COMMITTEE *on* CHILDREN

2023 Annual Report

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The Issues

Children's Law Center
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Governor Henry D. McMaster
President Thomas C. Alexander
Speaker G. Murrell Smith, Jr.
Members of the General Assembly,

The Joint Citizens and Legislative Committee on Children is pleased to present its 2023 Annual Report. The Committee is charged with identifying and studying key issues affecting South Carolina children and making recommendations to the Governor and General Assembly.

The Committee on Children's statewide public hearings are an important source of information and provide insight on citizens' concerns regarding our state's children. Committee members, stakeholders, partners, and constituents identified the issues covered in the 2023 Annual Report. These issues range from expanding access to crisis mental health supports for youth and children to eliminating the sales tax on feminine and diaper products, formula, and baby food - items whose expense burdens families. Perhaps most concerning is South Carolina's current number one ranking in the country for rates of preschool suspension and expulsion. The report addresses that issue and offers potential solutions involving increased participation and investment in early childhood mental and behavioral health services.

South Carolina's children face many challenges, some of which were exacerbated by the COVID-19 pandemic. Relatively simple statutory revisions can address some of these challenges. Others require a long-term commitment and investment to change systems for the better. Fortunately, Governor McMaster and the General Assembly are committed to advancing policies that benefit children and families. We look forward to harnessing the state's resources, innovative spirit, and commitment to children to address the issues raised in the Annual Report and beyond.

How we treat children is the most accurate indicator of our state's future. We appreciate the opportunity to recommend public policies and priorities for South Carolina's children.

R. Raye Felder, Chair

Katrina F. Shealy, Vice-Chair

"Children are not a distraction from more important work. They are the most important work."

-C.S. Lewis

Committee Membership

APPOINTED BY THE PRESIDENT OF THE SENATE

- **Senator Brad Hutto**, Orangeburg
- **Senator Darrell Jackson**, Columbia
- **Senator Katrina F. Shealy**, Lexington

APPOINTED BY THE SPEAKER OF THE HOUSE

- **Representative Beth E. Bernstein**, Columbia
- **Representative Neal A. Collins**, Easley
- **Representative Raye Felder**, York

APPOINTED BY THE GOVERNOR

- **Mrs. Bronwyn McElveen**, Sumter
- **Mr. W. Derek Lewis**, Greenville
- **Dr. Kay W. Phillips**, Summerville

EX OFFICIO

- **Dr. Robert Bank**, *Interim Director - Department of Mental Health*
- **Michael Leach**, *Director - Department of Social Services*
- **Constance Holloway**, *Interim Director - Department of Disabilities and Special Needs*
- **Eden Hendrick**, *Director - Department of Juvenile Justice*
- **Ellen Weaver**, *Superintendent of Education*
- **Dr. Edward Simmer**, *Director - Department of Health and Environmental Control*
- **Robert Kerr**, *Director - Department of Health and Human Services*
- **Sara Goldsby**, *Director - Department of Alcohol and Other Drug Abuse Services*
- **Georgia Mjartan**, *Executive Director - South Carolina First Steps*

COMMITTEE STAFF

- **Shealy Reibold**, Senior Resource Attorney
- **Morgan Maxwell**, Legislative Resource Attorney

CHILDREN'S LAW CENTER LEADERSHIP, UNIVERSITY OF SOUTH CAROLINA SCHOOL OF LAW

- **L. Michelle Dhunjishah**, Director

2022: Year in Review

JCLCC LEGISLATION ENACTED

During the second year of the 2021-2022 session, the Committee on Children introduced legislative and policy reforms to expand child welfare benefits for children and streamline agency processes. The Committee sponsored or endorsed the following bills that ultimately became state law:

ACT NO. 123 (H. 3211)

- Removed the sunset provision for the Joint Citizens and Legislative Committee on Children and added four new ex-officio agencies: DHHS, DHEC, DAODAS, and SC First Steps.

ACT NO. 143 (H. 3509)

- Established procedures for a child who is or was in the legal custody of the Department of Social Services on their 18th birthday to voluntarily remain in care until age 21.

ACT NO. 149 (S. 11)

- Provided six weeks of paid family leave for state employees due to the birth, adoption, or fostering of a child.

ACT NO. 168 (S. 222)

- Added fictive kin to DSS Kinship Foster Care Program statutes; provided legal status and eligibility for payments and services to kin and fictive kin placements during the licensure process.

ACT NO. 212 (S. 1025)

- Expanded the definition of "other legal representative" who can access a child's birth certificate to include kinship caregivers and verified entities who work with homeless youth and streamlines the birth certificate process between DSS and DHEC.

A number of other committee bills received hearings and prompted discussion, public debate, and study of key children's issues including juvenile status offenses, youth tobacco access, youth mental health, juvenile justice reform, and increasing sex buyer penalties.

2022 PUBLIC HEARINGS

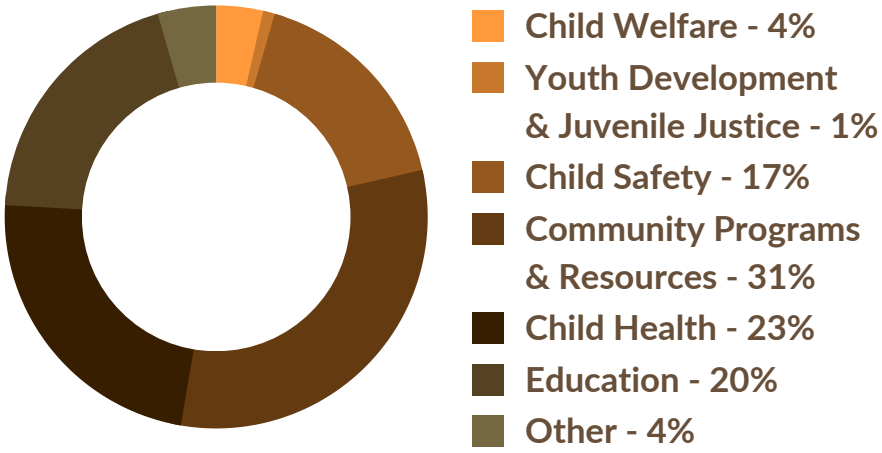
Each fall, the Committee on Children holds public hearings across South Carolina to receive testimony from parents, local stakeholders, and other children's advocates. These open-forum, town hall-style hearings allow members of the public to attend a meeting closer to their homes and speak directly to committee members about children's issues. These hearings yield vital information to guide and inform the Committee's future decisions.

The Committee held five public hearings in 2022–two in Columbia and one each in Charleston, Greenville, and Florence. The Committee heard nearly 13 hours of testimony on a range of topics: education curriculum, teacher retention, child access to pornography, youth homelessness, guardianship procedures, vaccinations, early childhood mental health, youth access to mental health services, extension of paid family leave, and much more. Additionally, the Committee received over 81 pieces of written testimony totaling over 350 pages.

EDUCATIONAL SERVICES FOR CHILDREN WITH DISABILITES REPORT

The Joint Citizens and Legislative Committee on Children published two reports concerning school districts' performance on service delivery to students with disabilities pursuant to Proviso 1.89 (2021) and 1.110 (2022), utilizing data provided by the Office of Special Education Services at the South Carolina Department of Education. The purpose of the provisos was to determine whether educational services provided to students with disabilities are delivered effectively and efficiently and whether services or funding should be reformed. The full reports can be found on the Committee's website.

2022 PUBLIC HEARING TESTIMONY TOPICS



Youth Access to Crisis Stabilization Units

THE ISSUE

Recent data document the precipitous rise in youth behavioral health needs over the last decade, especially during the COVID-19 pandemic.[1] Limited treatment options exist for youth experiencing a mental health crisis. Typically, a hospital emergency department (ED) is the first and sometimes only option for these youth, and pediatric behavioral health admissions to the ED have increased dramatically.[2] EDs are frequently unequipped to handle behavioral health emergencies, and hospitals often "board" youth while they wait for an inpatient bed in a residential facility.[3] Boarding of pediatric patients has reached crisis levels.[4]

One in three high school students reported "persistent feelings of sadness or hopelessness"[8]

Boarding of pediatric patients requiring psychiatric care can last a matter of hours, a few days, or weeks.[5] Hospital staff may place youth in seclusion, physically restrain them, or place them in a loud and overwhelming environment, all of which can cause additional stress for someone experiencing a crisis.[6] When a bed becomes available in a residential facility, adolescent patients are often then transported there "as a default, when [a residential facility] should only be used when it is the least restrictive setting available to provide the necessary intensity, clinical care and intervention, and supervision required by the child."[7]

Crisis stabilization units (CSUs) are another potential option for youth in crisis. CSUs provide short-term crisis care, often for 24 to 72 hours.[9] These facilities provide an array of services to stabilize the youth or adult in crisis, including diagnostic and medical assessments, treatment, support, and crisis interventions. These facilities can connect patients with community and home-based support services.[10] CSUs stabilize individuals in crisis while diverting them from EDs and residential facilities.[11]

South Carolina currently has one 24-hour CSU in operation, with more in development across the state. The SC Department of Mental Health operates the current CSU in Charleston. Since opening in June 2017 to serve adults 18 and older, the CSU has diverted 1,926 adults from other services.[12] The average length of stay is 3.26 days, with an average of 1.92 patients per day.[13]

Since opening in 2017, Tricounty Crisis Stabilization Center in Charleston has diverted 1,926 adults from other facilities.[14]

1,366 patients from mental health hospitals

40 detainees from local jails

14 patients from emergency departments

506 patients from mental health hospitals and EDs

POLICY & NATIONAL LANDSCAPE

South Carolina law currently limits access to CSUs to individuals **18 and older**.

» **CSUs are defined in Section 44-7-130(26) as: "a facility, other than a health care facility, operated by the Department of Mental Health or operated in partnership with the Department of Mental Health that provides a short-term residential program, offering psychiatric stabilization services and brief, intensive crisis services to individuals eighteen and older, twenty-four hours a day, seven days a week."**[15]

States serve a range of ages in their CSUs, and many states that began programs with more limited age ranges expanded eligibility to accommodate a broader age range based on need and demand.

- **Georgia** provides children and youth from ages five to 17 with psychiatric and behavioral stabilization services in its Child & Adolescent CSUs.[16]
- **Connecticut**'s two CSUs for children and youth initially offered services for children ages 12 to 17 but expanded services to reach children ages seven and older.[17]
- **New Jersey** initially served children ages 12 to 17 through its Children's Crisis intervention Services (CCIS) but expanded services to include children ages five to 17.[18]
- **Massachusetts** currently offers services for youth up to age 18 through its Youth Community Crisis Stabilization (CCS) Services with a unit for children up to age 12 and another unit for youth ages 13 to 18.[19]

OUR RECOMMENDATIONS

1. **Support and pass S. 343, Youth Access to CSUs, to expand access to children and youth ages five to 18 and open operations to entities outside the Department of Mental Health.**
   - » The statutory revision allows DHEC to develop guidelines and licensure criteria for CSUs operated by the SC Department of Mental Health or third parties to serve children and youth.
2. **The South Carolina Department of Health and Environmental Control (DHEC) must develop regulations and licensure criteria for youth access to CSUs before children and youth can be served. DHEC should require:**
   - » Children and youth being kept separate from adults due to safety concerns;[20]
   - » Younger children kept separate from older youth;
   - » Staff to be trained in child and adolescent behavioral health;
   - » Spaces within the facility be developmentally age-appropriate, with space for younger children to play;[21] and
   - » The child or youth's family involvement in treatment, when appropriate.[22]

Infant and Early Childhood Mental Health

THE ISSUE

South Carolina implemented positive changes for children's mental health in the last year, but much of that work focused on school-aged children in grades K through 12. Trauma and adverse conditions can impede a young child's development, mental health, capacity to connect with others, and ability to regulate emotions well before he or she enters kindergarten which can have long-term negative effects.[1] As one child development researcher noted, "It is easier to develop a healthier brain than to repair a damaged one. There are no do-overs in neuroscience, only work-arounds."[2]

1 in 6 children aged 2-8 years has a mental, behavioral, or developmental disorder.[3]

Infant and early childhood mental health (IECMH) services address these struggles by supporting relationships between young children and their parents or caregivers so children can thrive. A healthy relationship with a parent or caregiver helps children from birth to age five develop "close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn" within the greater context of the child's "family, community, and culture."[4]

In addition to behavioral health and other mental health providers, IECMH consultants play an important role in this development. **Consultants are mental health professionals who teach early childhood professionals, parents, and other adults about children's social, behavioral, and emotional development; how to treat challenging behaviors; and how to prevent mental health crises.**[5] Consultants can "translate" the ways young children communicate their needs, which can differ from older children and adults.[6] Educating adults who interact with children in this manner empowers them to handle and properly address a child's behavior and can reduce instances of challenging behavior in the classroom.[7]

INCREASE IN DEMAND

Practitioners report an increase in the demand for IECMH services since the COVID-19 pandemic began due to family stressors such as parents and caregivers losing jobs, income, and childcare.[8] Others are grieving the loss of loved ones, including primary caregivers, due to COVID-19-associated causes.[9] IECMH consultants report an increase in inquiries from school districts that now serve 3K and 4K students.[10] Districts state, due to the pandemic, many younger children missed opportunities to socialize with others and learn coping or regulation skills, which leads to meltdowns, running away, hitting, biting, and sometimes throwing chairs in the classroom.[11]

WORKFORCE CONSIDERATIONS

South Carolina's shortage of professionals qualified and trained to provide IECMH services is dire, especially professionals who provide diagnostic and treatment services. Additionally, the state's sole consultant organization report long waitlists or having to decline services to families.[12] Several causes contribute to the severe shortage:

- **Training costs** – Specialized training opportunities exist for professionals already in the workforce, including a three-tiered IECMH certification. Most private practitioners do not participate because they lose money when they close their offices to attend training.[13] Organizations and state agencies make it difficult for their employees to participate because employees receive no relief from administrative or productivity requirements while training. The lack of relief is partially due to workforce shortages and partially because IECMH services do not appear to be prioritized at this time. Training organizations report an inability to utilize grant funds for training even when it is provided at no cost to the provider.[14]
- **Lack of educational opportunities** – IECMH is a relatively new field.[15] While South Carolina-based organizations have worked with multiple state universities to include children from birth to age 5 into their curriculum and materials, South Carolina has few internship or post-doctoral opportunities for professionals who want to specialize in IECMH.[16]
- **Low reimbursement**– Providers report insurance often does not recognize that young children, particularly under age three, have treatable needs, so they push back on certain diagnoses. Without a recognized diagnosis code, providers report being reimbursed for services with lower rates. The state has also not adopted, mandated, or otherwise encouraged the use of DC: 0-5,[17] an age-appropriate diagnostic manual for mental health and developmental disorders in children ages zero to five. Utilizing DC: 0-5 for younger children in the way providers use DSM-5 and ICD-10 codes for diagnosing and billing would promote recognition of and billing for these age-appropriate services at the same reimbursement rates as services for adolescents or adults.[18]
- **Reciprocity** –South Carolina does not have license reciprocity with other states, which limits the state's ability to recruit from other states to address the shortage. Practitioners also report the SC licensing process is more burdensome than other states.[19]
- **Pay** - While efforts are being made to address the issue, South Carolina does not pay its public sector mental health professionals a competitive rate to attract out-of-state professionals, recruit new graduates, or retain current employees.[20]

Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant & Early Childhood Mental Health®

South Carolina has an Endorsement program, which is a formal designation for providers who complete "specialized education, work, in-service training, and reflective supervision/consultation that leads to competency in the promotion and practice of infant and early childhood mental health."[21] These internationally recognized standards provide a quality assurance measure that can be used to ensure professionals serving very young children are equipped with the skills and knowledge needed to effectively support early childhood mental health.[22] The SC Infant Mental Health Association awards endorsements in South Carolina.

The South Carolina Infant Mental Health Association (SCIMHA) recently reconvened a group of state child-serving agencies, health systems, practitioners, and other organizations in January 2023 to kick off a policy and finance initiative and create an action plan for IECMH services in South Carolina. Successful implementation will require prioritization and buy-in from agencies, policymakers, and others involved in IECMH. Representatives from these agencies previously partnered with SCIMHA to bring the Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant & Early Childhood Mental Health® to South Carolina.[23]

SOUTH CAROLINA
Infant Mental Health Association

OUR RECOMMENDATIONS

1. **Prioritize, develop, and fund a comprehensive State Behavioral Health Plan covering all ages.**
   - » Including infants and young children in the plan is critical for addressing issues when and where they begin. The Plan should prioritize training public sector professionals and incentivizing private sector professionals to serve infants and young children.

2. **Intentionally include consideration of services for children under five years of age and IECMH experts in current and future state government discussions, policies, reimbursement rates, and other actions related to behavioral and mental health.**

3. **Promote, incentivize, and eventually mandate usage of DC: 0-5, the diagnostic manual for mental health and developmental disorders for ages zero to five.**
   - » Offer enhanced Medicaid and Medicaid managed care organization reimbursement rates initially for endorsed mental health professionals who treat children, birth through age five, and their families.
   - » Require mental health professionals who treat children, birth through age five, and their families, to become endorsed in order to bill Medicaid and Medicaid managed care organizations for services by January 1, 2025.
   - » Require mental health professionals who treat children, birth through age five, and their families, to use DC: 0-5 for diagnostic assessments for children under five by July 1, 2025 and utilize the SC Department of Health and Human Services' billing crosswalk established in 2021[24] for billing Medicaid and Medicaid managed care organizations.
   - » Standardize reimbursement for these services across age groups so infant mental health is reimbursed at the same rate as services provided to adolescents and adults.

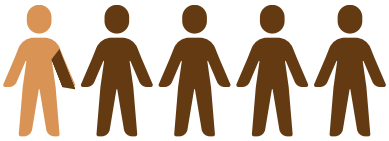
4. **Develop legislation allowing reciprocity with other states to aid in recruiting practitioners who specialize in this area and review the current licensure process to remove any unnecessary burden.**

Preschool Suspension and Expulsion

THE ISSUE

South Carolina has the highest raw number of children that had one or more out-of-school suspensions from preschool in the country at 438.[1] South Carolina has almost twice as many children suspended from preschool as the next highest state; Texas which had 262 children.[2] The actual number is likely higher because the data are limited to those self-reported by preschools in public schools. Children with disabilities and minority children are more likely to be suspended/expelled. South Carolina students with disabilities served under the IDEA made up 15.5% of suspensions and expulsions.[3] Black children account for almost 50% of public preschool suspensions in the country even though they comprise less than one-fifth of all preschoolers.[4] This figure is even higher in South Carolina, where 61.2% of the children suspended are black.[5]

SC has the highest rate of preschool suspensions in the country[6]



15.5% of SC children being suspended or expelled are students with disabilities[7]

Children suspended or expelled from preschool programs often suffer long-term consequences. Preschool expulsion can result in the development of ongoing behavior problems leading to later school difficulty, poor self-image, a generally negative view of educational systems and staff, and a lost opportunity to learn proper social behavior and skills.[8] These children are up to ten times more likely to experience later academic challenges, drop out, and be incarcerated as an adult.[9]

Children also experience "soft expulsions," which are not included in the data. Soft expulsions are actions a preschool or childcare provider takes that make it difficult for the family to continue bringing their child to that facility.[10] Families are often left with little choice other than to remove their child due to an unwelcoming environment.[11] Examples of soft expulsions include a school telling a family their child is not yet ready for group settings and requiring the parent to leave work to pick up his or her child multiple times due to behavior.[12]

Sixteen states currently have policies that limit or prohibit using suspension and expulsions.[13] These states provide comprehensive consultation and training programs for teachers and administrators, fund resources for children's behavioral health, and require schools to utilize a multi-tiered intervention program before they can expel students.

NATIONAL LANDSCAPE

The U.S. Departments of Health and Human Services and Education issued a joint policy statement addressing high rates of preschool suspension and expulsion in 2014.[14] The statement included **six recommendations to address, reduce, and eventually eliminate preschool suspension and expulsion**:

1. Establish fair policies that do not disproportionately impact a group of children and **use suspension and expulsion "only as a last resort in extraordinary circumstances where there is a serious safety concern that cannot be reduced or eliminated with reasonable modifications."**[15]
2. Develop a highly-skilled workforce by training childcare professionals to **manage difficult behaviors, develop nurturing relationships, and promote children's social and emotional development.**
3. Provide childcare professionals **access to specialized experts**, such as behavior coaches and IECMH consultants.
4. **Strengthen relationships and communication** between parents, teachers, schools, and programs so all can **collaborate on identifying problematic behavior and implementing solutions**.
5. Require **frequent screening for developmental and behavioral needs** to detect concerns and provide supports as early as possible.
6. States and programs should **set goals and collect data on rates of suspension and expulsion**, disaggregated by race, gender, and disability status **to determine if policies disproportionately affect a group or groups of children**.[16]

Arkansas is a model state for its focused effort to eliminate preschool suspension and expulsion. Arkansas Better Chance for School Success (ABC) is Arkansas's state-funded pre-K program, and serves over 20,000 children each year.[17] ABC has an expulsion prevention policy that includes a list of actions a program must take before considering expulsion:

- **Observation by a professional;**
- **Documenting incidents;**
- **Teaching social-emotional skills;**
- **Installing environmental modifications;**
- **Communicating with parents; and**
- **Seeking assistance from specialists.**[18]

Arkansas amended its childcare licensing regulations to require facilities to use a social-emotional development curriculum and reduce teacher-child ratios for ages 3 and under. The state used Child Care and Development Funds to double investment in its early childhood mental health consulting program, Project PLAY, and prioritized centers in areas with less access to high quality childcare and centers with licensing violations related to behavior discipline.[19]

Moving forward, Arkansas is considering incorporating its expulsion prevention policy in the participation agreements childcare centers must sign to utilize childcare vouchers, adding training on expulsion and suspension prevention in provider's annual policy test, sharing sample policies and self-assessment tools with programs, and launching a new data tracking system.[20]

OUR RECOMMENDATIONS

South Carolina lacks the workforce support needed to ban suspensions and expulsions at this time. Instead, we recommend the General Assembly take a **strong stance against the use of suspension and expulsion in early childhood programs and:**

1. **Allocate state funding to support existing and future organizations training early childhood teachers and other adults working with young children, such as SCIMHA's IECMH Consultation Network and South Carolina Child Care Inclusion Collaborative.[21] South Carolina should also investigate any federal funding opportunities.**
   - The early childhood workforce must be provided the support it needs to address children's needs, including addressing behavior in a way that precludes the need for suspension or expulsion. Medicaid does not cover consultant services for professionals working with children.
2. **Implement policies, much like Arkansas's, to require preschools and childcare centers to exhaust options before expulsion can be considered.**
   - These policies could take the form of legislation or be incorporated into childcare licensing and/or education regulations. Sample policies could be drafted and shared with centers and schools. Any program writing its own policy must have it approved by an appropriate state authority.
3. **Build and fund a suspension and expulsion data tracking system to determine the status quo, aid in setting goals, and measure progress over time.**

PUBLIC HEARING INPUT

"It happens a lot. It's not always called 'expulsion' sometimes it's just 'not the right fit.' I don't think any early childhood education providers have bad intent; I think they feel like they don't know how to handle this behavior. It is beyond what they can do in a group setting with the knowledge and training that they have."

"Mental health concerns can look like a preschooler who has trouble managing their big feelings and use their fists and their feet to kick and hit and throw things when they're scared or confused. This is likely the child who is expelled from preschool because their childcare providers don't have the knowledge or experience to recognize the manifestation of trauma and don't have the tools to respond in a way that can help the child cope."

Child Find and the IDEA

THE ISSUE

The Individuals with Disabilities Education Act (IDEA)[1] is a federal law requiring schools to "serve the educational needs of eligible students with disabilities."[2] Child Find is a mandate under the IDEA requiring all school districts to identify, locate, and evaluate children with disabilities in their community who may qualify for services.[3] The Child Find mandate applies to all children from birth through age 21 who reside in the state, including those who attend public or private schools, are homeschooled, are migratory or homeless, and are suspected of having a disability.[4]

Child Find procedures vary based on the child's age. In South Carolina, children from birth to age three receive a referral to BabyNet, the state's program for serving infants and toddlers under the age of three[5] with developmental delays or related conditions.[6] BabyNet has its own eligibility criteria children must meet to receive services. Parents, teachers, and physicians can refer children ages three through 21 to the local school district to determine if they need an evaluation for special education and related services.[7] Additionally, a universal screening process is in place for children from kindergarten to age 21[9] who are in school to identify students who may be at risk of experiencing academic difficulties in reading, math, or writing, or difficulties in social-emotional development.[10] As a result of performance on universal screeners, children may receive interventions and/or be referred for an evaluation to determine eligibility for special education and related services.[11]

Horry County School District Child Find Logo[8]

One of the major components of Child Find is public outreach by school districts. The districts must share information with the public about the availability of special education services and how to obtain them. The IDEA does not prescribe much about the methods for doing so outside of giving public notice. Guidance from the SC Department of Education advises districts to distribute information to agencies, professionals, and private schools in the area, among other contacts.[12] It also suggests utilizing methods such as newspaper ads and articles; posts in childcare facilities, health departments, doctors' offices, and grocery stores; letters to families and caregivers in the district; and announcements over radio and television.[13]

SOUTH CAROLINA'S POLICY

In South Carolina, the Department of Education defers to school districts to carry out the Child Find requirement, which is consistent with South Carolina's preference for local rule of education. School districts attest to the Department that they have completed the Child Find requirement, but they do not submit information about methods, techniques, effort, or success rates. The Department of Education does not currently establish best practices for Child Find, and little data currently exists at the state level as to how successful school districts are in their approaches to Child Find requirements.

BEST PRACTICES

The South Carolina Department of Education considers some districts to be exemplary for their approaches to Child Find. The districts' methods include:

1. Establish annual training for staff, parents, and caregivers with organizations such as Family Connection, Able SC, and Vocational Rehabilitation.
2. Publish accessible and consistent information on the district and individual schools' websites explaining services available for children, who can make a referral and how, and a point of contact.
3. Engage with community groups, organizations, or individuals serving children, such as childcare centers, preschools, Head Start, First Steps, and pediatricians twice a year.
4. Make information available in at least English and Spanish in both written and spoken communication.
5. Accept referrals through the year, including summer, to prevent a backlog in evaluations and commencement of services in the fall.
6. Share links to screening tools that caregivers can have their child complete, which can result in a direct referral if the parent notices the child having difficulty.
7. Educate front office staff at schools about the different terms parents may use in asking about services and provide a point of contact.
8. Engage with families outside the school building, including school and district events and local events, such as the Special Olympics.
9. Track foster children, incarcerated children, and children in residential placement. Retrieve records from a child's prior district(s) and share records with subsequent districts.
10. Engage regularly with private schools and homeschool families at least twice a year.
11. Take advantage of virtual meetings in addition to in-person opportunities to meet with families.

OUR RECOMMENDATIONS

South Carolina should track Child Find data to ensure districts are intentional about identifying children who may need services and not simply checking a box after public notice has been published. Congress's failure to fund the IDEA – most recently just 14.7% of costs – means school districts and taxpayers must make up the shortfall.[14] This shortfall creates a perverse and potential "incentive" for districts not to identify children as a cost-saving measure, which threatens compliance with the law and spirit of the IDEA and warrants additional safeguards at the state level.

1. Establish state-wide best practices for Child Find by July 1, 2024.

» Require the state Department of Education to collect Child Find data from districts regarding processes, methods, and rates of success for the 2022-2023 school year and to submit the data and a report analyzing statewide Child Find strengths, weaknesses, and suggestions for best practices to the Committee on Children by October 1, 2023. The state Department of Education's current guidance is not binding on districts. State policy establishing Child Find best practices would have the force and effect of law.

2. Appropriate funding for financial incentives and designations for exemplar districts.

» The General Assembly could reward financial incentives to those districts that comply with best practices, such as $10,000 per district, and designations like "Child Find Model District." The General Assembly should appropriate funds significant enough to encourage districts to implement best practices if they have not done so already. Rewards should also provide enough incentive for districts that already use best practices to continue to do so.

3. Provide financial and other assistance to districts that may need additional support to carry out Child Find best practices.

» Some districts may not have the technology, staff, or budget to carry out certain best practices. Districts requiring additional assistance should be identified and determined based on relevant, specific, and defined criteria as developed by the state Department of Education and identified in the Child Find report due on October 1, 2023 to the Committee on Children.

Homeless Youth and Children Definitions

THE ISSUE

The COVID-19 pandemic exacerbated existing issues like rising housing costs, increased evictions, and a lack of housing vacancies.[1] The number of individuals receiving homeless services in South Carolina increased 18% over a 12-month period.[2] Developing a comprehensive plan to address homelessness at the state level is complicated by the varying definitions of homelessness used by federal agencies. The U.S. Department of Education and the Department of Housing and Urban Development (HUD) use multiple definitions of homelessness in line with each program's "service parameters and intended use of funds."[3] The lack of a common definition of child and youth homelessness in South Carolina makes it difficult to determine accurately the number of homeless children and youth in the state.

Organizations serving families and youth experiencing or at risk of homelessness can more clearly determine this population's size, scope, and location when using common definitions. Using common language statewide lays the foundation for a comprehensive and efficient youth count and helps develop a state strategic plan to address homelessness.

11,970 children in South Carolina schools experienced homelessness[4]

755 youth were unaccompanied[5]

8 is the average age for SC children receiving services from homeless providers[6]

Additionally, many grant-making organizations consider whether a state has policies addressing homelessness in their grant criteria, placing South Carolina organizations at a disadvantage. A common language will optimize access to services and funding.

OUR RECOMMENDATION

» **Support S. 342, which adds definitions of unaccompanied homeless youth, homeless child or youth, and youth at risk of homelessness to the Children's Code.**

PUBLIC HEARING INPUT

"Can you imagine being young again and not having a place to lay your head, not having a place to take your shoes off and relax after a hard day of ball practice, cheer practice, debate team, a hard day of school, [a] hard day at work. Can you imagine not having a place to call home, to be secure? We have youth and young adults who are experiencing this . . . they also don't even have the basic necessities, such as shelter, food, mental health, and security."

"We know that there are youth and young adults facing these issues, and we know we all want to help . . . Help us establish a statewide count for youth and young adults who are experiencing homelessness. We need to find out who they are, where they are, resources that they feel like they need . . . Help us gather this crucial information that will help us work on ending homelessness for our children..."

Minors and Guardianship

THE ISSUE

In South Carolina, minors become adults when they reach the age of 18.[1] Some minors with cognitive disabilities will not be capable of making routine decisions expected of adults once they reach the age of majority. While most of these minors can take advantage of supported decision making as an adult, enlisting the help of friends and family to aid them in making decisions, some minors require a guardian to make decisions on their behalf after turning 18. These minors and their caregivers often face challenges petitioning for the guardianship prior to the time the minor turns 18. If guardianship is not in place when the minor becomes an adult, the minor and caregivers experience a gap of time in which the caregiver has no authority to make decisions for the new adult, and the new adult is incapable of making his or her own decisions.[2]

POLICY & NATIONAL LANDSCAPE

Several states have taken action to address this gap by lowering the age when an individual can petition the probate court for guardianship.

- Oklahoma and Florida allow a petition to be filed when the minor is 17 years and six months of age.[3]
- Connecticut allows petitioners to file up to 180 days before the minor turns 18 provided the order does not go into effect until the minor turns 18.[4]
- Vermont has a shorter time period and allows petitioners to file four months before the minor turns 18.[5]

Probate courts across the state vary in how they handle these proceedings, with some allowing petitioners to file before the minor turns 18 and others not allowing petitioners to file until the minor becomes a legal adult.[6] Under SC law, probate courts do not have jurisdiction over the "care, custody, and control of the person of a minor," adding confusion to guardianship proceedings for minors who are on the cusp of adulthood.[7]

OUR RECOMMENDATIONS

1. **Support S. 341, which amends the probate code to allow a petition for guardianship to be filed within 180 days before a minor turns 18 and narrowly extends probate court jurisdiction to cover these proceedings.**

2. **S. 341 also requires the probate courts to provide all due process rights to the minor including, but not limited to, appointment of an attorney for direct representation and a guardian ad litem, consistent with guardianship proceedings for adults.**
   - » Practitioners report probate courts are inconsistent in enforcing these due process protections in adult guardianship proceedings. Given the rights that stand to be lost by the minor in a guardianship proceeding, probate courts should ensure minors are appropriately represented throughout the process.

PUBLIC HEARING INPUT

"[Guardianship] is really the last option. You don't do that lightly . . . there are many alternatives. But for hundreds of families each year, guardianship needs to be filed. That petition can only be filed in the probate courts in South Carolina. You have to be 18 for that to happen."

". . . [it's] a recurring problem we see for families who are caring for teenage children with autism, special needs, and other disabilities. It's their 18th birthday . . . The legal consequences of that one day on the calendar, the 18th birthday, are profound under SC law for these families. Unintentionally, it creates anxiety, medical access and consent problems, and some serious continuity of care barriers. It's a problem not just for the families, it's a problem for the hospital, and a lot of medical providers."

OTHER CONSIDERATIONS: SUPPORTED DECISION MAKING

Supported decision making has become a popular alternative to guardianship.[8] Supported decision making **allows an adult to seek assistance and obtain advice from friends, family, and others when making a decision**.[9] Supported decision making is a less drastic remedy, and the individual retains more rights and autonomy than with guardianship.

Two state laws support families along these lines – the Adult Health Care Consent Act[10] and the Adult Students with Disabilities Educational Rights Consent Act.[11] The Adult Health Care Consent Act establishes a framework for health care decisions to be made for adult patients who are unable to consent, includes a priority list of individuals who may make health care decisions for an adult patient who is unable to consent, and allows an adult patient to designate a family member with whom a provider can discuss the patient's medical condition, among other provisions.[12] Similarly, the Adult Students with Disability Educational Rights Consent Act establishes procedures for a parent or other appropriate person to be appointed to represent the educational interest of an adult student in school.[13]

These laws are not a cure-all. Some medical providers are not comfortable providing care to an adult based on the Adult Health Care Consent Act. Practitioners report out-of-state entities, including pharmacy benefit managers and federal agencies (such as the Social Security Administration), will not accept the documents approved under state law in lieu of a guardianship agreement.

Expansion of Paid Parental Leave

THE ISSUE

In 2022, the Generally Assembly passed S. 11, which provides six weeks of paid parental leave for state employees classified as full-time equivalents (FTEs). This legislation was a positive step for parents of newborn children, parents adopting a child, and individuals fostering a child. However, paid parental leave should be expanded to include all full-time state employees and extended to 12 weeks of paid leave.

EXPAND TO INCLUDE ALL FULL-TIME STATE EMPLOYEES

The federal Family Medical Leave Act (FMLA) provides up to 12 weeks of unpaid leave during a 12-month period to care for a newborn, adopted or foster child, or a family member, or to attend to the employee's own serious medical health condition.[1]

South Carolina's current paid parental leave covers state employees classified as FTEs. However, state agencies and institutions of higher education use additional classifications for full-time employees, often based on the funding stream supporting the position.[2]

44% of state agencies employ TGE & time-limited full-time employees.[3]

1,362 state employees are classified as TGEs & time-limited, approximately 3.71%.[4]

Agencies also use time-limited employees, employees hired for a specific time frame or to carry out a specific project. Additionally, institutions of higher education classify some employees as RGPs - research grant positions, which can be funded by a federal grant, public charity grant, or private foundation grant.[5] Other than the lack of grievance rights, **these positions are nearly identical to FTEs** in that employees work full time, pay into state retirement, and are eligible to participate in state benefits.

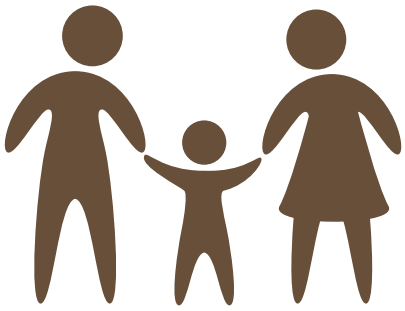
TGEs and RGPs are two of the full-time classifications currently excluded from receiving paid parental leave, even though they perform the same jobs as those classified as FTEs. **Paid parental leave should be expanded to cover all full-time state employees**. Failing to include all full-time employees creates internal discord with similarly situated employees receiving different benefits and creates an incentive for employees and applicants to prioritize FTE positions over TGE, time-limited, and RGP positions. South Carolina can aid state agency and higher education recruitment and retention by correcting this oversight and allowing these classifications to qualify for paid parental leave.

INCREASE TO 12 WEEKS

Paid parental leave should be expanded from 6 weeks to 12 weeks. Almost every industrialized country has established maternity leave policies of 12 weeks or more except for the United States.[6] Out of 193 countries in the United Nations, only a small handful do not have a national paid parental leave law: New Guinea, Suriname, a few South Pacific island nations, and the United States.[7]

There are many positive outcomes for infants when parents can stay home with them after birth. Some benefits include:

- **Improved infant and mother mental health, with a decrease in postpartum maternal depression rates and intimate partner violence;**[8]
- **Improved infant attachment and child development;**[9]
- **Decreased infant mortality rates and an increase in pediatric visit attendance;**[10]
- **An increase in initiation and duration of breastfeeding.**[11]



OUR RECOMMENDATIONS

Support and pass S. 27 and H. 3617, which will extend paid parental leave to 12 weeks for eligible employees giving birth to, fostering, or adopting a child, and four weeks of paid parental leave for secondary caregivers.

- S. 27 and H. 3617 also expand the definition of "eligible state employee" to include any person employed full-time by the state, a four-year or postgraduate institution of higher education, or a technical college under the state's control.

PUBLIC HEARING INPUT

"Providing 12 weeks of paid leave improves child health outcomes. Children whose mothers do not return to work full time in the first 12 weeks are more likely to receive medical checkups and critical vaccinations. Mothers who take at least 12 weeks of leave are also more likely to breastfeed, which provides important lasting health benefits for their children. Providing 12 weeks of paid leave improves maternal health and benefits both mothers and fathers. For new birth mothers, having less than 12 weeks of family leave is associated with increased symptoms of postpartum depression, which may make it difficult to return to the workforce. Fathers who take longer leaves experience greater engagement in their children's lives; greater paternal engagement has cognitive and developmental advantages for children."

Free School Meals

THE ISSUE

Every student in the country received free school meals for the past two years due to a federal pandemic relief program.[1] Since the program ended on June 30, 2022,[2] South Carolina children have struggled to afford school meals.[3] Although more than half of South Carolina schools qualify for federal school lunch assistance, many of them have not taken advantage of the funding.[4] 40,000 students in South Carolina carried lunch debt in 2021 averaging $168.52 per child.[5]

64% of SC students are eligible for free or reduced lunch - nearly half a million.[6]

School meals' impact on children is great. School participation in federal nutrition programs, including school breakfast, dramatically improves children's school behavior, from an overall increase in attendance and academic performance to a decrease in tardiness, hyperactivity, anxiety, and depression.[7] Hungry children and adolescents have more prevalent rates of behavioral, emotional, mental health, and academic challenges.[8]

THE SCHOOL LUNCH AND BREAKFAST PROGRAMS

South Carolina can ensure students are fed and ready to learn by taking full advantage of the National School Lunch Program (NSLP) and its Community Eligibility Provision (CEP). The National School Lunch Program is a federally-assisted meal program that provides no cost or low-cost meals to eligible children each school day.[9] Children can be eligible based on a variety of criteria, including but not limited to their participation in federal assistance programs like Supplemental Nutrition Assistance Program (SNAP) or based on household income and family size.[10] Children whose families earn at or below 130% of the federal poverty level ($36,075 annually for a family of four) are eligible for free meals, and children whose families earn between 130 and 185% of the federal poverty level ($51,338 annually for a family of four) are eligible for reduced price meals.[11] These standards are also applicable to School Breakfast Programs.[12] Participating schools and districts are reimbursed through cash subsidies from the United States Department of Agriculture (USDA) for each meal served.[13]

The **Community Eligibility Provision** allows high-poverty schools and districts to provide free breakfast and lunch to all students.[14] For a district to qualify, 40% or more of a district's students must qualify for free or reduced lunch. Individual schools can participate if 40% or more of their students qualify.[15] Resources exist to aid districts, including an online grouping tool to maximize the federal funding a school district receives if it adopts community eligibility.[16] These tools reduce administrative paperwork and costs, increase school meal participation, eliminate stigma from students who receive free meals, and maximize federal reimbursements.[17]

In South Carolina, 108 schools and 54 districts qualify for the Community Eligibility Provision but do not participate or only partially participate.[18] The lack of participation contributes to the approximately 153,000 children who go hungry each year in South Carolina.[19]

OUR RECOMMENDATIONS

Support and pass S. 148 that would:

1. **Require schools who participate in the School Breakfast and National School Lunch Programs to provide free breakfast and lunch to all enrolled students.**
2. **Incentivize school districts that qualify for the Community Eligibility Provision to take advantage of the program by receiving additional state funding to support school meal operations.**
3. **Reimburse school districts eligible for the Community Eligibility Provisions the difference between the federal free meal reimbursement rate and the standard federal meal reimbursement rate.**
4. **Require schools that qualify for the Community Eligibility Provision and participate in the School Breakfast Program to look for ways to encourage high participation and maximize reimbursement by utilizing many methods of distribution to the student body, such as Breakfast in the Classroom or Grab and Go.[20]**
   - » Breakfast in the Classroom typically occurs during a morning class while the teacher takes attendance or makes announcements, while Grab and Go breakfast provides a bagged to-go option before school or during a morning break.[21]
5. **Require schools provide children 30-minute lunch periods, with at least 20 minutes dedicated to consuming the meal, and require all lunch periods occur between 11 a.m. and 2 p.m.**

PUBLIC HEARING INPUT

"Food is one of the most basic human needs. Yet, according to Feeding America, 161,030 children in South Carolina do not know where their next meal is going to come from."

"Unfortunately, the lunchroom is where some students have been ostracized or punished for debt their families can't pay."

Private Behavioral Health Providers in Schools

THE ISSUE

The overwhelming demand for youth mental and behavioral health services in South Carolina has been well-documented, particularly the need for school mental health therapists.[1] The lack of Applied Behavior Analysis (ABA) therapists in the state generally, and especially in the school environment, has challenged families of children with autism for years as well.[2] Parents report waiting years to receive a diagnosis and then spending months or years on waitlists for a certified therapist to provide ABA therapy.[3] The state should remove as many roadblocks as possible for children who need these services.

One roadblock is school district policies prohibiting private providers, chosen by families to serve their children, from providing services in the school during the school day. For example, an ABA-trained therapist could work with a child in the classroom to help them with transitions and handle other behavioral challenges in the school environment. These professionals could work collaboratively with teachers and districts to ensure services are provided to children, reduce classroom disruptions, and allow teachers to focus on teaching.

NATIONAL LANDSCAPE

Florida passed a law in 2022 adding private Registered Behavioral Technicians to the list of private providers approved to access schools.[4] Speech and occupational therapists and social workers, among others, already had access.[5] Private providers must be allowed to observe the student at school, collaborate with the child's teachers during the school day, and provide services at school if the child's teachers and the principal agree on the place and time and if the provider undergoes required background checks.[6] Florida's statute emphasizes coordinating efforts to avoid duplicative or conflicting services or plans.[7]

Colorado passed a bill in 2022 permitting private providers in schools to perform medically necessary services.[8] The bill acknowledged schools provide special education and related services, but many children have unmet medical needs that "can be met by allowing access to services funded by third parties."[9] Refusing access to these services could result in "millions of dollars of therapies and supports needed later in life, as well as lost economic and employment opportunities over time."[10] Districts must develop policies for these medically necessary services by July 1, 2023. Districts must report annually on the number of private provider requests to serve a child and whether the requests were approved or denied.[11]

Understandably, school districts will have safety and privacy concerns. However, these concerns are not insurmountable if schools conduct background and other checks they use when allowing non-employees on school grounds. They could request private providers sign non-disclosure agreements so they do not disclose information about their client or information they may learn about other students while working with their client. Districts may also be concerned about their obligation to provide needed services under the IDEA or Section 504 of the Rehabilitation Act versus those services being provided by a private professional billing Medicaid or insurance. However, some districts have insufficient resources to provide any of these services; others provide only a fraction of what is needed. For example, Horry County employed 3 ABA therapists for 542 students with autism across 52 schools in 2019.[12]

It is paramount children receive these needed services. Private providers should be allowed into the school setting to ensure children receive these services instead of the alternative – going without. A district's refusal to allow providers onto school grounds to provide services could force many families to choose between their child attending a public school and receiving services deemed necessary for their health, wellbeing, and education.

OUR RECOMMENDATION

» **Support H. 3458, Behavioral Health Providers in Schools, to require districts to develop policies allowing private behavioral health providers to serve children at school.**

PUBLIC HEARING INPUT

"For many of our families, we have to pick either their public education or their medical necessity. ABA therapy has changed my son's life but he has never received the full 40 hours he needs."

"Our public schools unfortunately do not have ABA therapy . . . they do not provide as it should be provided to our children."

Tax Free Feminine Hygiene and Baby Products

THE ISSUE

Necessary products for girls, women, and families can be a significant drain on their budgets, especially new baby expenses. These costs have only increased during the pandemic, with supply chain issues contributing to shortages of necessary items and inflation. South Carolina can help girls, women, families, and caregivers by passing tax relief aimed at these necessities.

SALES TAX EXEMPTIONS FOR FEMININE HYGIENE PRODUCTS

Low-income women and girls struggle to afford menstrual products, a challenge referred to as period poverty.[1] A 2022 study found period poverty causes 72.8% of women to borrow products, 52.6% of women to use other materials such as socks or toilet paper, 48.4% of women to leave menstrual products in for too long, and 26.3% of women to simply go without any menstrual products.[2] Leaving in tampons for too long contributes to the risk of toxic shock syndrome, which can result in organ failure or death.[3] One in four teens has missed class because period supplies were inaccessible.[4]

The average US woman spends $13.25 on menstrual products per month, or $159 per year.[5] The 6% state sales tax results in an extra $9.54 annually spent on feminine hygiene products per person.[6] While that amount seems small, it can be prohibitive when combined with the price of products plus other necessary expenses for many women and girls, especially for the 200,000-plus South Carolina women ages 12 to 44 who live below the federal poverty line.[7]

SALES TAX EXEMPTIONS FOR DIAPERS AND TOILET PAPER

Young children require at least 50 diaper changes per week, and 200 diaper changes per month.[8] The estimated sales tax expense for diapers per year is $76.[9] The average cost of disposable diapers for a baby, dependent upon brand, is about $70 per month, meaning parents divert a month's worth of diaper expenses to sales tax.[10] Neither WIC nor SNAP assist with diaper purchases.[11] As a result, nearly one-third of mothers in the United States cut back on basic essentials so they can afford diapers.[12] Approximately 8% of families report skipping diaper changes and leaving babies in a wet diaper to stretch their supply to last the week, a practice associated with UTIs and diaper dermatitis.[13]

Once children outgrow diapers, they use toilet paper. Toilet paper is a necessary item required for daily hygienic living. Low-income families cannot replace toilet paper with any other item to accommodate their budget, so they are more likely to purchase less, or less healthy, food to compensate. In 2021, an average person in the United States spent $107.30 on toilet paper.[14] A single South Carolinian pays about $6.44 in sales tax a year for toilet paper while a family of four spends about $25.75 on sales tax per year.

SALES TAX EXEMPTIONS FOR BABY FORMULA AND BABY FOOD

Meals or food used for K-12 students in schools and meals for the elderly and individuals with disabilities are tax free in South Carolina based on the Educational and General Public Good sales tax exemptions, respectively.[15] While tax-free meals benefit these populations, the benefit does not extend to infants and toddlers. The US average monthly cost of baby formula is between $400 and $800, varying by age of the child.[16] The US average monthly cost of baby food is between $98 and $230.[17] South Carolina sales tax adds $24 to $48 per month ($288 to $576 annually) for baby formula and $5.88 to $13.80 per month ($70.56 to $165.60 annually) for baby food.

Sales tax adds $288 to $576 annually to baby formula expenses, dependent on the brand and the child's age. This cost is in addition to the $400 to $800 a month caregivers already spend on baby formula.

Families unable to afford formula and baby food may utilize unsafe practices to ensure their babies are fed, including watering down formula, adding cereal to formula, and introducing solids and cow's milk too early.[18] These practices can negatively impact a baby's physical development, including slower growth and mineral imbalances that can cause major health problems and seizures.[19]

OUR RECOMMENDATIONS

1. Pass **H. 3109** to provide an exclusion from sales tax for feminine hygiene products, baby diapers, and toilet paper.
2. Pass **S. 300** to provide an exclusion from sales tax for baby formula and baby food.

PUBLIC HEARING INPUT

"Pads aren't a big deal if you can afford them, but if you can't, that small thing means everything."

"We have heard story after story from [school] nurses of kids missing class, wearing pads and tampons for too long, bleeding through articles of clothing, all because they can't afford these necessities."

"55% of nurses are aware of situations where students miss class as a result of not having access to [feminine hygiene] products."

"33% of [school] nurses said they purchased [feminine hygiene] products out of pocket every month."

Children and Youth Access to Firearms

THE ISSUE

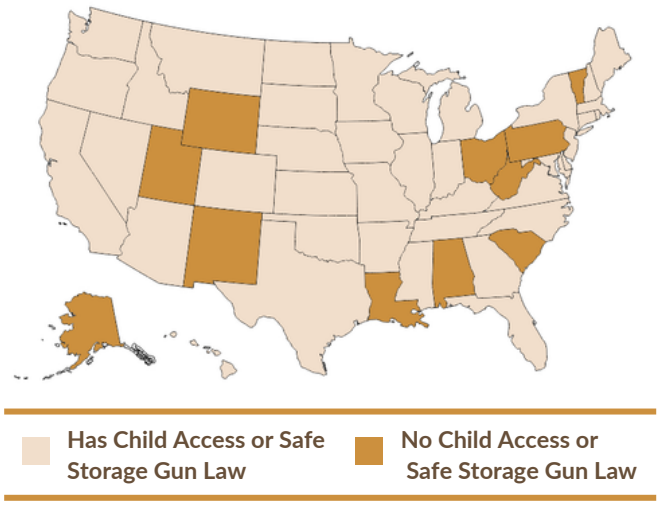
Firearms are the leading cause of death among children and youth ages one to 19 in South Carolina.[1] In South Carolina, 92 children and teens die by guns every year: 31% of all gun deaths among children and teens are suicides, and 59% of all gun deaths among children and teens are homicides.[2] National statistics show a dramatic increase in gun violence as well. In 2020, firearms became the leading cause of death among children nationwide.[3]

Access to firearms by children and youth is a large part of the problem. Guns are particularly dangerous for children because they do not appreciate the risk of handling and discharging a firearm.[4] Conversely, youth often choose to engage in risky behavior, so access to a firearm increases the stakes dramatically.[5]

Child access prevention laws could play a role in reducing suicides, unintentional injuries or deaths, and violent crime among children. Youth suicide attempts are "often impulsive acts, driven by transient life crises."[6] Easy access to guns is associated with increased suicide attempts and fatal outcomes are more likely than if attempts are made using other methods.[7] Those who attempt suicide with a gun often "don't get a second chance."[8] Additionally, limiting access can help prevent school shootings. A recent study found 76% of school shooters brought the firearm from the parent or another close relative's home.[9] In half those cases, the firearm was not secured properly or was readily accessible.[10]

NATIONAL LANDSCAPE

South Carolina is **one of 11 states without child access or safe storage gun legislation**.[11] While legislation varies state to state, these bills generally require adults to safeguard and secure firearms to prevent child and youth access. States such as Florida, North Carolina, Texas, and Virginia have safe storage gun legislation to prevent minors' access to firearms.[12]



Texas's law states if a minor gains access to a readily dischargeable firearm, the owner is criminally liable if he or she failed to reasonably secure the firearm or left the firearm in a place the person knew or should have known the child could access.[13] Lesser criminal charges apply if the minor does not fire the weapon; harsher penalties apply when a child discharges the firearm and causes death or serious bodily injury to themselves or another person.[14]

Florida's statute states any person who has or stores a firearm on his or her property and reasonably knows a minor is likely to gain access without lawful permission must keep their firearm in a lockbox or container, in a reasonably secure location, or secure the firearm with a trigger lock.[15] Criminal liability attaches if a minor gains access without lawful permission and possesses or exhibits the firearm in a public place or in a rude, careless, angry, or threatening manner.[16] The minor does not need to discharge the firearm for the owner to face criminal charges.[17]

SOUTH CAROLINA CHILD GUN ACCESS INCIDENTS

- **February 2023**, a 14-year-old boy died after accidentally firing a handgun he found in a kitchen cabinet.[18]
- **December 2022**, a 9-year-old boy was accidentally shot and killed while he and another child played with a gun found in the late child's home.[19]
- **December 2022**, a survivor of an August 2021 high school shooting (committed by a 14-year-old) was murdered by two individuals, one of whom was 17.[20]
- **June 2022**, a young child accidentally shot his pregnant mother with a loose gun lying in the backseat while they waited in a fast food drive-through.[21]
- **March 2022**, a 12-year-old boy shot and killed another 12-year-old student at their middle school.[22]
- **May 2021**, a student shot himself in the head and died in front of other students after taking a gun from his mother's car the night before.[23]

OUR RECOMMENDATIONS

Pass S. 21, the Children's Firearm Accident Prevention Act, to limit child and youth access to firearms.

1. **Require lawful firearms owners to store their firearm in a secure location when they know or reasonably should know children will be present and might gain access to the firearm without supervision.**
2. **Create the charge of misdemeanor criminal storage of a firearm.**
   - Criminal liability only attaches to the lawful owner if a child uses the firearm to injure or kill a person (2nd and 1st degree, respectively) or discharges the firearm without causing death (2nd degree).
   - S. 21 includes exceptions to the owner's liability, including but not limited to: a child obtains a firearm through illegal entry; a child obtains and uses the firearm for self-defense or defense of others; and a child obtains a firearm when the owner had no reason to believe a child would be present on the owner's premises.

PUBLIC HEARING INPUT

"Child deaths due to guns are not making the news anymore because they're really so routine . . . The number one killer of children."

""In 2019. . . there were 12 accidental shootings [in South Carolina] after a child accessed an unsecured firearm. These children ranged in age from 2 to 17. In that same year, at least 29 children died by suicide using firearms. In more than 75% of these cases, the firearm was stored in the home of either the victim, a relative or a friend."

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Nurturing our state's future.

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