

ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

February 7, 2013

3:04 p.m.

MEMBERS PRESENT

Representative Pete Higgins, Chair
Representative Wes Keller, Vice Chair
Representative Benjamin Nageak
Representative Lance Pruitt
Representative Lora Reinbold
Representative Paul Seaton
Representative Geran Tarr

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

OVERVIEW: CHILDREN'S JUSTICE ACT (CJA) TASK FORCE

- HEARD

HOUSE BILL NO. 54

"An Act relating to the identification, location, and notification of specified family members of a child who is in state custody."

- SCHEDULED BUT NOT HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

JAN RUTHERDALE, Chair
Alaska Children's Justice Act Task Force
Senior Assistant Attorney General
Child Protection Section
Civil Division (Juneau)
Department of Law (DOL)
Juneau, Alaska

POSITION STATEMENT: Testified and answered questions during the Overview of the Children's Justice Act (CJA) Task Force.

CATHY BALDWIN-JOHNSON, Medical Director
Alaska CARES
The Children's Place
Anchorage, Alaska

POSITION STATEMENT: Presented a PowerPoint, titled "Alaska Children's Justice Act Task Force."

THOM JANIDLO, Vice-Chair
Alaska Children's Justice Act Task Force
Attorney at Law
Anchorage, Alaska

POSITION STATEMENT: Presented a PowerPoint, titled "Alaska Children's Justice Act Task Force."

ACTION NARRATIVE

[3:04:35 PM](#)

CHAIR PETE HIGGINS called the House Health and Social Services Standing Committee meeting to order at 3:04 p.m. Representatives Higgins, Nageak, Keller, Tarr, Seaton, and Reinbold were present at the call to order. Representative Pruitt arrived as the meeting was in progress.

OVERVIEW: Children's Justice Act (CJA) Task Force

[3:06:12 PM](#)

CHAIR HIGGINS announced that the only order of business would be an Overview from the Children's Justice Act (CJA) Task Force.

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JAN RUTHERDALE, Chair, Alaska Children's Justice Act Task Force, Senior Assistant Attorney General, Child Protection Section, Civil Division (Juneau), Department of Law (DOL), directed attention to the two packets, "Alaska Children's Justice Act Task Force" and "Overview of the Alaska Children's Justice Act Task Force" [Included in members' packets] and said that these described the mission, the projects, and the membership of the task force. She noted that these also included a more complete description of the Adverse Childhood Experiences (ACE) project. She said that they would first focus on child maltreatment in Alaska and why it mattered to all of us, and then discuss the legislative changes proposed by the task force. She noted that,

although the task force had presented to the Legislature for many years, last year they had also proposed legislation to be considered.

[3:11:58 PM](#)

CATHY BALDWIN-JOHNSON, Medical Director, Alaska CARES, The Children's Place, introduced slide 3, "Alaskan Children in Danger." Moving on to slide 4, "Data Sources," she said that this information on the Office of Children's Services (OCS) website was very up to date. She moved on to slide 5, "Maltreatment- All Types," and shared that, in 2012, there were more than 16,000 reports of Alaskan children as victims of at least one incident of maltreatment. She pointed out that this was as many as 44 children a day, which would, on average, include 25 incidences for neglect, 7 for mental injury or exposure to domestic violence, 5 for physical abuse, and 2 for in-home sexual abuse. She noted that these numbers did not include out-of-home sexual abuse, and was likely a gross underestimation.

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DR. BALDWIN-JOHNSON directed attention to slide 6, "Overall 171 % of National Average," and said that, although still very high, this was an improvement over prior years. She indicated slide 7, "What does this mean for Alaskans?" and slide 8, "Consequences." She explained that maltreatment included physical abuse, sexual abuse, neglect, exposure to domestic violence, and drug endangerment, and that the consequences could be physical, psychological, behavioral, societal, both short and long term, and could have effects throughout the lifespan.

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DR. BALDWIN-JOHNSON stated that a short term impact was child death, slide 9, "Maltreatment-Related Child Deaths" and said that one in five Alaskan child deaths was maltreatment related, either abuse or neglect. She presented slide 10, "Child & Teen death in Alaska," a graph which depicted the higher rate in Alaska, with homicide being the fourth leading cause of death for Alaskan children. In response to Chair Higgins, she clarified that this was solely homicide, and did not include suicide.

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DR. BALDWIN-JOHNSON, indicating slide 11, "Violent death of teens in Alaska," said that this often combined suicide, homicide, and violent accidents, and that the rate was significantly higher in Alaska. She relayed that there were direct and indirect costs: costs for child protection and criminal justice systems, loss of future earnings and productivity during adulthood, and medical and mental health care costs, slide 12, "What does this cost?"

[3:17:14 PM](#)

DR. BALDWIN-JOHNSON reported that the estimated cost was \$220 million a day, or \$80 billion each year, slide 13, "Total Annual Cost of Child Abuse and Neglect in the US." She noted that the struggle to pay for increasing health care costs needed to address the underlying causes, slide 14, "Health Care Costs."

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DR. BALDWIN-JOHNSON moved on to slide 15, "The Adverse Childhood Experiences (ACE) Study," and explained that this landmark research project was a collaboration between researchers at the Centers for Disease Control (CDC) and Kaiser Permanente, a health maintenance organization (HMO) in California. She said that the first published article was titled, "Turning Gold into Lead," as it discussed the lifelong adverse effects from the abuse of children. She explained the study, noting that it involved more than 17,000 employed participants, almost the same ratio of men to women, with the majority being white, middle aged, and college educated, slide 16, "ACE Study Description."

[3:19:06 PM](#)

DR. BALDWIN-JOHNSON said that the study asked questions of the participants regarding their life growing up, slide 17, "Adverse Childhood Experiences During 1st 18 years of life." These included questions regarding any history of different abuse, family dysfunction, substance abuse, violence in the home, and neglect, and asked if any of these had happened at least once, slide 18, "Adverse Childhood Experiences." For every incident, each participant was given a score of one, so that sexual abuse and witnessing domestic violence would each have a score of one.

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DR. BALDWIN-JOHNSON observed that it was not uncommon for kids to be exposed to many things, slide 19, "ACEs are common,"

noting that 28 percent had been physically abused as kids, and an astounding number had been sexually abused. She reported that only 36 percent of the participants had not had any of these experiences, while 12.5 percent had experienced more than four categories of family dysfunction or abuse, slide 20, "ACE Scores." She observed that the higher the ACE score, the more likely to suffer from adverse health consequences, slide 21, "Results."

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DR. BALDWIN-JOHNSON directed attention to slide 22, "ACE Score vs. Smoking;" slide 23, "ACE Score vs. Alcoholism;" slide 24, "ACE Score vs. Ever Ingested Drugs;" slide 25, "ACE Score vs. Depression;" and slide 26, "ACE Score vs. Ever Attempted Suicide." She said that the correlation of a higher ACE score with a higher incidence was true throughout.

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DR. BALDWIN-JOHNSON identified slide 27, "ACE Score vs BMI;" slide 28, "ACE Score vs Sedentary Lifestyle;" and slide 29, "ACE Score vs Chronic Disease," stating that all of these reflected a significant graded relationship.

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DR. BALDWIN-JOHNSON stated that heart disease was the leading cause of death for men and women in the United States, and she noted that the significant correlation with ACE created an even stronger relationship than traditional risk factors, such as high blood pressure, diabetes, or smoking, slide 30, "ACE Score & Heart Disease."

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DR. BALDWIN-JOHNSON shared that there were links between higher ACE scores and reproductive health problems, mental health problems, auto-immune diseases, fractures, work productivity, and future victimization, slide 31, "More ACE links."

[3:23:39 PM](#)

DR. BALDWIN-JOHNSON cited that other research had similar findings, slide 32, "Sampling of other confirmatory research." She described a study of adolescent suicide attempts which reported that children who had been physically abused were five

times more likely to commit suicide, while sexually abused children were three times more likely, slide 33, "Adolescent suicide attempts." She communicated the significant correlation between bad things happening in childhood with more bad things happening in adulthood, slide 34, "Revictimization & substance use."

[3:24:52 PM](#)

DR. BALDWIN-JOHNSON discussed a 30 year study which found a correlation between childhood physical abuse and adult obesity, even when other factors such as genetic disposition were controlled, slide 35, "Adult obesity." Summarizing slide 36, "Evidence from ACE study suggests:" she stated that adverse childhood experiences should be considered as one of the most basic causes of health risk behavior, illness, premature death, and increased health care cost.

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DR. BALDWIN-JOHNSON moved on to slide 37, "Next Questions:" and said that this connection was probably multi-factorial, as there was the impact of toxic stress on brain development, impacts on the immune system, and the question of epigenetics, the study of how genes are turned on or turned off, and expressed.

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DR. BALDWIN-JOHNSON presented slide 38, "Mechanisms..." and, pointing to the top of the pyramid graphic, explained that the traditional approach for time and resources was toward disease, disability, high risk behaviors, and social problems. She declared that the concentration of efforts would be more effective toward the outsized base of the pyramid, adverse childhood experiences. She emphasized that prevention through earlier identification and intervention would be far more effective.

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DR. BALDWIN-JOHNSON jumped to slide 40, "Support for Child Advocacy Center Funding" and slide 41, "Alaska CACs." She informed the committee that the child advocacy centers (CACs) had been an effective means for providing services and support for children and their families during times of concern for child physical and sexual abuse. She reported that the first CAC opened in 1996 in Alaska, first received federal funding in

2001, and, beginning in 2008, obtained funding from the State of Alaska. She stated that there were now 10 CACs, with an additional 2 satellites, and they had served more than 18,000 children. She pointed out that state funding had remained flat despite the significant increase in CAC utilization and expansion of services.

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DR. BALDWIN-JOHNSON presented slide 42, "Recommendations," and declared that the CACs had requested an increase in funding to \$520,000, although the Governor's current budget allocation was only for \$400,000. She considered slide 43, "Support for HB 22/SB 73," and requested support for these companion bills, which included stronger provisions against sex trafficking, sentencing provisions for investigations of exploitation of child abuse images, expansion of admission of evidence of prior bad acts, and a statutory revision for the definition of mandatory reporter.

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REPRESENTATIVE TARR asked about the impacts from adverse health effects to performance in school.

DR. BALDWIN-JOHNSON, replying that most of the slides reflected health consequences, expressed her agreement that there was clear evidence that childhood stresses affected the ability to learn.

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REPRESENTATIVE NAGEAK asked how long the respondents were tracked for the ACE study.

DR. BALDWIN-JOHNSON, in response, said that different studies had looked at various age groups. She said the aforementioned ACE study had followed adults for 20 years in adulthood, but that there had also been a range of other studies.

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REPRESENTATIVE SEATON asked for more information regarding the compilation for the ACE score. He questioned whether kids attending a CAC would have the same scores as those who did not receive this treatment.

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DR. BALDWIN-JOHNSON pointed out that CACs were not in existence until the mid-1970s, so the study was done on actions from decades earlier. She agreed that the impact from CACs was still unknown, though she expressed anecdotal data that kids were benefiting from the CACs.

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CHAIR HIGGINS asked to receive a budget breakdown for the funding request.

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THOM JANIDLO, Vice-Chair, Alaska Children's Justice Act Task Force, Attorney at Law, said there were not many child protective laws in place until the late 1960s.

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REPRESENTATIVE SEATON expressed his concern that it was unclear whether the CAC services had resulted in a reduction to any problems.

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DR. BALDWIN-JOHNSON replied that there were fewer reports of child sexual abuse for both Alaska and the nation, and it was theorized that more advocacy centers similar to CACs, coupled with better laws, had resulted in a drop of abuse.

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MR. JANIDLO directed attention to slide 44, "System Improvement...", slide 45, "Recommendation #1," and slide 46, "Mandatory Reporting: Background." He declared that the mission of the task force was to provide recommendations, and he clarified that, currently, there was a mandatory reporting statute in all the states.

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MR. JANIDLO provided slide 47, "Problems:" and stated that research showed that child abuse was still underreported, and that there was still confusion about who was required to report. He noted that, although Alaska law required certain

professionals to report, it did not include many adults with daily contact with children. He noted that emergency medical technicians (EMT) did not have to report, and yet, they were often the first responder to an incidence of child abuse. It was often unclear not only who had to report, but who they had to report to, and that often people were reluctant to report. He shared that almost 33 percent of the states required that anyone with reasonable cause to suspect child abuse had to report.

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CHAIR HIGGINS asked for a definition to a mandatory reporter.

MR. JANIDLO explained that, under the current law, professionals in contact with children had a duty to report any reasonable belief that a child was being abused. He opined that in Alaska everyone was responsible to report any reasonable belief of child abuse, slide 48.

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REPRESENTATIVE KELLER asked if there was evidence that mandatory reporting had significantly lowered the incidence of child abuse.

MR. JANIDLO, in response to Representative Keller, said that the Children's Justice Act Task Force was in support of all citizens being responsible for mandatory reporting.

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CHAIR HIGGINS asked if there were any re-education programs on reporting for health professionals.

DR. BALDWIN-JOHNSON replied that this was ongoing training.

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MS. RUTHERDALE explained that the task force budget was population based, and it was necessary to make project choices. She declared that, as understanding mandatory reporting was so necessary, the task force decided to create and distribute a CD about the program. She added that the Office of Children's Services (OCS) also used and disseminated the CD.

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CHAIR HIGGINS shared some professional anecdotal incidences of child dental neglect, and emphasized the need for the continuing education of health care professionals.

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MR. JANIDLO said that the goal was to protect kids, and to take responsibility as adults.

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REPRESENTATIVE SEATON expressed his agreement with all the statements regarding abuse, but he pointed out that Alaska statutes referred to "abuse or neglect," and that "neglect" was a state-wide standard which did not take into account a situation, such as inadequate clothing. He opined that it was necessary to advocate for mandatory reporting of abuse, but that there needed to be definitions for levels of neglect. He declared that he did not want to have unintended consequences from a legal definition of neglect.

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MS. RUTHERDALE explained to Representative Seaton that the law clarified that poverty was not neglect. She established that a report to OCS for a reasonable suspicion of harm allowed for experienced staff to determine whether an investigation was necessary. She said that a very small percentage of investigations went to legal action.

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REPRESENTATIVE SEATON declared that the question was whether people were in violation for not reporting and that it was necessary to better define the standard for neglect.

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MS. RUTHERDALE agreed that it was a training issue to better understand mandatory reporting for a "reasonable cause to suspect."

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CHAIR HIGGINS shared that he had used the threat for reporting of neglect, but he pointed out that the definition for neglect and abuse was unclear to many health care professionals.

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MR. JANIDLO declared that Alaska still had one of the highest rates of child abuse in the nation, 171 percent of the rest of the country. He opined that Alaska should be leading the rest of the country as the state did not have so many of the old laws to deal with. He endorsed that all Alaskans should be responsible for reporting child abuse, slide 49.

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REPRESENTATIVE REINBOLD commented that it was necessary to define abuse. She declared that she did not see any statistics that intervention and mandatory reporting was working. She considered that abuse was interpreted differently in different cultures. She offered her belief that it was very important to focus on the serious at-risk cases, and that the best intervention was from friends. She offered her belief that government officials could cause more trauma, and would demand more reporting, more exposure, and more involvement, as opposed to a confidential, safe, gentle intervention. She opined that this gentle intervention in high risk areas was "so much more effective than a big bureaucracy that really doesn't look statistically like their doing much good."

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MR. JANIDLO expressed his agreement that if everyone watched out for their neighbor, then many of the laws would not be necessary.

REPRESENTATIVE REINBOLD replied, "there's a lot of wonderful parents... we do have wonderful people all over the place, and interventions that are free all over."

MR. JANIDLO expressed his agreement that everyone wanted kids to have the necessary safety and protection. He declared that intervention was only necessary where there was reasonable cause for concern for the child's safety.

REPRESENTATIVE REINBOLD asked if reporting was helping with positive outcomes, and not creating more problems.

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REPRESENTATIVE SEATON asked to clarify that mandatory reporting was for seeing abuse or neglect, and that there would be violation of the statute, even if you intervened, if you did not report.

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MR. JANIDLO offered his belief that there were fewer children being taken into custody because there were more programs to help before there was abuse.

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MR. JANIDLO moved on to slide 50, "Alternate Solution:" which he described as an addition to the patchwork to fill in the reporting gaps. He indicated slide 51, "First Responders," and listed that first responders, fire fighters, and emergency medical personnel should be added to the mandatory reporter list. He listed social workers, juvenile justice personnel, court appointed advocates, and guardian ad litem, as mandatory reporters, slide 52, "Social Services Personnel."

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MR. JANIDLO indicated slide 53, "Veterinarians and animal control officers," and shared that studies linked animal abuse and child abuse, so animal control officers should also be included as mandatory reporters.

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CHAIR HIGGINS asked what were the consequences for not reporting.

MR. JANIDLO replied that not reporting was a Class A misdemeanor, but he clarified that no professionals had been prosecuted. He stated that the objective was as an incentive to report.

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REPRESENTATIVE TARR asked if there had been previous legislation for this.

REPRESENTATIVE SEATON replied that he remembered debate revolving around the parameters of neglect. He said that part of the perspective was for the legislature to pass laws that people obey, and there needed to be consequences, otherwise it became a bad system.

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CHAIR HIGGINS opined that the rights and liberties of people were taken away under the guise of safety.

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REPRESENTATIVE REINBOLD reflected on successful interventions by youth, and expressed her concern for the unintended consequences of adult interventions, which raised her concern for mandatory reporting.

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MR. JANIDLO said that the first child abuse came through a cruelty to animals' case, because there were not any laws about abusing children in the 1870s. He declared that clergy needed to be added to the list for mandatory reporting, as they often had access to information, slide 54, "Clergy." He moved on to slide 55, "Persons providing instruction and coaching to children," and noted that coaches, music teachers, and others needed to help stop the abuse.

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MR. JANIDLO declared that slide 56, "Certain other volunteers," also needed to be added to the mandatory reporters list, as they often came in frequent contact with children. He reminded the committee that this addition to the list was an alternative to making it mandatory for everyone to report abuse. He established that the second recommendation from the task force was to update the current statute concerning medical evaluations of suspected child abuse, slide 57.

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DR. BALDWIN-JOHNSON reviewed slide 58, "Problem:", and explained that the law for diagnostic testing in suspected child abuse cases was limited to x-rays and photographs, and did not include other tests, such as CT scans and MRIs, which were more accurate and less invasive, and could help differentiate between abuse

and non-abuse. She noted that parents were not always available or cooperative.

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MR. JANIDLO, slide 59, "Solution:" suggested that modernizing AS 47.17.64 would allow the necessary testing of abused children with current technologies. He moved on to the "Recommendation #3," slide 60, which would add a new section to the criminal code regarding children's exposure to domestic violence. He explained that the "Problem:", slide 61, was that children who were exposed to domestic violence were subject to the same outcomes as children directly experiencing abuse, and it was not a crime. He suggested to add and define a new section to the Alaska Criminal Code making it unlawful to expose a child to domestic violence, slide 62, "Solution:" He noted that Anchorage already had this in place.

MR. JANIDLO announced that the fourth recommendation was to add victim protections to the criminal and child protection laws, slide 63, "Recommendation #4." He explained that the problem was with the information exchange during the discovery process, when mental health interviews and forensic interviews had ended up in the wrong hands, slide 64, "Problem:" He suggested to make it a crime for unauthorized publication of a victim's protected material, to modify the rules of discovery in criminal and child protection cases regarding redistribution of protected materials, and to protect mental health records of a victim, slide 65, "Solution:"

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MR. JANIDLO summarized and said that the task force supported increased funding for CACs, supported the proposed aforementioned legislation, HB 73 and SB 22, recommended making all Alaskans responsible to report child abuse, recommended modernizing the statute for medical evaluation and making it unlawful to expose a child to domestic violence, and protecting children from further victimization in the discovery process, slide 66, "Summary of Recommendations." He declared that the task force was looking for champions for Alaskan children, as everyone was responsible for them.

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REPRESENTATIVE SEATON, referring to "CJATF Proposed Legislation" [Included in members' packets], asked about the proposed

legislation on page 4, line 15. He asked who the financially obligated party was if a doctor decided to have tests on the child.

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DR. BALDWIN-JOHNSON, in response to Representative Seaton, said that the responsible payer could be the parent or the third party payer, insurance or Medicaid; however, if the child was taken into custody, then the state would be responsible, as the guardian of the child.

DR. BALDWIN-JOHNSON, in response to Representative Seaton, clarified that this was only if the parent was not available or would not supply consent if the tests had indicated reasonable cause.

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MR. JANIDLO pointed out that this was current law, and the proposed legislation was only adding imaging studies and diagnostic testing to the existing law.

REPRESENTATIVE SEATON pointed out that this proposed legislation was adding more expensive procedures.

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DR. BALDWIN-JOHNSON clarified that the proposed legislation was only updating to include current technology.

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REPRESENTATIVE KELLER endorsed the membership list for the task force, noting that it was impressive and included a broad spectrum of knowledge which offered an excellent resource. He offered his assumption that there were no salaries paid to its members. He expressed his appreciation for the recommendation to expand the CACs, although he questioned whether there was significant data to "really make a really hard core case for their success." He expressed his suspicions about the vetting process for the proposed legislation. He asked who proposed the legislation, if everyone on the task force had submitted comments, and if it had been influenced by national advocacy groups. He requested more background on the process.

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MS. RUTHERDALE replied that, during brainstorming sessions for improvement to the programs, "mandatory reporting always rises to the top of the list." She referenced the nationwide awareness and discussion for mandatory reporting since the revelations about child sexual abuse by Jerry Sandusky at Penn State University. She specified that the majority of the work came from the task force's review of the statutes and discussions based on personal experience about "where the gaps lay."

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DR. BALDWIN-JOHNSON pointed out that, as the task force had statewide multi-disciplinary representation, there were others who offered information. She shared an example from the EMS personnel, who had disclosed that they were not on the practitioners of the healing arts mandatory reporting list.

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REPRESENTATIVE KELLER, directing attention to the \$80-90,000 budget for the task force which included payment for trainings and part-time staff, asked how often the task force met and if it was paid for from "the meager budget that you have and the grant." He asked if the meetings were broadcast and open to the public.

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MS. RUTHERDALE replied that anyone was welcome to attend the meetings, and that the task force did invite outside speakers. She pointed out that there were subcommittee meetings and teleconferences, in addition to the quarterly meetings. She disclosed that the cost for the teleconferences was also paid from the budget. She reported that the committee which prepared this presentation had been meeting weekly.

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REPRESENTATIVE SEATON directed attention to page 3 of the Proposed CJATF Alternative to Universal Reporting [Included in members' packets], and asked to clarify that the intent was for any report to be submitted to the Department of Health and Social Services.

MS. RUTHERDALE replied that this was existing law, and that this proposal merely clarified that the reporting had to be to the Office of Children's Services (OCS), in the Department of Health and Social Services.

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REPRESENTATIVE SEATON directed attention to page 4, proposed Section 7, and asked who was included as "regular volunteers of the church or religious body."

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MS. RUTHERDALE explained that this definition was modeled on evidence rules, and she could research further for who was included.

REPRESENTATIVE SEATON surmised that it could be any volunteers at a church.

MS. RUTHERDALE expressed her agreement.

REPRESENTATIVE SEATON asked if this was the intent of the proposal.

MS. RUTHERDALE stated that this was clarified on page 4 to include those who "supervise, educate, coach, train, or counsel children."

REPRESENTATIVE SEATON asked to clarify whether "and persons employed" also included the volunteers.

MS. RUTHERDALE agreed that there would need to be further legislative clarity, even though the task force had worked to "make as shovel ready as possible."

REPRESENTATIVE SEATON analyzed that the intent was for volunteers to be analogous with persons employed, but only to include those volunteers who supervise, educate, coach, train, or counsel children.

MS. RUTHERDALE expressed her agreement with this analysis.

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REPRESENTATIVE TARR shared a personal anecdote, and expressed her appreciation to the task force presenters and to

Representative Reinbold for her comments about keeping families together. She asked for details to the CAC process.

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DR. BALDWIN-JOHNSON explained that the CACs provided a neutral locale, when there was an allegation of abuse, for the agencies involved with evaluation of a child to bring their resources to the child. She noted that most children at the CAC were referred by Office of Children's Services (OCS), medical providers, or law enforcement when a complaint had been made. She shared that a child, when old enough, would be interviewed by a person trained in forensic interviews with children. There would be a medical evaluation, if appropriate, by a medical provider specially trained for evaluating children for abuse; a psycho-social evaluation for the child, and an evaluation for the needs of the family; and ongoing support for the family through the follow up process. She communicated that the CAC would coordinate the team for case review and ongoing tracking.

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REPRESENTATIVE TARR asked if a parent could access the resources of CAC without a complaint, in order to better understand any cultural differences which could result in reported incidents.

DR. BALDWIN-JOHNSON replied that this was not part of the core services provided by the CAC program. She offered her belief that some CACs could have community outreach and support programs for parents.

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REPRESENTATIVE REINBOLD asked to clarify her earlier comments about organizations that served youth. She noted that youth would share with someone they trusted, and if the incident was then reported, the youth could be banned from future outings by their family for exposing these abuses. She declared her desire to ensure that kids who were not getting help were cared for and given the opportunity to talk. She expressed her concern for doing more damage than good. She asked for the effects from this proposed legislation on the Health Insurance Portability and Accountability Act (HIPAA) regulations.

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MS. RUTHERDALE clarified that the proposed legislation would restrict the number of people with access to the information, which was compatible with HIPAA.

MR. JANIDLO, in response to Representative Reinbold, said that medical records were already being released to the relevant agencies, but remained confidential during the discovery process, so this was all in compliance with HIPAA.

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REPRESENTATIVE SEATON reported that he had visited the CAC in Homer, and he declared that it was a really enlightening experience. He pointed out that, whereas most state troopers were intimidating and not adequately trained to interview a child, the CAC was well trained and very child friendly. He questioned whether the CAC became directly involved when a medical provider had a concern for a child abuse, and if this would bypass the Department of Health and Social Services.

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DR. BALDWIN-JOHNSON explained that the CAC notified OCS if there was a medical referral, and then OCS and law enforcement would determine whether to become immediately involved, or, depending on the nature of the complaint, to wait for completion of a medical examination. She noted that this situation most often involved pre-verbal children.

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CHAIR HIGGINS declared that children are the most valuable resource.

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ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 4:44 p.m.