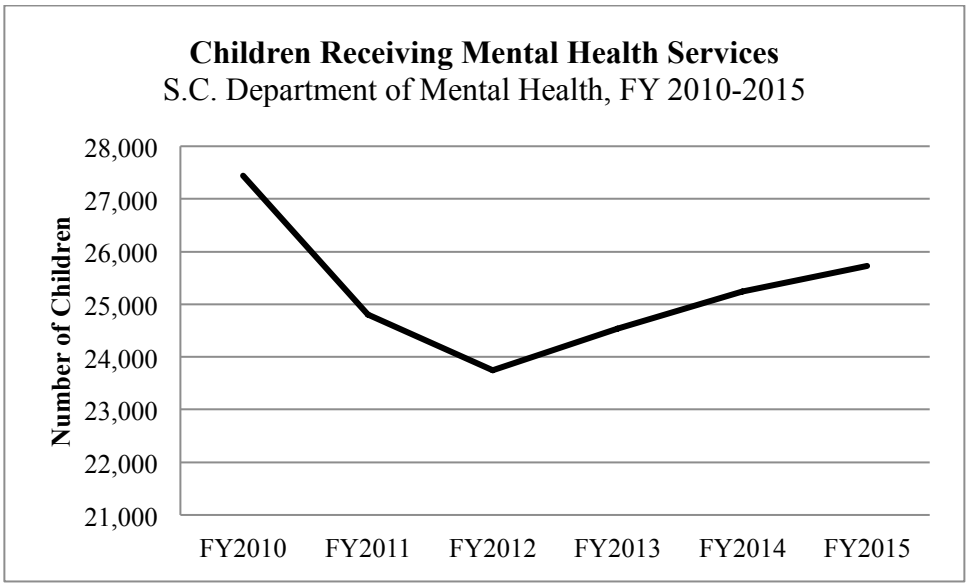
The Department of Mental Health provides treatment services for people with mental illnesses. In South Carolina, 25,731 children ages 0 to 17 were served from July 2014 to June 2015, which was a 3% increase from 2014 and an 8% decrease from 2010.[68]

Of all the children served, the primary mental health diagnoses were attention deficit, conduct, and disruptive behavior disorders (43.8%), adjustment disorders (15.8%), mood disorders (15.3%) and anxiety disorders (14.2%).[69] The majority of children receiving mental health services accessed outpatient treatment in their community and schools.[70] Community-based mental health treatment includes mental health centers, mental health clinics, forensic

[65] U.S. Vaccination Coverage Reported via National Immunization Survey (NIS). **http://www.cdc.gov/vaccines/imz-managers/coverage/imz-coverage.html** (Last visited December 18, 2015). The recommended combination of vaccines is commonly referred to as the 4313314 combination (4 DTap, 3 Polio, 1 MMR, 3 Hep B, 3 HIB, 1 Var, and 4 PCV).
[66] Those types of vaccination include 4 doses of DTaP, the full Hib series, 4 doses of PCV, 2 doses of HepA, and rotavirus vaccine.
[67] Morbidity and Mortality Weekly Report (MMWR), National, State, and Local Area Vaccination Coverage Among Children Aged 19–35 Months — United States, 2012, September 13, 2013 / 62(36);733-740. **http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6236a1.htm** (last visited January 8, 2015).
[68] S.C. Department of Mental Health. Total Number of Children (Admit Age 0 - 17) Served. Unpublished report generated in February, 2016.
[69] The diagnosis Categories were based on DSM-V (effective 10/01/2015).
[70] S.C. Department of Mental Health. Services by Place of Service. Unpublished report generated in February, 2016.

facilities, and telemedicine services. In 2015, a total of 22,132 or 86% of children with mental illness received community-based mental health treatment and 477 were served in inpatient treatment settings at William S. Hall Psychiatric Institute.

Nationally, it is estimated that 13 to 20 percent of children, or one out of five children in the U.S. experienced a mental health problem in a given year, which accounted for an estimate of $247 billion spent on child mental health problems each year. ADHD was the most prevalent diagnosis among children ages 3 to 17 years, other prevalent mental health problems included behavioral or conduct problems, anxiety, depression and autism spectrum disorders.[71]



D. Children Needing but Not Receiving Mental Health Services

Mental health is important to overall health. Mental disorders are chronic health conditions that can continue through the lifespan. Without early diagnosis and treatment, children with mental disorders can have problems at home, in school, and in forming friendships. This can also interfere with their healthy development, and these problems can continue into adulthood. Because of the impact on children, families, and communities, children's mental disorders are an important public health issue in the United States.[72] This indicator examined the current mental health needs among children of different subgroups in South Carolina.

According to the 2011/2012 National Survey of Children's Health, parents in South Carolina reported that approximately 49.9% of children needed mental health treatment or counseling but did not receive mental health services. In terms of age, 70.6% of children ages 2

[71] Centers for Disease Control and Prevention, Children's Mental Health, **http://www.cdc.gov/Features/ChildrensMentalHealth/** (Last visited, February 13, 2015).
[72] Centers for Disease Control and Prevention, Children's Mental Health, **http://www.cdc.gov/features/childrensmentalhealth/** (Last visited, March 21, 2016).

to 5 years needed but did not receive mental health services, followed by children ages 6 to 11 years (51.9%) and children ages 12 to 17 years (43.2%).

In 2011/2012, South Carolina Parents Reported:

Children needing but NOT receiving mental health services by subgroups:	South Carolina	Nation-wide	Difference %
All Children	49.9%	39.0%	+ 10.9%
Children ages 2 to 5 years	70.6%	56.6%	+ 14.0%
Children ages 6 to 11 years	51.9%	37.4%	+ 14.5%
Children ages 12 to 17 years	43.2%	35.9%	+ 7.3%
Males	55.0%	39.8%	+15.2%
Females	42.7%	37.5%	+ 5.2%
Black	69.4%	55.1%	+ 14.3%
Hispanic	64.1%	46.2%	+ 17.9%
White	34.6%	31.9%	+ 2.7%
Other Races	55.8%	35.3%	+ 20.5%
Currently Uninsured	87.0%	58.1%	+ 28.9%
Public Insurance	50.4%	40.8%	+ 9.6%
Private Insurance	47.8%	34.0%	+ 13.8%
100-199% FPL	57.9%	41.5%	+ 16.4%
200-399% FPL	53.0%	35.5%	+ 17.5%
0-99% FPL	47.7%	44.9%	+ 2.8%
400% or higher FPL	26.1%	30.8%	- 4.7%

All children have the right to happy and healthy lives and deserve access to effective care to prevent or treat any mental health problems that they may develop.[73] However, in South Carolina there is a tremendous amount of unmet need of mental health services. The unmet need is particularly pronounced among young children (ages 2 to 5 years) living in low-income

[73] American Psychology Association, Children's Mental Health, **http://www.apa.org/pi/families/children-mental-health.aspx** (Last visited, March 21, 2016).

families and children who are currently uninsured. These data urge more efforts to promote the service adequacy, availability and accessibility for South Carolina children.[74]

E. Prevalence of Adverse Childhood Experiences (ACEs)

Adverse childhood experiences (ACEs) include verbal, physical, or sexual abuse, neglect, and family dysfunction including having an incarcerated, mentally ill, or substance-abusing family member, domestic violence, or absence of a parent because of divorce or separation.[75] Adverse childhood experiences can profoundly affect many outcomes later in life. Research has shown that adverse childhood experiences impair children's social, emotional, and cognitive functioning -- literally changing the way that a child's brain develops. This impairment can lead to a host of negative outcomes, including risk taking behaviors, disease, disability, and social problems.[76] The most costly of these problems include poor educational achievement and poor physical health later in life. Examining the prevalence of adverse childhood experiences offers an opportunity to address negative outcomes for South Carolinians.

National Survey of Children's Health 2011/12 (NSCH) provides parent-reported data on nine ACEs among children in the United States under eighteen years of age. Nearly half of children in the survey experienced one or more adverse childhood experiences. The survey showed that in South Carolina, over half of children experienced at least one of the nine adverse experiences surveyed.[77]

S.C. Prevalence of Adverse Child or Family Experiences based on the 2011/12 NSCH

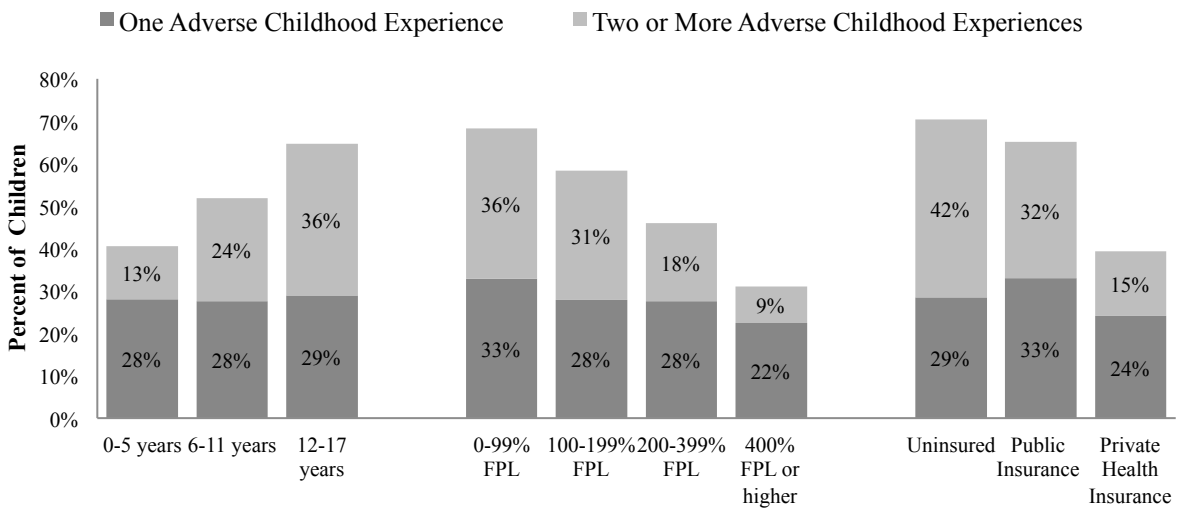
Adverse Child or Family Experiences	South Carolina	Nationwide
Child had ≥ 1 Adverse Child/Family Experiences	52.3%	47.9%
Child had ≥ 2 Adverse Child/Family Experiences	24.2%	22.6%
Socioeconomic hardship	27.0%	25.7%
Divorce/parental separation	23.0%	20.1%
Lived with someone who had an alcohol or drug problem	10.8%	10.7%
Lived with someone who was mentally ill or suicidal	9.6%	8.6%
Victim or witness of neighborhood violence	8.0%	8.6%
Domestic violence witness	8.1%	7.3%
Parent served time in jail	6.8%	6.9%
Treated or judged unfairly due to race/ethnicity	5.4%	4.1%
Death of parent	4.3%	3.1%

Compared to children nationwide, a significantly higher percent of children in South Carolina had adverse child experiences in the categories of socioeconomic hardship,

[74] South Carolina Department of Mental Health continues to expand school based Mental Health Services to increase access to care. In 2015 SCDMH had a presence in 42 of the 46 counties statewide.
[75] Substance Abuse and Mental Health Services Administration, The Role of Adverse Childhood Experiences in Substance Abuse and Related Behavioral Health Problems, **http://www.samhsa.gov/capt/sites/default/files/resources/aces-behavioral-health-problems.pdf**. (Last visited, January 13, 2016).
[76] Children's Bureau/ACYF/ACF/HHS, Understanding the Effects of Maltreatment on Brain Development, **https://www.childwelfare.gov/pubPDFs/brain_development.pdf** (Last visited, March 21, 2016).
[77] Data Resource Center for Child & Adolescent Health, **http://www.childhealthdata.org/browse/survey/results?q=2257&r=42&r2=1** (Last visited, January 13, 2016).

divorce/parental separation, lived with someone who was mentally ill or suicidal, domestic violence witness, treated or judged unfairly due to race/ethnicity, and death of parent. While the prevalence of ACEs for South Carolina children was higher than the national average, certain groups of children experienced higher rates of adverse childhood experiences.

S.C. Prevalence of Adverse Childhood Experiences by Subgroups



Adverse childhood experience data offer an opportunity to target interventions aimed at reducing costly outcomes for South Carolinians. These data suggest that **children ages 12 to 17 years, children in families with the lowest income and children who are uninsured** should be screened for adverse childhood experiences. When appropriate, interventions should be designed to mitigate potentially negative educational and health outcomes.

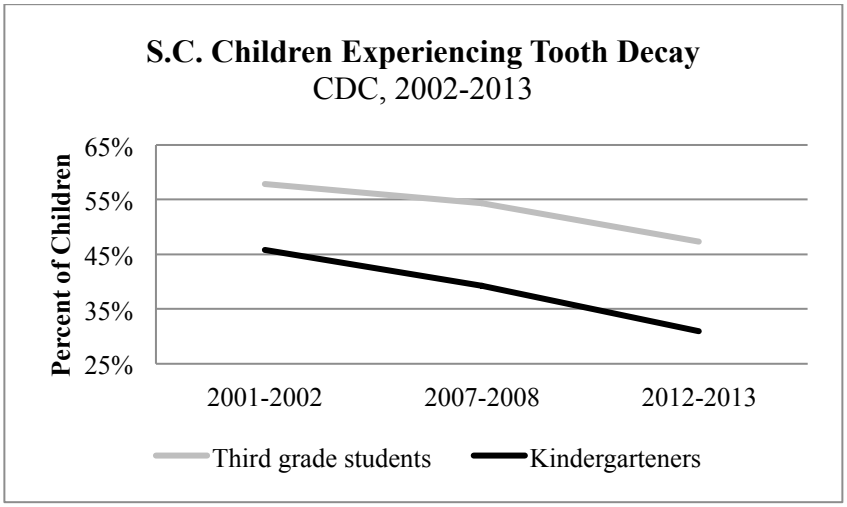
F. Children with Tooth Decay

This indicator reports the percent of students with treated or untreated tooth decay.[78] In South Carolina, an estimate of 47.2% of 3rd grade students and 30.9% of kindergarteners had treated or untreated tooth decay. The percent had been decreasing for both 3rd grade students and kindergarteners since 2002. No comparable national data were available on this indicator.

Tooth decay results from bacteria on teeth that breakdown foods and produce acid that destroys tooth enamel.[79] Tooth decay (cavities) is the single most common childhood disease. Hundreds of thousands of children nationwide go untreated each year.[80] Untreated oral diseases are associated with eating, speaking, sleeping and systematic health problems.[81] Children with

[78] Centers for Disease Control and Prevention, Division of Oral Health, Oral Health Data, South Carolina, **http://www.cdc.gov/oralhealthdata/** (Last visited, January 13, 2016).
[79] Centers for Disease Control and Prevention, Water, Sanitation & Environmentally-related Hygiene, Dental Caries (Tooth Decay), **http://www.cdc.gov/healthywater/hygiene/disease/dental_caries.html** (Last visited, January 13, 2016).
[80] American Academy of Pediatric Dentistry. Every Child Deserves a Dental Home. http://www.aapd.org/foundation (last visited, January 8, 2015).
[81] Department of Health and Human Services. Oral Health in America: a Report of the Surgeon General. **http://silk.nih.gov/public/hck1ocv.@www.surgeon.fullrpt.pdf** (last visited, February 6, 2015).

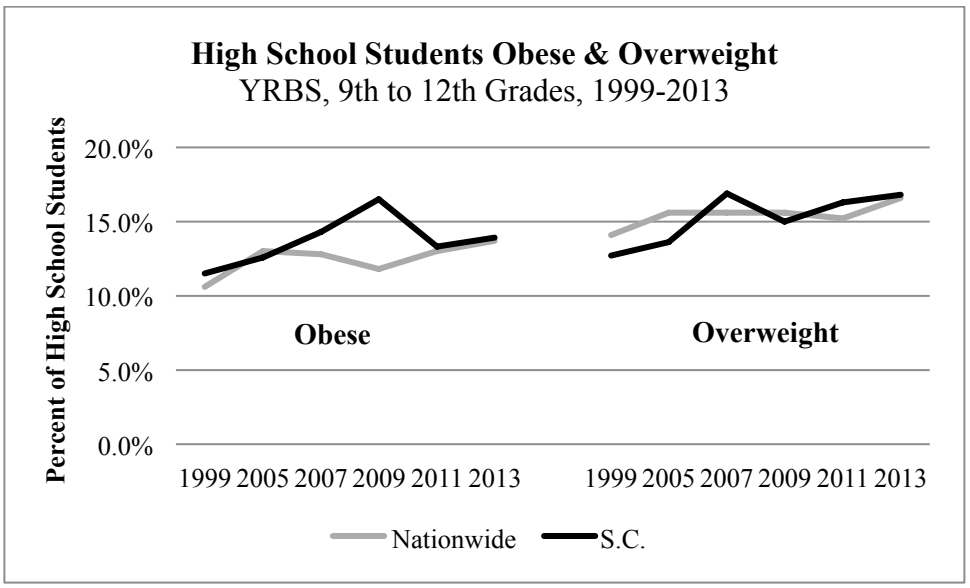
poor oral health are more likely to miss school due to dental pain and have poor school performance.[82] Children from low income families were less likely to receive dental care. Expanding access to dental benefits is key to improving the oral health of this population.[83]



G. High School Students Obese and Overweight

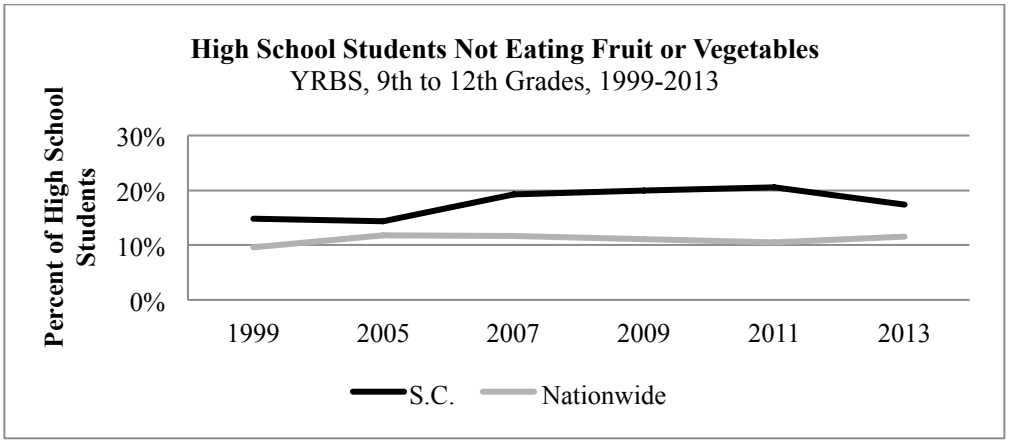
This indicator reports the percent of high school students in South Carolina who were obese (i.e., >= 95th percentile for body mass index) and overweight (i.e., >= 85th percentile but <95th percentile for body mass index).[84] In South Carolina, 30.7% of high school students were obese and overweight in 2013, which was a 6.5% increase from the 1999 survey. Nationally, the percent of high school students who were obese and overweight were 30.3% in 2013 and 24.7% in 1999. Since 2007, the percent of high school students who were obese had been **consistently higher** than the national percent. The percent of students who were overweight had also exceeded the national level since 2011.[85]

[82] Jackson, S. L., Vann Jr, W. F., Kotch, J. B., Pahel, B. T., & Lee, J. Y. (2011). Impact of poor oral health on children's school attendance and performance. *American Journal of Public Health*, 101, 1900-1906.
[83] Kenney, G. M., McFeeters, J. R., & Yee, J. Y. (2005). Preventive dental care and unmet dental needs among low-income children. *American Journal of Public Health*, *95*, 1360.
[84] Body mass index based on sex- and age-specific reference data from the 2000 CDC growth charts.
[85] Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS), **https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=XX** (Last visited January 25, 2016).



H. High School Students Not Eating Fruits or Vegetables

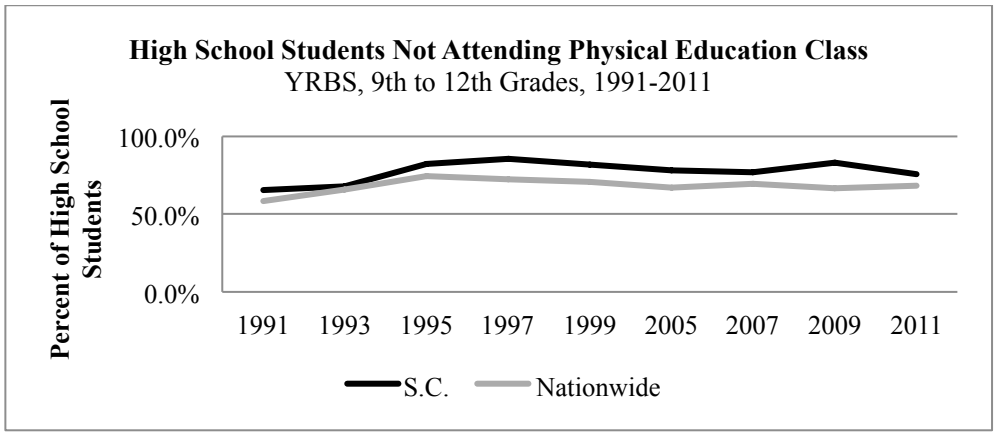
This indicator reports the percent of high school students in South Carolina who did not eat a serving of fruit or vegetable (i.e., green salad, potatoes[86], carrots, or other vegetables) during the 7 days before the 2013 High School Youth Risk Behavior Survey. In South Carolina, 17.4% of high school students reported that they did not eat fruit or vegetable during the 7 days before the survey. The national percent was 11.6%, consistently lower than South Carolina.[87]



[86] Potatoes excluding French fries, fried potatoes, or potato chips.
[87] Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS), **https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=XX** (Last visited January 25, 2016).

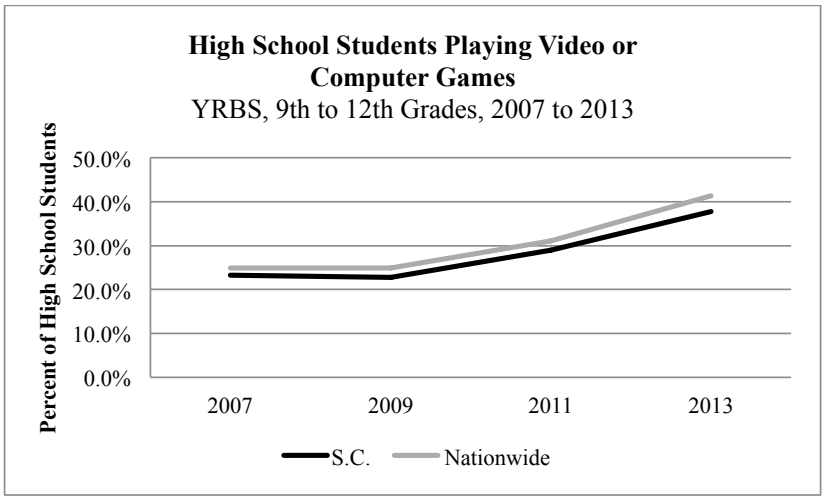
I. High School Students Not Attending Physical Education Classes

This indicator reports the percent of high school students in South Carolina who did not attend physical education classes on all 5 days (in an average week when they were in school) according to the 2011 High School Youth Risk Behavior Survey (YRBS). In South Carolina, 75.8% of high school students reported that they did not attend physical education classes in 2011. The national percent was 68.5% in 2011, consistently lower than South Carolina.[88]



J. High School Students Playing Video or Computer Games

This indicator reports the percent of high school students in South Carolina who played video or computer games or used a computer 3 or more hours per day (for something that was not school work on an average school day), according to the 2013 High School Youth Risk Behavior Survey (YRBS). In South Carolina, 37.7% of high school students reported they played video or computer games or used a computer three or more hours per day for non-school work in 2013. The national percent was 41.3% in 2013.[89] The number has been increasing since 2009 for both South Carolina and children nationwide.



[88] Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS), **https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=XX** (Last visited February 8, 2016).
[89] Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS), **https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=XX** (Last visited February 8, 2016).

K. High School Students Not Eating Breakfast

This indicator reports the percent of high school students in South Carolina who did not eat breakfast on all 7 days during the 7 days before the 2013 High School Youth Risk Behavior Survey. In South Carolina, 67.2% of high school students reported that they did not eat breakfast on all 7 days. Nationally, the percent was 61.9% in 2013.[90]

Breakfast consumption is associated with positive outcomes in terms of weight status, nutrient intake, behavior, cognitive and school performance in children.[91] Children and adolescents are most likely to eat breakfast in families where the adults eat breakfast themselves.[92] The importance of breakfast to children's growth and development as well as the high percent of high school students who did not have breakfast in South Carolina urged parents and educators in South Carolina to set a good example for their children and to ensure that their children eat breakfast regularly.

[90] Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS), **https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=XX** (Last visited January 25, 2016).
[91] Adolphus, K., Lawton, C. L., & Dye, L. (2013). The effects of breakfast on behaviour and academic performance in children and adolescents. Frontiers in human neuroscience, 7. **http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3737458/**
[92] Pearson N, Biddle SJ, Gorely T. (2009). Family correlates of breakfast consumption among children and adolescents. A systematic review. Appetite 52(1):1-7.

Education Indicators of Child Well-Being

Education affects many areas of child well-being and future success as an adult. Educational indicators can reflect how well the state is preparing children for success in school and training its future workforce. Education indicators include information on publicly funded pre-K, family reading to young children, children with disabilities in public schools, dollar spent per student in public students, high school graduation rate, and standardized test scores.

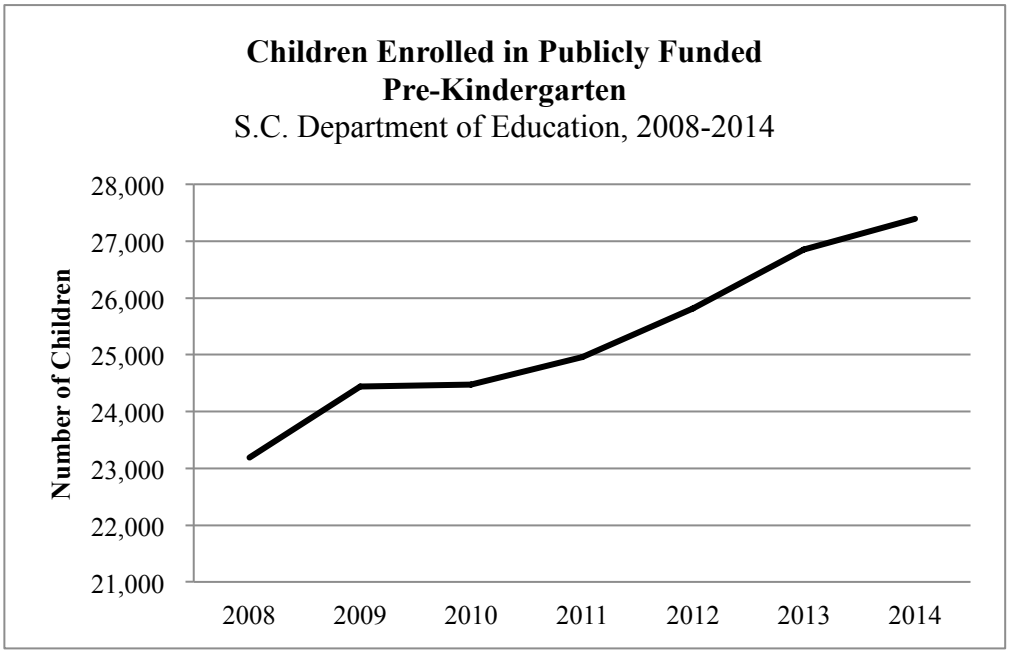
Indicators	2011	2013	2015	Trend
A. Children Enrolled in Public Pre-K	24,954	26,851	27,391 (2014)	*Increasing*
B. Family Reading to Young Children (ages 0-5 years)	47.2% (2003)	49.6% (2007)	48.3% (2012)	*No trend*
C. Students with Disabilities in Public Schools	7.4%	13.1%	13.1%	*Increasing*
D. Dollars Spent per Student in Public Schools	9,445	9,411	9,907	*No trend*
E. High School Graduation Rate [93]	74.8%	79.2%	80.3%	*Increasing*
F. 4th Grade PASS Scores				
Percent of Students Scoring "Not Met" for Social studies	22.9%	18.2%	14.7%	*Decreasing*
Percent of Students Scoring "Not Met" for Science	29.1%	26.9%	30.1%	*No trend*
8th Grade PASS Scores				
Percent of Students Scoring "Not Met" for Social Studies	28.1%	28.7%	26.6%	*No trend*
Percent of Students Scoring "Not Met" for Science	29.9%	28.9%	34.8%	*No trend*
G. 4th Grade NAEP Scores				
Average Reading Score	215	214	218	*No trend*
Average Math Score	237	237	237	*No trend*
8th Grade NAEP Scores				
Average Reading Score	260	261	260	*No trend*
Average Math Score	281	280	276	*Decreasing*

A. Children Enrolled in Publicly Funded Pre-Kindergartens

Children ages 3 and 4 years participating in public-funded pre-kindergartens are included in this indicator. In South Carolina, 27,391 children enrolled in publicly funded pre-K programs in 2014, which is an 18% increase from 2008, and a 2% increase from 2013.[94] This number includes children attending private pre-kindergarten programs only if those programs are paid for using South Carolina Child Development Education Pilot Program (CDEPP) funds.

[93] Percent of students receiving a regular high school diploma within 4 years of entering high school.
[94] S.C. Department of Education. Children Enrolled in 3 and 4 Year Olds Pre-Kindergarten. Unpublished report generated in February, 2015. This data remained the same as the data published in 2015 Child Well-Being Data Reference Book.

Nationally, approximately 55.8% of children ages 3 and 4 years enrolled in different types of schools in 2013, a 1.4% increase from 2012 and an 18.2% increase from 1980. The percent of enrollment has been increasing since 1980.[95] Research showed that children participating in high-quality center-based care, preschool, and prekindergarten programs were more likely to have better pre-academic skills and language performance at age four and a half years old, perform better in math and reading in the early grades of elementary school,[96] were more likely to attend a four-year college, and were less likely to have a teen pregnancy.[97] An increase in the recognition of the importance of early childhood education and funding for public prekindergarten programs is needed to improve school readiness, especially among children from low-income families.[98]

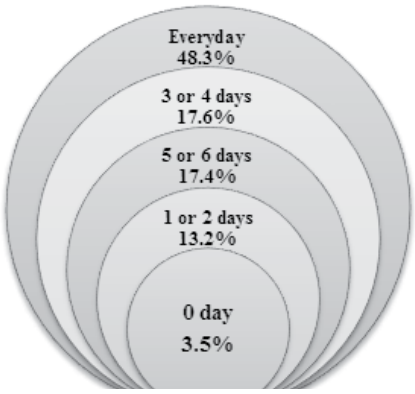


[95] U.S. Department of Education. National Center for Educational Statistics. **http://nces.ed.gov/programs/digest/d14/tables/dt14_103.10.asp?current=yes** (last visited, February 10, 2016).
[96] NICHD Early Child Care Research Network. (2002). *Early child care and children's development prior to school entry: Results from the NICHD study of early child care*. American Educational Research Journal, 39: 133-164. **http://www.jstor.org/stable/10.2307/3202474** (last visited, February 2, 2015).
[97] Campbell, F., Ramey, C. T., Pungello, E., Miller-Johnson, S., & Sparling, J. J. (2002). Early childhood education: Young adult outcomes from the Abecedarian Project. **http://larrycuban.files.wordpress.com/2011/03/campbell-et-al.pdf** (last visited, February 2, 2015).
[98] Barnett, W. S., Lamy, C., & Jung, K. (2005). *The effects of state prekindergarten programs on young children's school readiness in five states*. New Brunswick, NJ: National Institute for Early Education Research.

B. Family Reading to Young Children (ages 0-5 years)

This indicator reported the percent of children ages 0 to 5 years being read stories to by family every day. The National Survey of Children's Health 2011/12 surveyed the parents in South Carolina on reading time with their children ages 0 to 5 years old. In South Carolina, 48.3% of children, or an estimate of 175,423 children were read stories to by family every day. While the national average was 47.9%, South Carolina is still ranked 35th in the nation. The percent of children being read stories to by family everyday ranges across states from 38.2% (Texas) to 71.6% (Vermont).[99]

In South Carolina, children ages 0 to 5 years living in households with adults who did not complete high school (13.4%) were reported to have fewest family reading experiences, followed by Hispanic children whose household language was Spanish (12.9%), children in family below 100% of the federal poverty level (8%) and children who were uninsured (6%).



Family Reading to Young Children in S.C.

According to the American Library Association, reading is as important to a child's growth and development as food and water. Research has shown that babies who are read to in the first nine months of their lives are better prepared for school than babies who had little interaction with books. Neuroscience teaches us that the human brain has a remarkable capacity to change but timing is crucial. While learning continues throughout the life cycle, there are "prime times" for optimal development. Babies and young children's brains are being primed for learning. Their brains develop more than double its size in the first year of life and, by the age of three, a child's brain is twice as active as an adult's brain. By the age of five, the brain is 90% of the size of the adult brain. This is the period of time the brain is preparing the groundwork for a lifetime of learning, problem-solving and for academic success. Reading to babies and young children can stimulate the early brain growth and shape a child's life. It is never too early for adults to start reading to babies and children.[100,101]

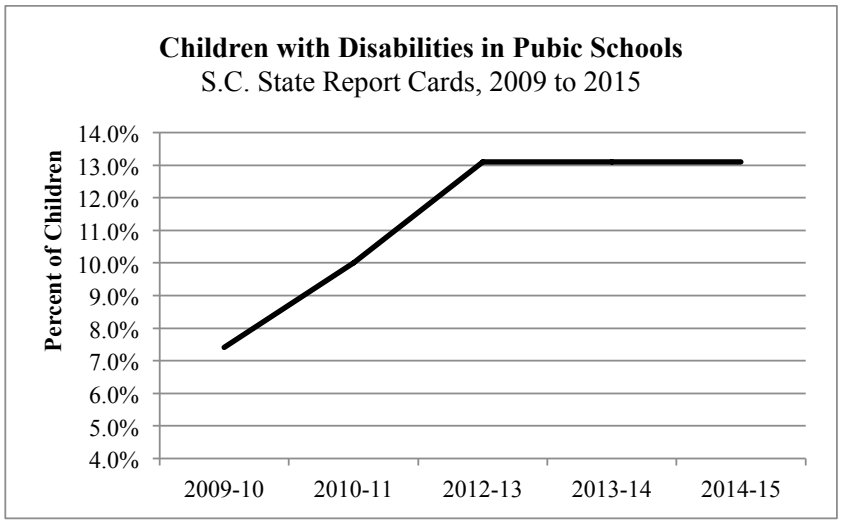
Although the data showed that the majority of children in South Carolina were read stories to by family at least one day in a week, certain household characteristics place a child at risk of not being read to at all, placing them at a distinct disadvantage. Less than half of the children in South Carolina are read to by family members every day. Because reading is so important in early childhood development, this number must increase. Additionally, quantity is not the only measure when considering early childhood literacy development. Further research are warranted to investigate the quality of book reading in South Carolina.

[99] Data Resource Center for Child & Adolescent Health, 2011/12 National Survey of Children's Health, **http://www.childhealthdata.org/browse/survey/results?q=2284&r=1** (Last visited, March 21, 2016).
[100] Association for Library Service to Children, American Library Association, **http://www.ala.org/alsc/issuesadv/borntoread/resources**
[101] Brain Development, Multnomah County Library, **https://multcolib.org/parents/early-literacy/brain-development**

C. Children with Disabilities in Public Schools

South Carolina education state report cards reported that the average percent of students with disabilities in public schools was 13.1% in school year 2014 to 2015. This reflects a 5.7% increase from school year 2010 to 2011.[102] Children with disabilities may be eligible for special education services through an individual education program (IEP). 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.

Nationally, the number of children and youth ages 3 to 21 receiving special education services was 6.4 million, or about 13% of all public school students, in school year 2012 to 2013. This corresponded to 13% of total public school enrollment. Approximately 35% of students receiving special education services had specific learning disabilities. The number of children and youth ages 3 to 21 who received special education services has increased 11% from 1990 to 1991 school year to 2004 to 2005, but declined from 2004-2005 through 2011-2012.[103] Of the children served, speech or language impairment (35.2%), intellectual disability (26%), specific learning disability (21.5%), and emotional disturbance (7.7%) were the top disabilities among children and youth.[104] Boys were more likely to have an identified learning disability than girls. Children in families with an income of less than $35,000, children in single-mother families, and children with poor health status were at a higher risk of having learning disabilities.[105]

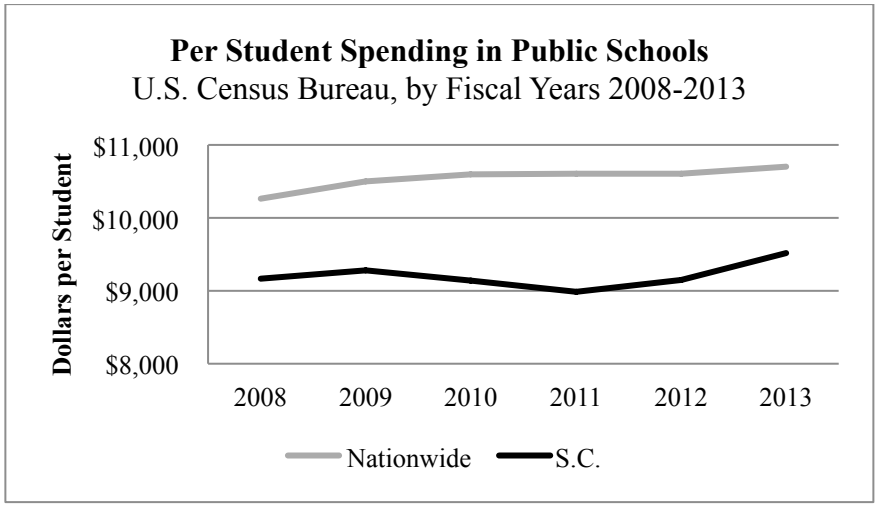


[102] S.C. Department of Education, 2015 State Report Cards, http://ed.sc.gov/data/report-cards/state-report-cards/2015/ (Last visited, March 16, 2016).
[103] National Center for Educational Statistics, Children and Youth with Disabilities, **http://nces.ed.gov/programs/coe/indicator_cgg.asp** (Last visited, March 16, 2016).
[104] National Center for Educational Statistics, Children 3 to 21 years old served under Individuals with Disabilities Education Act (IDEA), Part B, by type of disability: Selected years, 1976-77 through 2012-13, **http://nces.ed.gov/programs/digest/d14/tables/dt14_204.30.asp** (Last visited, March 16, 2016).
[105] Centers for Disease Control and Prevention. National Center for Health Statistics. **http://www.cdc.gov/nchs/data/series/sr_10/sr10_258.pdf** (last visited, January 8, 2015).

D. Dollars Spent per Student

South Carolina education state report cards reported that the average spending per student in public schools was $9,907 in 2014 to 2015 school year. The amounts of spending per student was declining from 2009-2010 school year to 2011-2012, but increased 5% from school year 2012-2013 to the most recent school year of 2014-2015.[106]

Nationally, the most recent data showed that the average spending per student in public elementary-secondary school system was $10,700 in fiscal year 2013, higher than the per pupil spending in South Carolina. South Carolina was ranked the 33th with the 1st being the highest spending in this indicator. South Carolina has been consistently lower than the national per student spending since fiscal year 2008.[107]

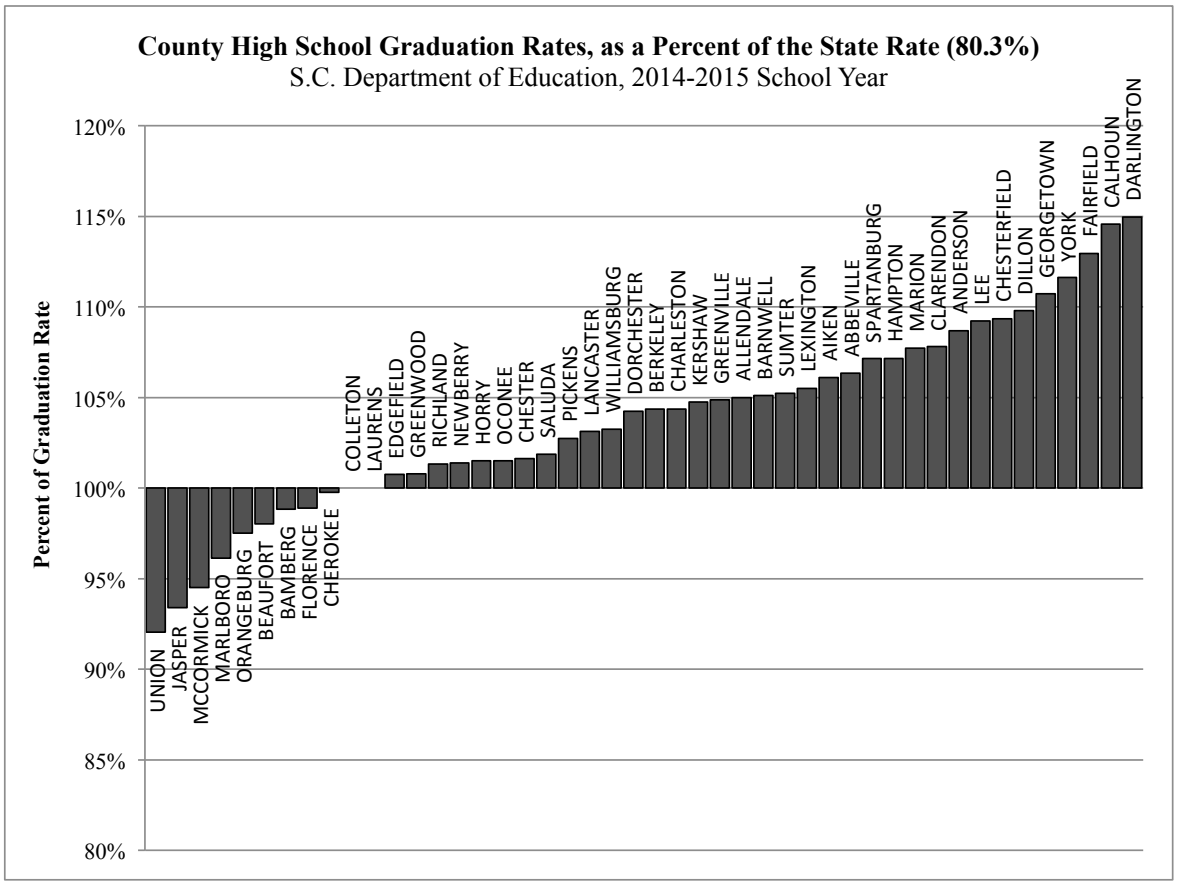


[106] S.C. Department of Education, 2015 State Report Cards, http://ed.sc.gov/data/report-cards/state-report-cards/2015/ (Last visited, March 16, 2016).
[107] U.S. Census Bureau, Economics and Statistics Administration, U.S. Department of Commerce, the Educational Finance Branch, Public Education Finances: 2013, Economic Reimbursable Surveys Division Reports, Issued June 2015, **http://www2.census.gov/govs/school/13f33pub.pdf** (Last visited, March 16, 2016).

E. High School Graduation Rates

The graduation rate for South Carolina students in public schools was calculated using data provided by the report cards from the Department of Education. This indicator reflects the percent of eligible students who graduated on time with their age group. Since 2010, the statewide high school graduation rate has increased from 72% to 80.3% in 2015.[108]

The following graph reflects the South Carolina average high school graduation rate at the county level in 2015. The county high school graduation rate is as low as 73.9% in Union County and as high as 92.3% in Darlington County. The graduation rates for the majority of counties in South Carolina (80%) were at or above the state graduation rate. According to the most recent data available, the national high school graduation rate was 81.4 % in 2012 to 2013 school year. The high school graduation rates for economically disadvantaged students (73.3%), students with limited English proficiency (61.1%), and students with disabilities (61.9%) were all lower than the average national rate.[109]

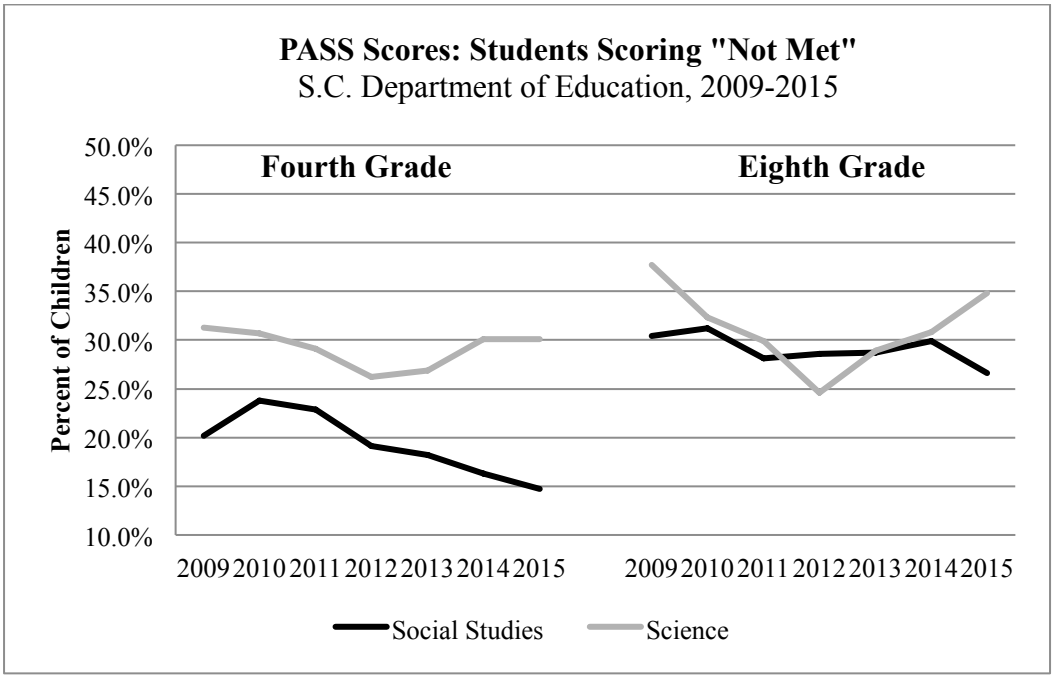


[108] S.C. Department of Education, Four Year High School Graduation Rate, **http://ed.sc.gov/data/report-cards/state-report-cards/2015/** (Last visited, February 29, 2016).
[109] National Center for Educational Statistics. Public High School Four-Year On-Time Graduation Rates and Event Dropout Rates: School Years 2012–13, **http://nces.ed.gov/ccd/tables/ACGR_RE_and_characteristics_2012-13.asp** (Last visited, March 2, 2016).

F. Fourth and Eighth Grade PASS Scores

The South Carolina Palmetto Assessment of State Standards (SCPASS) is a statewide assessment administered to students in grades four through eight to assess knowledge and mastery of state standards. All students in these grade levels are required to take the SCPASS except those who qualify for the South Carolina Alternate Assessment (SC-Alt). SCPASS includes tests in two subjects: science and social studies. Scores are reported in three categories: *met*, *unmet*, and *exemplary*. This indicator is comprised of science and social studies scores for fourth-grade and eighth-grade students.[110,111]

In 2015, approximately 30.1% of fourth-grade students scored "not met" for science and 14.7% scored "not met" for social studies. For eighth-grade students, approximately 34.8% scored "not met" for science and 26.6% of students were "not met" for social studies. There was not significant change compared to scores in 2013.[112] Compared to 2014, the percent of students who scored "not met" in social studies slightly decreased for both fourth- and eighth grade students in 2015. The percent of "not met" in science for fourth-grade students in 2015 remained the same with 2014. There was a 4% increase of eighth-grade students who scored "not met" in science in 2015.

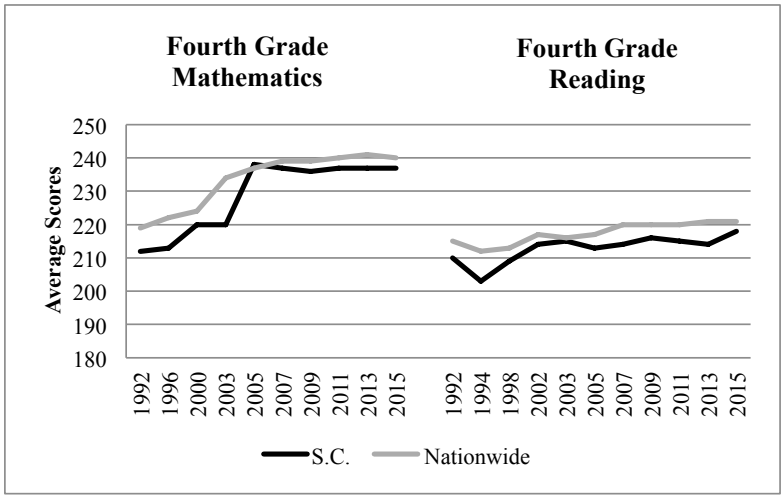


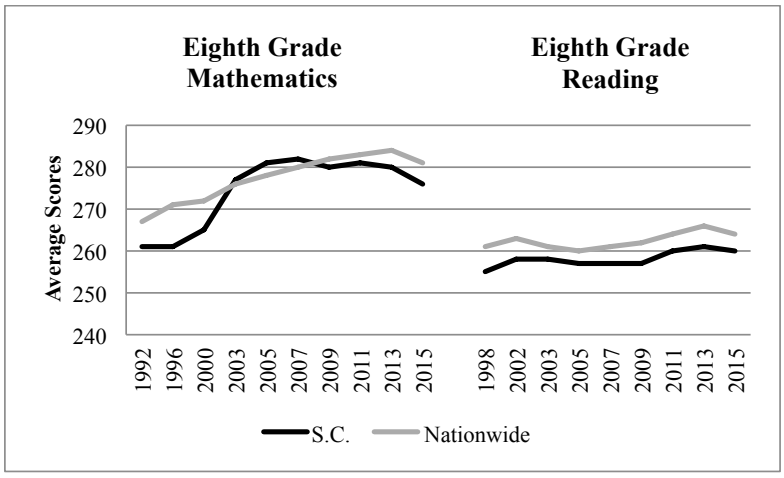
[110] 2014 was the final year for PASS tests in English Language Arts and Math.
[111] S.C. Department of Education. South Carolina Palmetto Assessment of State Standards (SCPASS) Science and Social Studies Grades 4-8 **http://ed.sc.gov/tests/middle/scpass/** (last visited, December 18, 2015).

G. Average NAEP Scores[113]

The National Assessment of Educational Progress (NAEP) reports comprehensive information regarding what fourth-grade and eighth-grade students have learned and their performance levels in various subject areas. This indicator shows the average math and reading scale scores that fourth-grade and eighth-grade students in South Carolina earned on the NAEP, compared to the national average.

The average reading score of fourth-grade students in South Carolina was 218 in 2015. This was lower than the average score of 221 for public school students nationwide. The average reading scores for eighth-grade students in South Carolina was 260, which was lower than the national average of 264. The average math score of fourth- and eighth-grade students in South Carolina were also lower than the national average.





[112] S.C. Department of Education. Palmetto Assessment of State Standards (PASS) Test Scores. **http://ed.sc.gov/data/test-scores/state-assessments/scpalmetto-assessment-of-state-standards-pass/2015/** (last visited, December 18, 2015).
[113] National Center for Education Statistics. Institute of Education Sciences. **http://nces.ed.gov/nationsreportcard/states/**(last visited, December 18, 2015).

Responsibility Indicators of Child Well-Being

When children 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. Responsibility in children is nurtured by participation in constructive activities, positive connections with adults, and the encouragement of constructive interests. There are many ways to measure responsibility in children; however, very little of this data are currently captured in South Carolina. Responsibility indicators include information on employment, births to teens, high school students currently using tobacco, children in treatment for drug and alcohol abuse, and juvenile crime.

Indicators	2011	2013	2015	Trend
A. Youth Employment	22.1%	26.3%	26.1% (2014)	*No trend*
B. Births to Teenagers	1,761	1,313	1,235 (2014)	*Decreasing*
C. High School Students Currently Used Tobacco	27.3% (2009)	28.4% (2011)	23.2% (2013)	*No trend*
D. Children in Treatment for Drug and Alcohol Abuse[114]	4,281 (2012)	4,690 (2014)	3,476	*No trend*
E. Juvenile Offenses	18,114	16,754	15,697	*Decreasing*

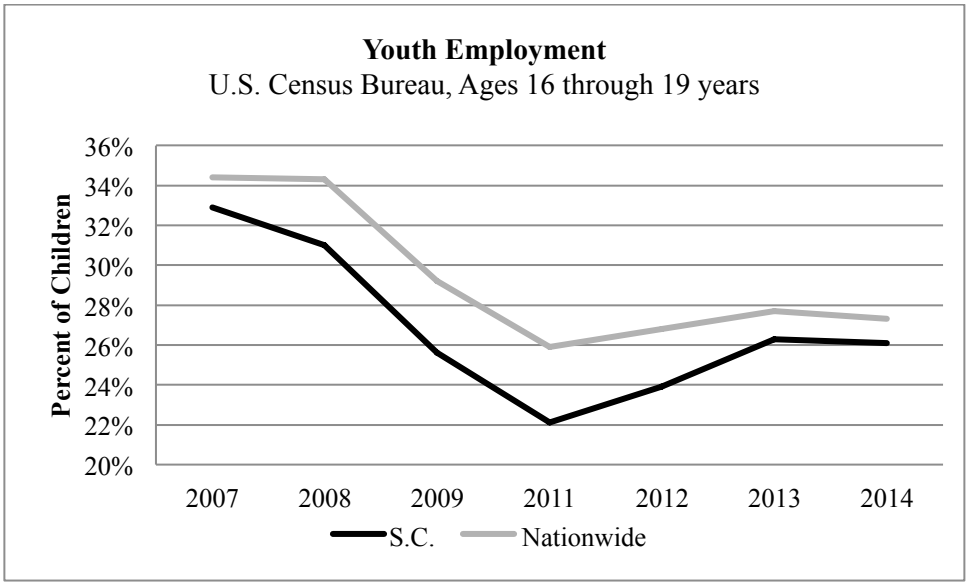
A. Youth Employment

This measure represents youth ages 16 through 19 years who are gainfully employed outside the home, as reported by U.S. Census Bureau.[115] In South Carolina, the youth employment rate among youth ages 16 through 19 was 26.1% in 2014, which was a 3% increase from the previous years of 2013, and a 6.8% decrease from 2007.[116]

Nationally, youth employment rate was 27.3% in 2014, a 0.4% increase from the previous year and a 7.1% decrease from 2007.[117] The youth employment rate in South Carolina has been consistently lower than the national rate since 2007.[118] According to the U.S. Bureau of Labor Statistics, high school graduates not enrolled in college were more likely than graduates

[114] FY 2013 data omitted in the summary table due to duel clinical record system operation impacting the state's ability to unduplicate client entry activity.
[115] United States Census Bureau, American Fact Finder, **http://factfinder.census.gov/help/en/index.htm#glossary.htm** (last visited, January 6, 2015).
[116] Bureau of Statistics, U.S. Department of Labor. Geographic Profile of Employment and Unemployment, 2014. Estimates for States. **http://www.bls.gov/opub/gp/gpsec2.htm** and **http://www.bls.gov/opub/gp/pdf/gp14_14.pdf** (last visited, December 18, 2015).
[117] Bureau of Statistics, U.S. Department of Labor. Geographic Profile of Employment and Unemployment, estimates for Census regions and divisions2014. **http://www.bls.gov/opub/gp/laugp.htm** and **http://www.bls.gov/opub/gp/pdf/gp14_01.pdf** (last visited, December 18, 2015).
[118] United States Census Bureau, American Fact Finder, **http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t** (last visited, January 6, 2015).

enrolled in college to be working or looking for work. High school dropouts had a lower labor participation rate than high school graduates not enrolled in college.[119,120]

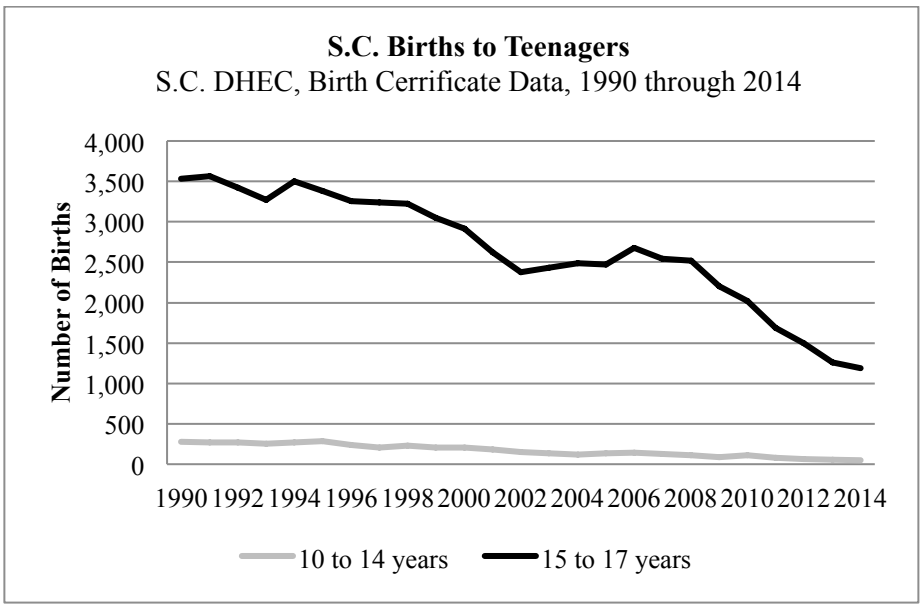


B. Births to Teenagers

This indicator reflects the number of live births to female teenagers ages 10 to 17 years. In 2014, there were 1,235 births to teenagers in 2014 with a birth rate of 6.1 births per 1,000 female teenagers. The birth rates continued to decline in 2014 and reached its record low since 1990. The birth rates were higher among black teenagers ages 15 to 17 years (16.6 births per 1,000 female teenagers) than white teenagers (11.5 births per 1,000 female teenagers).[121]

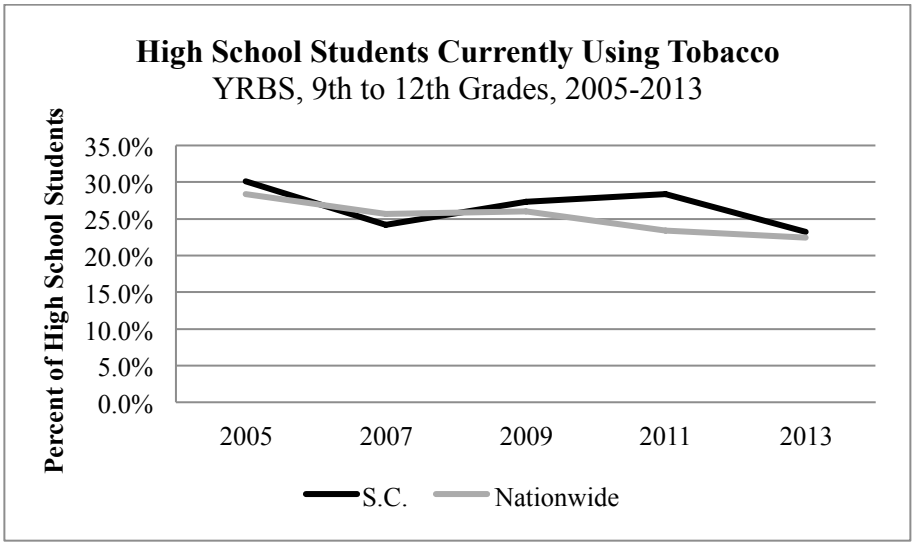
Nationally, birth rates for female teenagers ages 15 to 19 years (i.e., 24.2 births per 1000 female teenagers) continued to decrease in 2014, marking another record low for the nation.[122] South Carolina birth rate for female teenagers ages 15 to 19 years was 28.5 per 1000 female teenagers, higher than the national rate.[123]

[119] Bureau of Statistics, U.S. Department of Labor. College Enrollment and Work Activity of 2012 High School Graduates. **http://www.bls.gov/news.release/archives/hsgec_04172013.pdf** (last visited, January 8, 2015).
[120] Bureau of Labor Statistics, U.S. Department of Labor. (2010). America's youth at 22: School enrollment, training, and employment transitions between ages 21 and 22. **http://www.childtrends.org/?indicators=youth-employment#_edn2** (last visited, January 8, 2015).
[121] S.C. Department of Health and Environment Control, Birth Certificate Data, http://scangis.dhec.sc.gov/scan/bdp/tables/birthtable.aspx (Last visited, January 5, 2016).
[122] Centers for Disease Control and Prevention. Births in the United States, 2014. http://www.cdc.gov/nchs/data/databriefs/db216.htm#birth (Last visited, December 22, 2015).
[123] S.C. Department of Health and Environment Control, Birth Certificate Data, http://scangis.dhec.sc.gov/scan/bdp/tables/birthtable.aspx (Last visited, January 5, 2016).



C. High School Students Currently Using Tobacco

This indicator describes the percent of high school students currently used tobacco (current cigarette use, current smokeless tobacco use, or current cigar use) according to the 2013 High School Youth Risk Behavior Survey (YRBS). In South Carolina, 23.2% of high school students reported that they currently used tobacco. Nationally, the percent was 22.4% in 2013.[124]

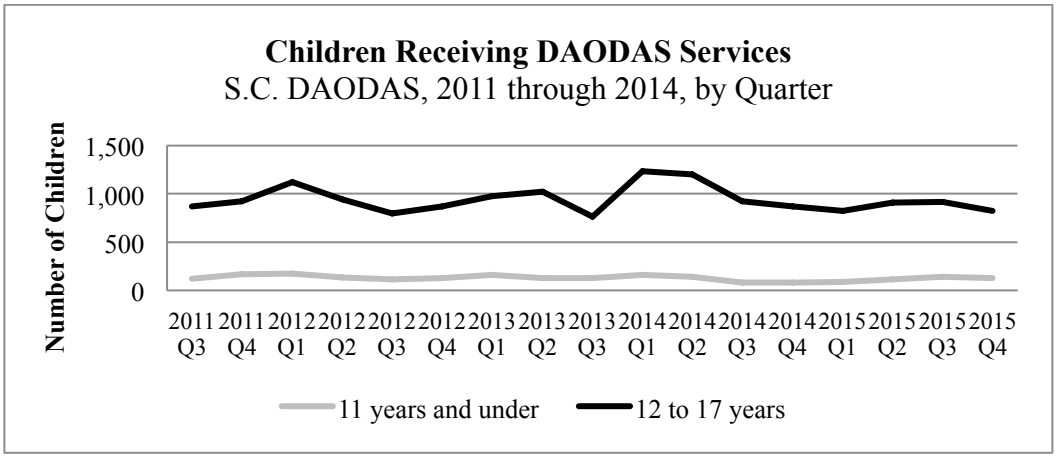


[124] Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (YRBSS), **https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=XX** (Last visited February 8, 2016).

D. Children in Treatment for Drug and Alcohol Abuse

This indicator presents the number of children under the age of 18 years who received inpatient, residential, or outpatient treatment for drug and alcohol abuse. In South Carolina, there were 3,476 child admissions for treatment of drug and alcohol abuse in 2015, which was a 26% decrease from 2014 and a 19% decrease from 2012. Almost half of the admissions in 2015 were due to a primary problem of marijuana abuse (i.e., 45.4%) and 5.6% were due to alcohol abuse.[125]

Nationally, there were 101,404 admissions for treatment of substance and alcohol abuse in 2013 for children ages 12 to 17 years, which represented 6% of the total admissions. The percent of child admissions decreased 2.4% since 2003. Approximately 76% were for treatment of marijuana abuse and approximately 5.6% were related to alcohol abuse for children ages 12 to 17 years in 2013.[126] Research showed that teenagers are more impulsive, aggressive, emotionally volatile, more likely to take risks, reactive to stress, vulnerable to peer pressure, prone to focus on short-term payoffs and underplay longer-term consequences of risk behaviors such as alcohol and drug consumption.[127,128] Teenagers are especially at risk for developing serious alcohol and drug problems when they are depressed, with a family history of substance use disorder, lack of parental supervision and support, associating with drug-abusing peers, having low self-esteem or low self-control.[129,130]



[125] S.C. Department of Alcohol and Other Drug Addiction Services, unpublished reports generated in December 2015. The most recent data available. FY 2013 Q4 data omitted in the bar graph due to duel clinical record system operation impacting the state's ability to unduplicate client entry activity.

[126] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Treatment Episode Data Set (TEDS): 2003-2013. National Admissions to Substance Abuse Treatment Services. BHSIS Series X-XX, HHS Publication No. (SMA) XX-XXXX. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. (Last visited January 5, 2016).

[127] "The Teen Brain: Still Under Construction," National Institute of Mental Health, **http://www.nimh.nih.gov/health/publications/the-teen-brain-still-under-construction/index.shtml** (Last visit, November 5, 2014).

[128] Winters, K. C., Adolescent Brain Development and Drug Abuse, supported by Archie & Bertha Walker Foundation, RKMC Private Foundation, and Mentor Foundation. **http://www.mentorfoundation.org/uploads/Adolescent_Brain_Booklet.pdf** (last visit, November 5, 2014).

[129] American Academy of Child and Adolescent Psychiatry, Teens: Alcohol And Other Drugs, **http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/Teens_Alcohol_And_Other_Drugs_03.aspx** (last visited, February 9, 2015).

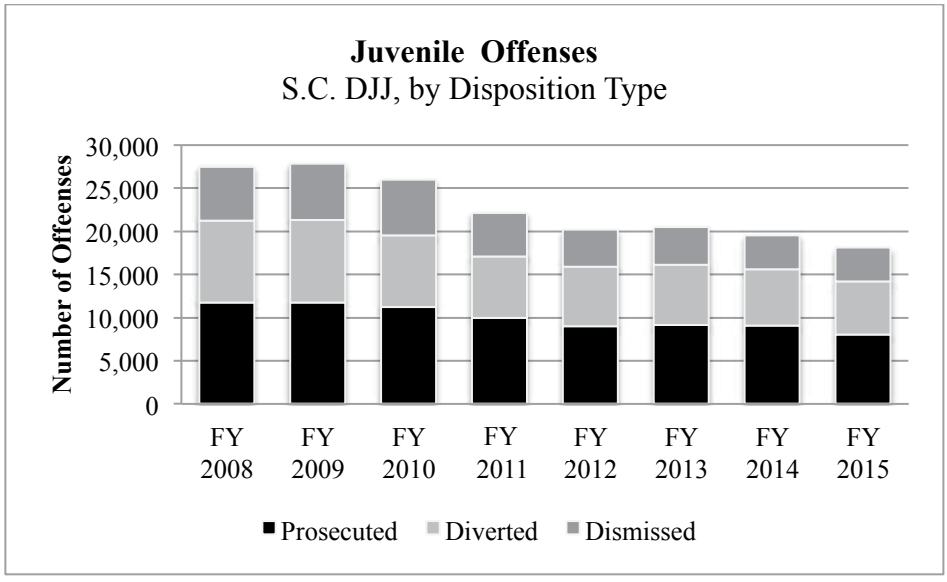
[130] National Institute on Drug Abuse, Preventing Drug Use among Children and Adolescents, **http://www.drugabuse.gov/sites/default/files/preventingdruguse_2.pdf** (last visited, February 9, 2015).

E. Juvenile Offenses[131]

This indicator reports the number of juvenile delinquency cases involving the Department of Juvenile Justice (DJJ). A child referred to DJJ may be formally prosecuted by the solicitor in a family or circuit court, diverted to an alternative program, or the charge may be dismissed. A juvenile may have multiple charges over the course of an annual reporting period.

The South Carolina Department of Juvenile Justice (DJJ) processed 15,697 new juvenile cases in 2015, which was a 4% decrease from the previous year of 2014, and a 36% decrease from 2007. Of all the juveniles referred to DJJ in 2015, 59% were black, 37% were white, 3% were Hispanic and 2% were other race/ethnicity. In terms of age, 67% of the juveniles were under age 16 years, and 33% were ages 16 or older. The gender breakdown for the referrals was 69% male and 31% female. Assault and battery (3rd), shoplifting and disturbing schools were the three most frequent offenses associated with referrals to DJJ.[132]

Nationally, in 2011, courts with juvenile jurisdiction handled an estimated 1,058,500 delinquency cases, a 9% decrease between 1985 and 2013, and a 44% decrease between its peak year 1997 and 2013. Between 1997 and 2013, the number of cases decreased for all offense categories: property (59%), person (35%), public order (29%), and drugs (26%). Property offense cases accounted for the decline in the delinquency caseload between 1985 and 2013. Of all the delinquency cases processed by juvenile courts, 53% of cases involved children under 16 years, 72% of cases involved males and 62% of cases involved white children.[133]



[131] S.C. Department of Juvenile Justice, **http://www.state.sc.us/djj/pdfs/2012-13%20Annual%20Statistical%20Report.pdf** (last visited, February 24, 2014).
[132] S.C. Department of Juvenile Justice, 2014-2015 Annual Statistics Report , **http://www.state.sc.us/djj/pdfs/2015-Annual-Statistical-Report.pdf** (Last visited, January 11, 2016).
[133] Hockenberry, Sarah, and Puzzanchera, Charles. 2015. Juvenile Court Statistics 2013. Pittsburgh, PA: National Center for Juvenile Justice. **http://www.ojjdp.gov/ojstatbb/njcda/pdf/jcs2013.pdf** (Last visited, January 11, 2016).

Support Indicators of Child Well-Being

When children have adequate emotional and financial support, they have a better opportunity to reach their full potential. Support indicators include information on children living in poverty, children experiencing homelessness, students receiving free and reduced meals, child participation of the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and children on Medicaid.

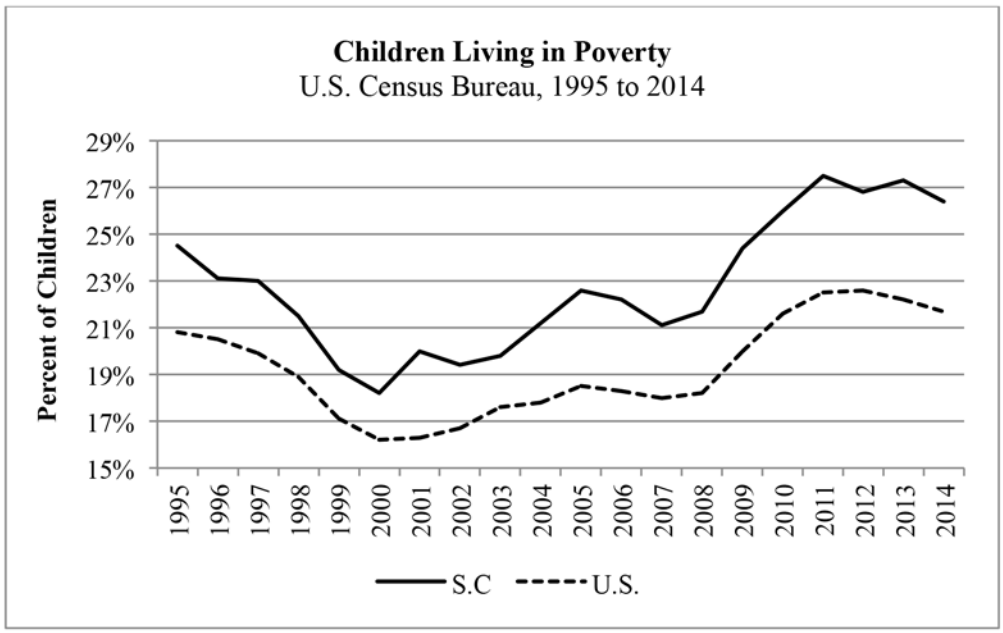
Indicators	2011	2013	2015	Trend
A. Children Living in Poverty	27.5%	27.3%	26.4% (2014)	*Decreasing*
B. Children Experiencing Homelessness	21,143 (2011)	20,741(2012)	22,614 (2013)	*No trend*
C. Students Receiving Free and Reduced Meals	55%	57%	58%	*Increasing*
D. Children Receiving Food Support	288,505	265,574	240,541(2014)	*Decreasing*
E. Children Receiving Medicaid Benefits	590,386	676,668	721,198	*Increasing*

A. Children Living in Poverty

This indicator is a Census Bureau estimate of the number of persons whose household income falls below the poverty threshold. In 2014, the poverty threshold for a family of two parents and two children was $24,008.[134] In South Carolina, there were 281,738 children (i.e., 26.4%) in poverty in 2014. This is an 8.2% increase from 2000 and a 0.9% decrease from the previous year of 2013. Nationally, there were 15,686,012 children (i.e., 21.7%) in poverty in 2014, a 5.5% increase from 2000 and a 0.5% decrease from the previous year of 2013. The percent of children living in poverty in South Carolina has been consistently higher than the national percentage since 1995, according to the data available.[135]

Family economic hardship has been consistently associated with academic failure, poor health and maladaptive behavior. Other risk factors such as living in a single-parent family or low parent education level can significantly increase children's chances of adverse outcomes, especially when combined with poverty.[136]

[134] U.S. Census Bureau, Poverty thresholds by Size of Family and Number of Children, **http://www.census.gov/hhes/www/poverty/data/threshld/** (Last visited, January 6, 2016).
[135] U.S. Census, Small Area Income and Poverty Estimates, **http://www.census.gov/did/www/saipe/data/index.html** (Last visited, January 6, 2016).
[136] National Center for Children in Poverty. **http://www.nccp.org/publications/pub_1073.html** (Last visited, February 10, 2015).



B. Children Experiencing Homelessness

This indicator reports the newest federal and state data related to child homelessness documented by the report of America's Youngest Outcasts produced by the National Center on Family Homelessness at American Institutes for Research. Data included the most recent annual count of homeless children in public schools made by the U.S. Department of Education (2012-2013 school year; released in September 2014) and U.S. Census data.[137]

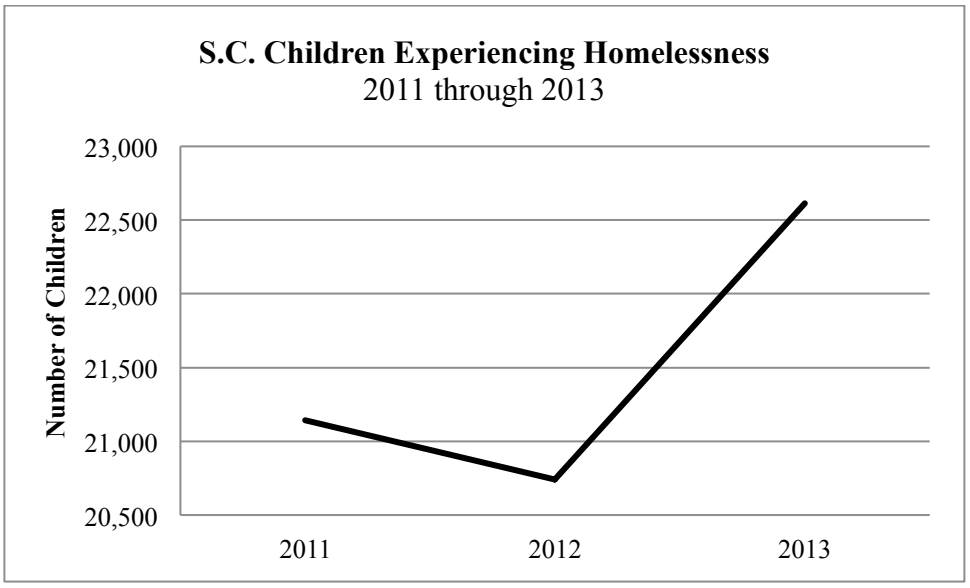
Homeless individuals were defined as any individual or family (1) lacking a fixed, regular, and adequate nighttime residence; (2) living in a residence that is a public or private place not designed for human beings (e.g., car, park, abandoned buildings); (3) living in a shelter providing temporary living arrangements (including hotels and motels), congregate shelters and transitional housing; (4) an individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided; (5) an individual or family who (a) will imminently lose their housing, (b) has no subsequent residence identified; and (c) lacks the resources or support networks needed to obtain other permanent housing; and (6) unaccompanied youth and homeless families with children and youth defined as homeless under other Federal statutes.[138,139]

In South Carolina, 22,614 children experienced homelessness in 2013, which represented one in every 50 children in South Carolina, and was a 9% increase from the previous year of 2012 and 7% increase from 2011.Nationally, approximately 2.5 million children experienced

[137] America's Youngest Outcasts: A Report Card on Child Homelessness. (2014). Waltham, MA: The National Center on Family Homelessness at American Institutes for Research. (Last visited, January 11, 2016).
[138] U.S. Congress. (2009). The McKinney-Vento Homeless Assistance Act as amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009; SEC. 103. [42 USC 11302]. Retrieved from **https://www.hudexchange.info/resources/documents/S896_HEARTHAct.pdf** (Last visited, January 11, 2016).
[139] Note: The report of America's Youngest Outcasts uses McKinney-Vento definition of child homelessness and ED's annual school-based count of students who are homeless as the basis from which to estimate the number of homeless children in the U.S.

homelessness in 2013. This represented one in every 30 children in the U.S., and was an historic high in the number of homeless children in the U.S. South Carolina was ranked the 17th in terms of the current extent of child homelessness and the 48th as for the risk for child homelessness, with the 1st indicating the lowest extend and risk and 50th being the highest.[140]

Factors contributing to child homelessness include high poverty rate; lack of affordable housing; continuing impacts of the Great Recession; racial disparities; the challenges of single parenting; and the impact of traumatic experiences for children and families. Research shows that homeless children experience hunger and sickness more often, at a higher risk to struggle at school and have mental health problems compared to children who are not homeless.[141]



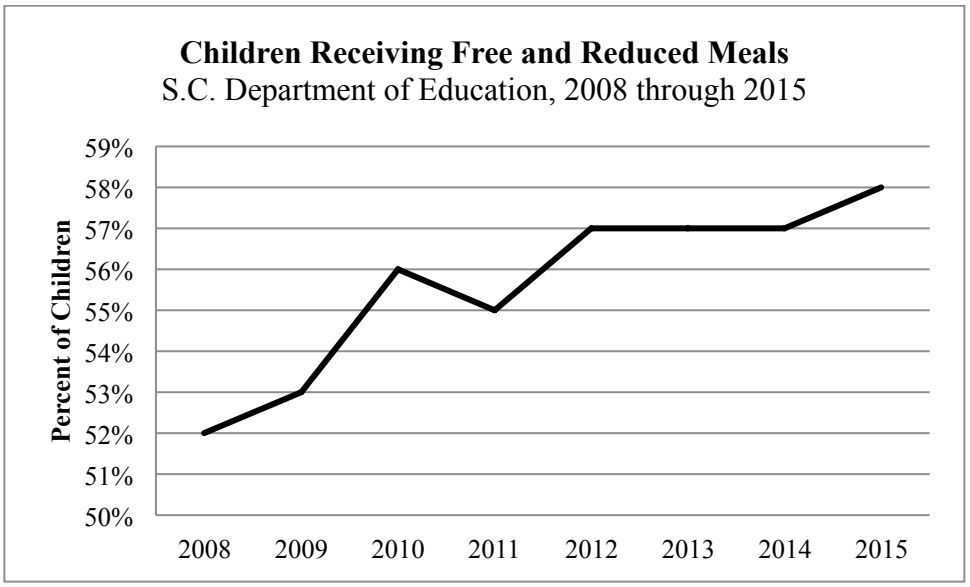
C. Children Receiving Free and Reduced Meals

The percent of students receiving free and reduced meals is collected by the Department of Education.[142] In South Carolina, approximately 58% of children were receiving free and reduced meals in 2015, which did not reflect significant data changes from 2014 (i.e., 57%). Nationally, approximately 30.5 million (or 72.6% of children enrolled in public schools) participated in National School Lunch Program in 2015.[143]

According to the National School Lunch Program, for lunch, schools must offer students all five required food components in at least the minimum required amounts. The components

[140] America's Youngest Outcasts: A Report Card on Child Homelessness. (2014). Waltham, MA: The National Center on Family Homelessness at American Institutes for Research. (Last visited, January 11, 2016).
[141] America's Youngest Outcasts: A Report Card on Child Homelessness. (2014). Waltham, MA: The National Center on Family Homelessness at American Institutes for Research. (Last visited, January 11, 2016).
[142] S.C. Department of Education, Children Receiving Free and Reduced, **http://ed.sc.gov/data/erate/** (Last visited, January 6, 2016).
[143] Food and Nutrition Service, United States Department of Agriculture. National Level Annual Summary Tables, **http://www.fns.usda.gov/pd/slsummar.htm** (Last visited, January 6, 2016).

include meats/meat alternates; grains; fruit; vegetables; and fluid milk.[144] Children from families with incomes at or below 130% of the poverty level are eligible for free meals. Those with incomes between 130% and 185% of the poverty level are eligible for reduced-price meals, for which students can be charged no more than 40 cents. For the period of July 1, 2015, through June 30, 2016, 130% of the poverty level is $31,525 (annual income) for a family of four; 185% is $44,863.[145]



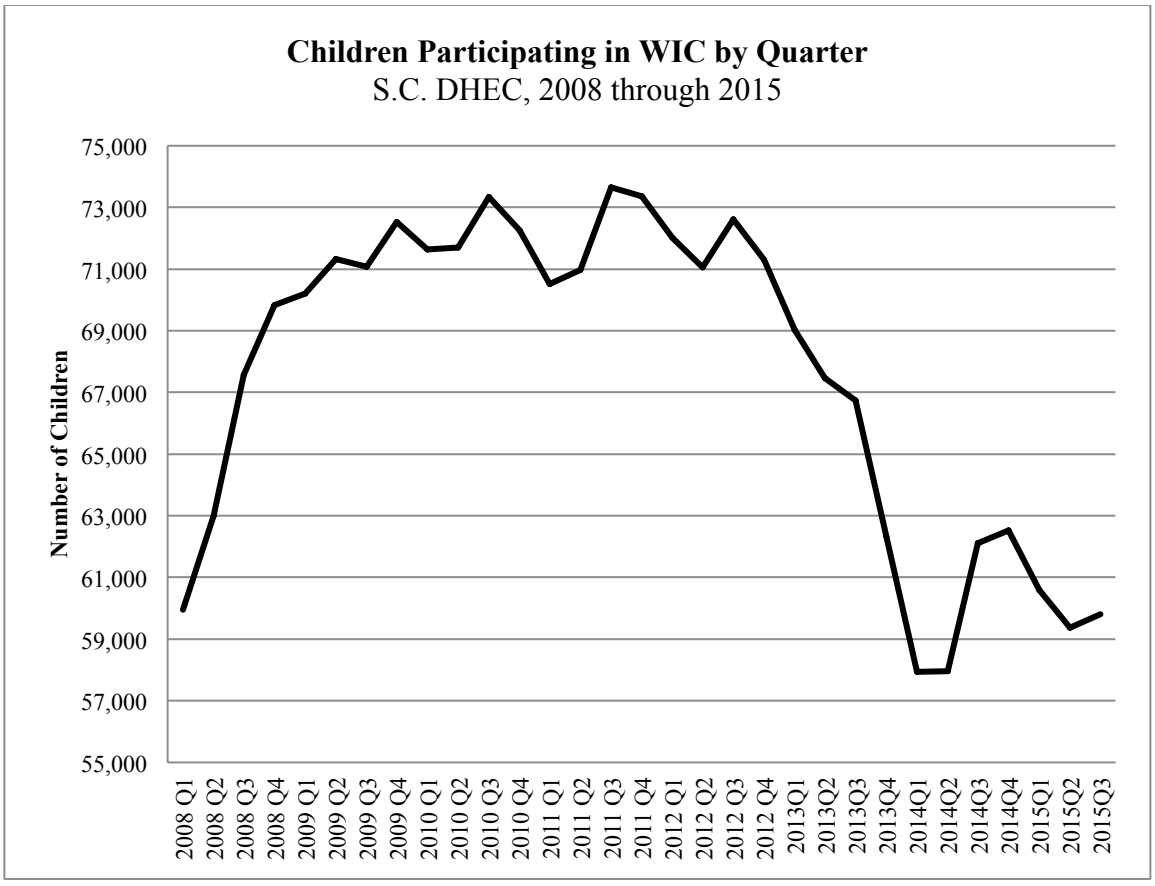
D. Children Receiving Food Support

The Special Supplemental Food Program for Women, Infants, and Children (WIC) is a nutrition program that provides nutritious foods, nutrition education, and access to health care to low-income pregnant women, new mothers, and infants and children at nutritional risk.[146] This indicator reflects the number of children participating in WIC through the Department of Health and Environmental Control county offices in the Women, Infants and Children program.[147] In South Carolina, there were 179,772 child participants for the first three quarters in 2015, which was a 1% increase from the same period in 2014, and a 6% decrease from 2008.[148]

Nationally, there were 6,099,071child participants in the WIC program in fiscal year 2015, a 3% decrease from the previous year of 2014 and a 12% decrease from 2009. Of all the

[144] Food and Nutrition Service, United States Department of Agriculture. Offer versus serve guidance for the national school lunch program and the school breakfast program **http://www.fns.usda.gov/sites/default/files/SP57-2014a.pdf** (Last visited, January 6, 2016).
[145] Food and Nutrition Service, United States Department of Agriculture. Income eligibility guidelines. **http://www.fns.usda.gov/school-meals/income-eligibility-guidelines** (Last visited, January 6, 2016).
[146] USDA, WIC's Mission, **http://www.fns.usda.gov/wic/aboutwic/mission.htm** (Last visited, February 24, 2014).
[147] 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, February 13, 2015).
[148] Public Health Statistics and Information Services, Division of Biostatistics, S.C. South Carolina Department of Health and Environmental Control. Unpublished reported generated in December, 2015.

WIC participants in 2015, 24% were infants and 52% were children. The average monthly food cost per person was 43.52 dollars in 2015.[149] To be eligible on the basis of income, applicants' income must fall at or below 185% of the U.S. Poverty Income Guidelines ($44,863 for a family of four in 2015).[150] A person who participates or has family members who participate in certain other benefit programs, such as the Supplemental Nutrition Assistance Program, Medicaid, or Temporary Assistance for Needy Families, automatically meets the income eligibility requirement.[151]

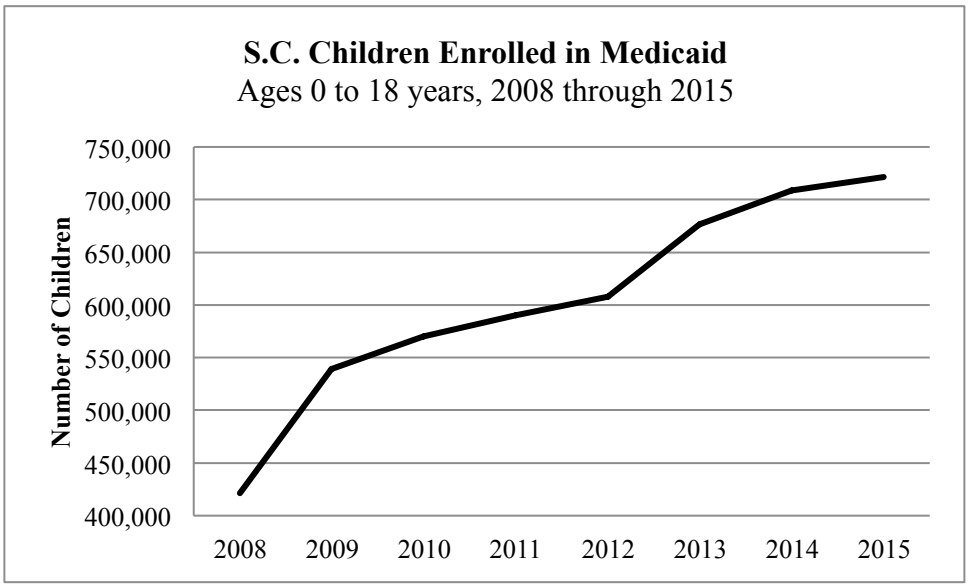


E. Children Receiving Medicaid Benefits

This indicator reports an unduplicated number of children ages 0 to 18 years enrolled in Medicaid.[152] In South Carolina, Medicaid covers 6 out of every 10 children.[153] In 2015, 721,198 or approximately 66% of children in South Carolina enrolled in Medicaid, which was a 2% increase from the previous year of 2014 and a 71% increase from 2008. In South Carolina,

[149] U.S. Department of Agriculture, Food and Nutrition Service, **http://www.fns.usda.gov/pd/wisummary.htm** (Last visited, January 6, 2016).
[150] U.S. Department of Agriculture, Food and Nutrition Service, WIC Income Eligibility Guidelines, **http://www.fns.usda.gov/wic/wic-income-eligibility-guidelines** (Last visited, January 6, 2016).
[151] U.S. Department of Agriculture, Food and Nutrition Service, **http://www.fns.usda.gov/sites/default/files/WIC-Fact-Sheet.pdf** (Last visited, January 6, 2016).
[152] South Carolina eHealth Medicaid Statistics, Medicaid Enrollment, **http://www.schealthviz.sc.edu/medicaid-enrollment** (Last visited, January 6, 2016).
[153] Medicaid Enrollment in South Carolina-2014, **http://www.schealthviz.sc.edu/Data/Sites/1/media/2014quickfacts_enrollment.pdf** (last visited, January 7, 2015).

children under age 18 years with household incomes up to 208% of poverty (i.e., monthly income of $4,134 for a family of four as of October 1, 2014) are eligible for Medicaid.[154] All children enrolled in Medicaid are entitled to the comprehensive set of health care services known as Early, Periodic Screening, Diagnosis and Treatment (EPSDT).[155] Nationally, 36,133,260 children enrolled in Medicaid in 2014, which was 3% increase from the previous year of 2013 and 1% increase from 2011.[156]



[154] Medicaid.gov .,Medicaid and CHIP Eligibility Levels, **https://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-eligibility-levels/medicaid-chip-eligibility-levels.html** (Last visited, January 6, 2016).
[155] Medicaid.gov., Children on Medicaid, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Children/Children.html** (Last visited, January 6, 2016).
[156] Medicaid.gov., Reports & Evaluations, **https://www.medicaid.gov/chip/reports-and-evaluations/reports-and-evaluations.html** (Last visited, January 6, 2016).

Acknowledgments

The 2016 Annual Report and the 2016 Child Well-Being Data Reference Book of the Joint Citizens and Legislative Committee on Children are the result of countless hours of hard work, and the cooperation of many agencies and individuals. Much assistance was provided to the Committee with its data collection, analysis, research, policy review, and editing to ensure that issues affecting children in South Carolina are accurately and clearly presented.

The Committee thanks the many citizens who took time to attend the public hearings and present testimony to the Committee. The Committee relies heavily on the concerns and recommendations offered by citizens who deal with children's issues on a daily basis.

The Committee expresses its appreciation to the many agency staff whose work contributed indirectly to this 2016 Child Well-Being Data Reference Book. The members of the Committee are especially grateful for the contributions and efforts of the following departments and individuals who assisted in the preparation of this Annual Report:

The Department of Alcohol and Other Drug Abuse Services: Dan Walker
The Department of Health and Environmental Control: Michael Smith
The Department of Mental Health: Sarah Osborne, Louise Johnson
The Department of Social Services: Brad Leake, Paulette Salley
The Revenue and Fiscal Affairs Office: Chris Finney

The Joint Citizens and Legislative Committee on Children extends its appreciation to the staff at the Children's Law Center, USC School of Law for compilation of the 2016 Annual Report and the 2016 Child Well-Being Data Reference Book. In particular, we thank Harry W. Davis, Jr., Director; Carolyn S. Morris, Assistant Director; Amanda Adler, Committee Senior Resource Attorney; and Liyun Zhang, Graduate Research Assistant.

Contact Information:
Amanda Adler
Children's Law Center
amandaadler@sc.edu
803-777-1646

Joint Citizens and Legislative

Committee on Children

For more information, visit
www.sccommitteeonchildren.org

Produced by Children's Law Center
University of South Carolina School of Law
803-777-1646

For more information, visit
http://childlaw.sc.edu