2/08/12
PRESENTATION
ALASKA CHILDREN'S JUSTICE ACT TASK FORCE

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Alaska Children's Justice Act Task Force

Presentation to Joint Senate Judiciary and HSS Committees, Alaska Legislature

February 8, 2012

hss.state.ak.us/ocs/ChildrensJustice/default.htm

OVERVIEW OF 2012 PRESENTATION

- Background on CJA: Who we are and what we do
- Child maltreatment in Alaska
- Proposed legislative changes

OVERVIEW OF CJA TASK FORCE

- Background: Founded 2002
  - Federal mandate: Child Abuse Prevention and Treatment Act (CAPTA) 42 U.S.C. 5101 and Victims of Crime Act 42 U.S.C. 10601
  - Multidisciplinary/statewide representation
  - Federally funded based on population

Mission

- Identify areas where improvement is needed in the statewide response to child maltreatment, particularly child sexual abuse, make recommendations and take actions to improve the system

Task Force Projects

- Develop and distribute better data
  - Collaboration with DHSS, Maternal Child Health Epidemiology Unit - Surveillance of Child Abuse and Neglect (SCAN) program
- Improve system response
  - Support the development of Child Advocacy Centers (CACs) and Multidisciplinary Teams (MDTs)
  - Support innovative programs
  - Support education and training
- Make recommendations for law changes

IMPROVE THE SYSTEM RESPONSE

Support the development of CACs and MDTs

- Alaska now has 10 regional CACs and 2 satellite centers
- Publications:
  - Guidelines for the Multidisciplinary Response to Child Abuse in Alaska
  - Standardized medical documentation forms

Support Innovative Programs

- Pathway to Hope
  - Tribal facilitator curriculum to assist community healing from intergenerational trauma due to sexual abuse
- Sexual exploitation of children protection
  - Internet Crimes Against Children
  - NetSmartz
  - In-school education programs

Education and training

- Educate mandatory reporters
  - Developed Mandatory Reporter Training CD
- Encourage professional development
  - Scholarships for trainings
  - Sponsor biennial Alaska Child Maltreatment Conference (collaboration with the Alaska Children's Alliance)
- Yearly legislative presentations

Yearly legislative presentations

- Children's Caucus
- Legislative committee presentations
- 2012 presentation to Senate Judiciary & HSS
  - Child maltreatment in Alaska
  - Proposed legislation

Child maltreatment in Alaska

- Data
- Fiscal impact

Maltreatment-Related Child Deaths

Deaths occurring between 2000-2008,
children ages 0 – 9 years

- Approximately **1 out of everv 5** (20%) Alaskan child deaths is maltreatment-related
  - ~ **1 out of everv 4** (25%) for Alaska Native children
- Nearly **3 out of everv 4** (~75%) maltreatment-related deaths occur in infants

Maltreatment - All Types

- In 2008 ~ **12,400 Alaskan children** were likely victims of at least one incident of maltreatment
  - **24%** had at least one incident confirmed
    - Substantiated or conviction
    - "Tip of the iceberg"
  - As many as **34 children a day** are likely maltreated, or **3,000** during this 90 day legislative session

Maltreatment - Neglect

- In 2008 ~ **8,900 Alaskan children** were the likely victims of at least one incident of neglect
  - **25%** had at least one incident confirmed
  - As many as **25 children a day** ,or **2,200** during this 90 day legislative session

Maltreatment – Physical Abuse

- In 2008 ~ **2,700 Alaskan children** were likely victims of at least one incident of physical abuse
  - **22%** had at least one incident confirmed
  - As many as **7 children a day**, or **630** during this 90 day legislative session

Maltreatment – Sexual Abuse

- In 2008 ~ **1,900 Alaskan children** were likely victims of at least one incident of sexual abuse
  - Among the children experiencing sexual abuse, **16%** had at least one incident confirmed
  - ~ **As many as 5 children a day**, or **450** during this 90 day legislative session

What does this cost?

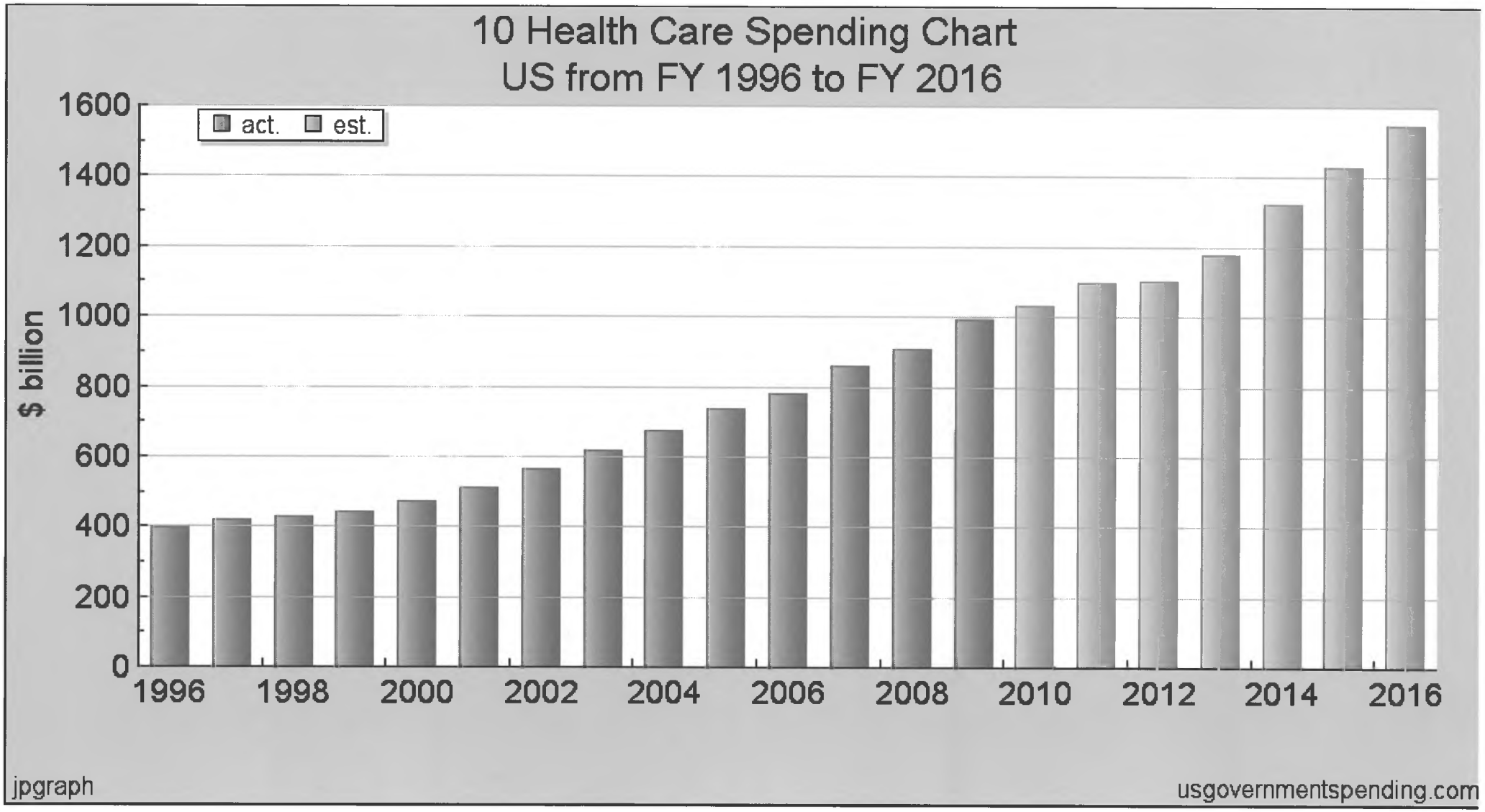
- Medical & mental health care
  - Short and long term
- Child protection system
- Criminal justice system
- Future earnings
- Quality of life

Health Care Costs

- Adverse Childhood Experiences Studies: "Turning Gold Into Lead"
- "…much of what is recognized as common in adult medicine is the result of what is not recognized in childhood."
- Link to ALL most common causes of adult disease and death in US today

www.cdc.gov

Health Care Costs



Average lifetime cost per case of fatal child maltreatment

• Medical costs	• $ 14,000
• Productivity losses	• $1,258,800
• Total	• $1,272,900

2012 The economic burden of child maltreatment in the United States Child Abuse and Neglect

Annual economic burden to Alaskans: fatal child maltreatment (infants only)

• Medical costs	• $ 140,000
• Productivity losses	• $12,588,000
• Total	• $12,729,000

Average lifetime cost per case of nonfatal child maltreatment

• Short-term health care costs	• $ 32,648
• Long-term health care costs	• $ 10,530
• Productivity losses	• $144,360
• Child welfare costs	• $ 7,728
• Criminal justice costs	• $ 6,747
• Special education costs	• $ 7,999
• Total	• $210,012

Estimated annual economic burden for Alaskans

• Short-term health care costs	• $97 – 405 million
• Long-term health care costs	• $31 - 130 million
• Productivity losses	• $430 million -1.8 billion
• Child welfare costs	• $23 – 96 million
• Criminal justice costs	• $20 -84 million
• Special education costs	• $24 – 99 million
• Total	• $625 million - 2.6 billion

based on ~3000 - 12,400 children annually

SYSTEM IMPROVEMENT THROUGH CHANGES TO OUR CRIMINAL STATUTES

RECOMMENDATION #1

Modify assault statutes to create broader criminal liability for assaults to children

Problem: Required for felony prosecution

- Serious physical injury OR
- Multiple events OR
- Reasonable caregiver would seek medical diagnosis and treatment

Problem: Definition of "serious physical injury"

- "**(A)** physical injury caused by an act performed under circumstances that create a substantial risk of death; or
- **(B)** physical injury that causes serious and protracted disfigurement, protracted impairment of health, protracted loss or impairment of the function of a body member or organ, or that unlawfully terminates a pregnancy."

Solutions: New definition "serious bodily injury to a child"

- "Serious bodily injury to the child" includes, but is not limited to, second- or third-degree burns, a fracture of any bone, a concussion, subdural or subarachnoid bleeding, retinal hemorrhage, cerebral edema, brain contusion, strangulation, injuries to the skin that involve severe bruising or the likelihood of permanent or protracted disfigurement, including those sustained by striking children with objects, or other physical injury that results in significant physical injury to the child

Solutions

- Apply the proposed "serious bodily injury" definition to
  - children under 12
  - children under age 16 who are mentally or physically impaired
- Add new theories to all three felony assault statutes that incorporate the definition of serious bodily injury to a child

Post-conviction recommendation:

- To recognize mental harm resulting from physical injury:
- Create a sentencing aggravator if the serious bodily injury caused to a child resulted in significant mental injury to the child

RECOMMENDATION #2

STRENGTHEN STATUTES REGARDING EXPOSURE OF CHILDREN TO DRUGS

Problem:

- Difficult to prosecute person who has exposed a child to drugs to extent that child tests positive for drug
- Examples: meth lab, leaving drugs laying around, using drugs around child

Solution:

- Amend endangering the welfare of a minor statute by creating 2 new subsections to:
  - Penalize reckless exposure of child to controlled substance and, because of exposure, the child tests positive for the controlled substance
  - Penalties vary depending on dangerousness of drug

Section 5, subsections (b)(2) and (g)

Problem:

- Inability to prosecute for indirect exposure to dangerous chemicals used in drug labs

Solution

- Penalize reckless exposure of child to chemicals used in meth labs

Section 5, subsections (b)(4)

RECOMMENDATION #3

INCREASE PENALITES WHEN A PARENT INTENTIONALLY WITHHOLDS ADEQUATE FOOD OR LIQUIDS

Problem:

- Current punishment for criminal nonsupport is a misdemeanor
- Intentional failure to provide adequate food or liquids to a child should be a felony

Solutions:

- Modify criminal nonsupport to create a class C felony for parent or guardian who intentionally fails to provide adequate food and liquids to the child
- Standard for determination: “a reasonable person would conclude the child was not receiving adequate food or liquids”

RECOMMENDATION #4

CREATE A CRIMINAL LAW THAT PROHIBITS AN INCARCERATED PERSON FROM CONTACTING A VICTIM OR WITNESS

Problem:

- Current statutes do not fully protect a child victim from influences and pressure prior to trial and sentencing
  - Only after sentencing
- Examples:
  - Incarcerated accused sex offender can contact under age victim
  - 3rd party can forward phone calls, letters from defendant to victim

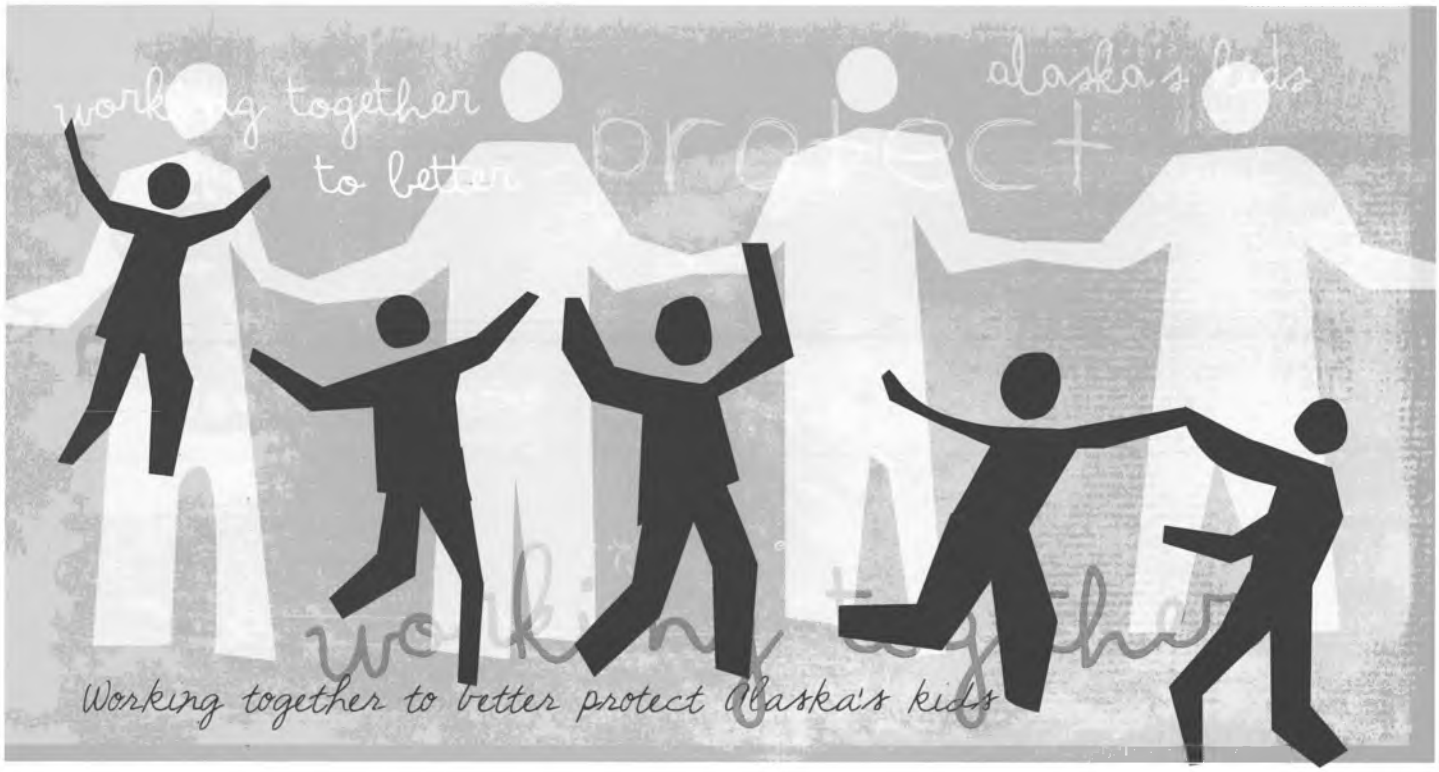
Solutions:

- Add two new theories to unlawful contact statute to:
  - Penalize a person incarcerated before trial or sentencing for contacting a victim or witness of the offense in violation of no-contact order
  - Penalize person who assists the defendant in engaging in such contact

Alaska Children's Justice Act Task Force

- Problem: need legislative changes to enhance safety of Alaskan children
- Solution: introduce and pass proposed legislation

We need champions for children!



GUIDELINES FOR THE MULTIDISCIPLINARY RESPONSE TO CHILD ABUSE IN ALASKA

A Project of the
Alaska Children's Justice Act Task Force

Alaska Children's
Justice Act Task Force

This document is intended to assist the dedicated people who participate in the evaluation of children for whom there is a concern for maltreatment: child protection, law enforcement, medical and mental health, Child Advocacy Centers (CACs), tribes/tribal organizations, victim advocates, prosecutors and others. The work is hard and often under-appreciated, but there is little we do that is more important than making a difference in the life of a child.

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SECTION ONE: OVERVIEW

Guiding Principles

- These guidelines are intended to be used in the best interests of children. Every effort should be made to avoid re-traumatizing a child who has possibly suffered abuse.

- Child abuse occurs in families from every race, culture, religion, economic status and educational level. Children from infants to teens, both boys and girls, are victims of child abuse.

- Child maltreatment has life-long ramifications that include adverse outcomes in future physical and mental health, substance abuse, suicide, criminal behavior, productivity, and a host of other societal ills with enormous direct and indirect costs.[1], [2]

- A multidisciplinary approach affords the best opportunity for breaking the cycle of child abuse and neglect through effective investigations, holding offenders accountable, access to medical and mental health evaluation and treatment, and assistance to support families in providing safe and nurturing environments for their children to heal from abuse.

- Response to child abuse in small rural communities presents unique obstacles that can complicate the investigation, victim support and family services, prosecution and the healing process. Interagency cooperation is essential to minimize the trauma experienced by children in rural Alaska.

- Bringing children from rural communities into hub or urban areas for forensic evaluation and investigation requires management of logistical and emotional support including lodging, transportation, meals and additional advocacy and support. Lack of adequate and culturally-informed support while the child is away from their home community may result in recantation or difficulty in cooperating with the investigation and prosecution.

- Critical attention must be given to the reactions of the child's supporters and extended family, particularly in small rural communities because unsupportive or negative reactions to an abuse disclosure/investigation may cause further trauma to the child, compromise safety and inhibit the child's healing.

- All evaluations of possible child maltreatment must take into account aspects of individual and family diversity including regional/geographic practices and lifestyles, primary language, and physical, emotional and cognitive ability.

- Multidisciplinary team members should have, at a minimum, training on normal child development, dynamics and impacts of child abuse on children at different developmental stages, profiles of those who abuse children, and how children tell about abuse. Each member of the team should become informed regarding the diversity of their specific service area in order to remain objective and avoid bias based on demographic, educational, economic, ethnic or cultural factors.

- It is expressly understood that each agency will work within its departmental mandates and policies.

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1 *Wang and Holton; Economic Impact Study 2007 from Prevent Child Abuse America;* http://www.preventchilda-buse.org/about_us/media_releases/pcaa_pew_economic_impact_study_final.pdf

2 *Adverse Childhood Experiences Study conducted through the Centers for Disease Control* http://www.cdc.gov/nccdphp/ace/

INTRODUCTION

Child abuse and neglect is a widespread problem in the United States, especially in Alaska. It is critical that we effectively respond. During the years 2007 -2008 approximately six in every 100 Alaskan children were potential victims of at least one form of child maltreatment, nearly 24 per week had concerns for sexual abuse, and over 2920 children required the services of our Child Advocacy Centers. These cases are complex and require the cooperation and sharing of information by those involved. No single agency or organization can effectively deal with the issues of child abuse and neglect, and a multidisciplinary approach that is cooperative and mutually respectful will result in a professional assessment with the least amount of trauma to the children and families involved.

"Child abuse and neglect is a widespread problem in the United States, especially in Alaska. It is critical that we effectively respond."

Statement of Purpose

The purpose of this multidisciplinary guideline document is to provide those involved in the initial evaluation of suspected child abuse and neglect with guidance based on existing best practice recommendations. We believe that consistency in the approach to these complex cases will greatly increase the effectiveness of Alaska's response to child abuse and neglect cases.

In this document **initial response** refers to any investigation and/or assessment conducted in order to make a decision on whether or not to move forward with a criminal or civil case. The initial response generally involves investigative steps, a forensic interview, a medical exam, if indicated, and an assessment of child and family needs for services.

This document represents the best knowledge about multidisciplinary practices in response to child abuse and neglect available at the time of publication. Furthermore, these are standards toward which professionals should strive to reach in these cases. This document is not intended to create substantive rights for any individual. Finally, the authors assume that any individual agency's ability to follow these guidelines will depend to some degree on the availability of resources and the necessity to balance priorities among several cases.

Intended Audience

These guidelines are for those who work in child protection, law enforcement, medical and mental health, Child Advocacy Centers (CACs), tribes/tribal organizations, prosecutors and others who participate in the evaluation of children for whom there is a concern for maltreatment. Multidisciplinary teams (MDTs) typically have two over-lapping and inter-related purposes, with participating agency membership varying depending on location and purpose. The MDT that initially responds to an allegation of abuse generally includes investigators from the Office of Children's Services and/or law enforcement, CAC staff, a medical provider, an ICWA worker (if concerning a Native child), a victim advocate, and sometimes a mental health provider. In addition, there may also be a larger MDT that meets to review cases, which may include all of the above as well as supervisors and representatives from other agencies as defined in AS 47.14.300. This document may be helpful to those wishing to understand the framework for multidisciplinary teams and to those who are involved with later stages of child abuse investigations. However, the primary intended audiences are those involved in the initial evaluation/assessment/investigation, whether the case falls within criminal and/or civil jurisdictions.

BACKGROUND

History of the Alaska Children's Justice Act Task Force

The Alaska Children's Justice Act Task Force is a statewide multidisciplinary group established in 1999 in order to comply with the Federal Child Abuse Prevention and Treatment Act requirement to undertake a comprehensive review and evaluation of law, policy and the investigative, administrative and judicial handling of cases of child abuse and neglect. The purpose of the Task Force is to promote State system enhancements or changes, including training, policies, procedures and laws that will improve how Alaska responds to children and families involved in these cases. The CJA Task Force members represent multiple disciplines and are employed in state, private and Tribal agencies.

History of Child Advocacy Centers in Alaska

CACs are community-based facilities that bring together law enforcement, child protection workers, prosecutors, child and family advocates, tribal representatives, medical and mental health professionals to utilize a collaborative team approach to the investigation of child sexual abuse and other forms of maltreatment as well as providing necessary follow-up services. CACs provide a safe neutral environment for the evaluation of child abuse and exploitation, as well as coordination of services for victims and families.

CACs were developed in Alaska as a result of community MDTs and others working in the field who recognized that child sexual abuse cases needed to be approached differently than adult sexual assault cases. The first CAC in Alaska, Alaska CARES in Anchorage, opened in 1996, followed by The Children's Place in Wasilla in 1999. Now CACs are present in 10 different hub communities, allowing a majority of children in Alaska to have access to CAC services. CACs in Alaska are based on a national model first developed in Huntsville Alabama in the 1980's with each reflecting the unique needs and resources of their community/region.

The benefits of a CAC include:

- Allegations of sexual abuse are more thoroughly investigated
- The trauma experienced by children and families is reduced
- Non-offending parents are empowered to protect and support their children
- Children and families receive services tailored to their family's needs
- More offenders are held accountable
- The community is more aware of the problem of child abuse in general and sexual abuse specifically
- The CAC becomes a resource to MDT professionals, providing specialized training and consultation

Alaska is fortunate to now have a Child Advocacy Center in each of the following communities:

- Anchorage, Alaska CARES -- 1-877-561-8301 http://www.providence.org/alaska/tchap/cares/default.htm
- Wasilla – The Children's Place – 1-907-357-5157 http://www.thechildrens-place.org/
- Juneau – S.A.F.E. Child Advocacy Center -- 1-907-463-6157 -- http://www.ccsjuneau.org/51
- Fairbanks – Stevie's Place -- 1-907-374-2850 -- http://www.rcpcfairbanks.org/Stevie's%20Place.htm
- Nome – Kawerak Child Advocacy Center--1-907-443-4379 -- http://www.kawerak.org/servicedivisions/cfs/cac/index.html
- Bethel – The Children's Center -- 1-907-543-3144
- Dillingham – Nitaput Child Advocacy/Family Support Center -- 1-907-842-1230 -- www.bbahc.org/child_advocacy
- Copper River – Copper River Basin Child Advocacy Center -- 1-907-822-3733 -- http://crbcac.com/purpose.html
- Kenai – Central Peninsula Child Advocacy Center -- (907)690-2113
- Homer – Haven House Child Advocacy Center --(907)235-7712 -- http://www.havenhousealaska.org/

Additional CACs are under development at the time of publication. Contact the Alaska Children's Alliance for an up to date list with contact information.

The Alaska Children's Alliance (ACA) is a coalition of established and developing CACs, MDTs, and child protection teams (CPTs) dedicated to improving Alaskan community responses to child maltreatment. The ACA is a state chapter of the National Children's Alliance (NCA). The NCA is a non-profit membership organization whose mission is to assist communities seeking to improve their responses to child abuse by establishing and maintaining CACs.

DEFINITIONS

These are definitions of commonly used terms and terms used throughout this document, and are not necessarily legal definitions (which may be found under pertinent statutes).

Child Advocacy Center: A child-focused, community-based program that provides coordination between the various agencies and professionals responsible for responding to child maltreatment with the primary goal to prevent re-traumatization by the system response.[3]

Child maltreatment: Any act or series of acts of commission or omission by a parent, caregiver, or person in position of authority over a child that result in harm, potential for harm, or threat of harm to a child.[4]

Child neglect: The failure to provide for a child's basic physical, emotional, or educational needs or to protect a child from harm or potential harm. Harm to a child may or may not be the intended consequence. The following types of maltreatment involve acts of omission:[5]

- Failure to provide
  - Physical needs
  - Emotional needs
  - Medical/dental needs
  - Educational needs
- Failure to supervise
  - Inadequate supervision
  - Exposure to violent environments

Child physical abuse: The intentional use of force against a child that results in, or has the potential to result in, physical injury. Physical abuse includes physical acts ranging from those which do not leave a physical mark on the child to physical acts which cause permanent disability, disfigurement, or death. Physical abuse can result from discipline or physical punishment.[6]

Child sexual abuse: Child sexual abuse occurs when a child is engaged in sexual activities that he or she cannot comprehend, for which he or she is developmentally unprepared and cannot give consent, and/or that violate the law or social taboos of society. The sexual activities may include all forms of oral-genital, genital, or anal contact by or to the child or abuse that does not involve contact, such as exhibitionism, voyeurism, or using the child in the production of pornography.[7]

Forensic Interview: A forensic interview is a process of asking, when feasible, non-leading and age appropriate questions to determine whether a crime against a child has been committed or if a child is in need of protection. A forensic interview should be performed by someone who is specially trained in child development and the many dynamics of child abuse.

Guardian Ad Litem: A GAL is a person appointed by a judge to conduct an independent investigation and advocate for the best interest of a child in the child's court case, which can include Child in Need of Aid cases where abuse or neglect is alleged, domestic violence cases where a restraining order

3 *National Children's Alliance*

4 http://www.cdc.gov/ViolencePrevention/childmaltreatment/definitions.html

5 http://www.cdc.gov/ViolencePrevention/childmaltreatment/definitions.html

6 http://www.cdc.gov/violenceprevention/pdf/CM_Surveillance-a.pdf

7 *Kempe CH. Sexual abuse, another hidden pediatric problem: the 1977 C. Anderson Aldrich lecture. Pediatrics. 1978;62 :382 –389*

is filed on behalf of the child, in juvenile delinquency cases, in private child custody cases between divorcing parents, or in adult criminal cases where there is a child victim. A GAL may or may not be an attorney, and must meet specific qualifications.

ICWA worker: A person who represents the tribe in an Indian Child Welfare Act case.

Multidisciplinary team: A group of professionals and agency representatives brought together because of a report of concern that a child has been maltreated and/or that a crime has been committed against a child (the initial response). The MDT also continues to meet to provide ongoing consultation, follow up on services and case review. These meetings may include other people as listed in AS 47.14.300b.

Protective Services Report (PSR):
A report to OCS of suspected child abuse or neglect.

Victim Advocate: A trained individual who works with children and non-offending family members to provide support and referrals for services; may be a CAC staff member.

SECTION TWO: GUIDELINES FOR THE INITIAL RESPONSE

MDT Roles and Responsibilities in the Initial Response
General Guidelines

- To the best of their ability, each agency will work with and assist other members of the multidisciplinary team to ensure that the best interest and protection of children will be served.
- All reasonable efforts will be made by each agency to coordinate each step of the investigation/assessment process in order to minimize the number of interviews and interviewers involved with the child, as well as the number of medical exams.
- All agencies participating in this process will share pertinent case information with other appropriate agencies except as prohibited by law or policy.
- To the best of their ability, agencies should provide specially trained professionals with skills in forensic interviewing, assessment, and investigation to handle appropriate cases of child abuse and neglect.
- It is expressly understood that each agency will work within its departmental mandates and policies.

Role of the Office of Children's Services (OCS)

In the context of the initial response, it is the role of OCS to assess whether a parent or guardian has abused or neglected their child, or created conditions that caused such abuse or neglect. The steps involved in this process include:

- Receiving, documenting, screening, and prioritizing Protective Services Reports;
- Assessing "screened in"[8] allegations of in-home abuse or neglect of children;
- Notifying the appropriate law enforcement agency when a crime against a child may have been committed;
- Making a referral to CAC serving the area, in accordance with MDT team protocol, when a screened-in PSR involves sexual abuse or severe physical abuse, or when a child discloses sexual abuse during an assessment of less severe physical abuse or neglect. At a minimum, OCS staff should adhere to the following protocol when their safety assessment work involves a CAC:
    - Submit information from the protective services report to the CAC and coordinate with law enforcement and the CAC to schedule an interview of the child. Any information about the reporter's identity will be redacted prior to submission
    - If a non-offending caregiver (of physical or sexual abuse) is identified, request that caregiver bring the child to the CAC or to give their consent for the child to be transported to the CAC for an interview
    - If the non-offending caregiver refuses to allow the child to be transported, or there is no non-offending caretaker available, determine if there is probable cause to assume emergency custody of the child
    - Help coordinate the interview, making every effort to coordinate the interview with the necessary members of the investigation team to minimize trauma to the child. At a minimum, the OCS worker and a law enforcement officer should be present at the interview
    - Help coordinate any necessary follow-up medical examination(s) or services
    - Limit the number of interviews with a child.
    - Filing a civil child-in-need-of-aid petition, if warranted

Note: If the MDT initial response is not initiated by OCS, OCS is available as a professional resource to the MDT.

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8 If, after a preliminary evaluation of a PSR involving in-home abuse or neglect of children, OCS may either determine that a more complete assessment is needed ("Screened In") or determine that no further assessment is needed ("Screened Out")

Role of Law Enforcement

It is the role of the law enforcement detective/investigator/officer to investigate and determine whether a crime has been committed. The investigation includes but is not limited to:

- Ensuring that all interviews are completed, including victims, witnesses, suspects and other collateral people involved
- Conducting a thorough crime scene investigation
- Collecting evidence, including any corroborating evidence
- Preserving the chain of possession of any collected evidence

Law enforcement presents the case to the prosecutor's office or agency if enough evidence of the crime exists for a criminal prosecution. As a mandated reporter, law enforcement will notify OCS of any possible cases of child maltreatment, even if out of home.

Role of Federal Bureau of Investigation (FBI)

It is the role of the Federal Bureau of Investigation (FBI) to investigate certain federal criminal cases in Alaska and certain interstate crimes. When a serious child physical or sexual abuse case falls within federal jurisdiction, the FBI role includes:

- Working with OCS on child safety issues
- Working with Alaska State Troopers (AST), and/or other local law enforcement agencies on investigation
- Serving on the MDT when there is a current investigation involving the FBI

Role of the Child Advocacy Center (CAC)

It is the role of the CAC to provide a child-focused, neutral, community-oriented program in which representatives from many disciplines meet to provide a comprehensive approach to the investigation, assessment, treatment, and prosecution of child abuse cases. The CAC provides a facility for:

- Legally sound forensic interviews of children who may have been sexually abused, physically abused, severely neglected, drug endangered, or who may be a witness to violence, plus others depending on the resources of the CAC and MDT
- Medical services for children by specially-trained medical providers, including medical treatment, follow-up exams, and medical referrals, either on site or through collaboration with community medical providers
- Referrals for families and children to an appropriate mental health provider and other indicated services

Child Advocacy Centers in Alaska strive to meet the Accreditation Standards set forth by the National Children's Alliance (see Appendix 2).

Role of the Medical Provider

It is the role of the medical providers to be responsible for medical and forensic child abuse evaluation and treatment within their licensing scope of practice. This includes the following:

- Interpretation of exam findings (or lack of findings)
- Identification of unmet health care needs
- Careful and complete written and photographic documentation
- Work with other team members to promote future health and safety of the child
- Reassurance for child and family

Role of Mental Health

The role of the mental health provider includes:

- Notifying OCS, as a mandated reporter, of any suspected child maltreatment
- Assessing and treating the emotional and psychological needs of the child and non-offending family member, with a special emphasis on working with those who have experienced complex trauma
- Providing crisis intervention as needed.

Role of Victim Advocate

It is the role of the victim advocate to assist the child victim and/or witness during the initial response, which includes:

- Providing a crisis response and preparing the child for the forensic interview and medical evaluation, if any
- Supporting the non-offending caregiver during investigation, forensic interview, medical evaluation
- Explaining legal process to caregiver and child
- Providing logistical support for child and non-offending family, including arranging transportation, assistance with appointments for services, etc.
- Conveying child's and non-offending caregiver's concerns and abilities to prosecutor and MDT members
- Serving as a resource on the dynamics of abuse, responses of children, child development and psycho-social needs of child victims

Roles of Tribes/Tribal Organizations

Under federal law, Tribes and Tribal organizations have a specific additional mandate regarding initial response to suspected or known child abuse. Mandatory reporters of child abuse who are employed by a Tribe or Tribal organization that receives federal funds are obligated to report suspected child abuse to both local child protection and local law enforcement agencies.[9] Except for Chevak, Metlakatla and Native Village of Barrow, the local child protection agency is OCS; local law enforcement may be Alaska State Troopers, City Police or Borough Police.

In addition to these mandatory reporting duties, Tribes and Tribal organizations may have a consultative role to address cultural and family dynamics in specific cases, and develop and/or assist in developing community education efforts. Tribes and Tribal organizations may have programs and services that can provide direct support and assistance to the child and family as well.

9 *Public Law 101-630, Indian Child Protection and Family Violence Prevention Act*

Forensic Interviewing of Children[10]

The forensic interview can empower a child to disclose maltreatment in a legally defensible manner.[11] Forensic interviews are typically the cornerstone of a child abuse investigation, effective child protection and subsequent prosecution. Actions taken at the initial forensic interview may significantly impact the child's understanding of and ability to respond to the intervention process and/or criminal justice system, and may also mark the beginning of the journey to healing for the child and family. The best forensic interviewing practice includes:

- An age-appropriate, neutral interview setting
- Effective communication among MDT members
- Utilization of legally sound and culturally informed interviewing techniques
- Appropriately trained and supervised interviewers

"Actions taken at the initial forensic interview may significantly impact the child's understanding of and ability to respond to the intervention process and/or criminal justice system, and may also mark the beginning of the journey to healing for the child and family."

At a minimum, forensic interviews should be child-centered and coordinated to avoid multiple interviewers and duplication in questions asked of the child.

The purpose of a forensic interview is to obtain a statement from a child, in a developmentally and culturally sensitive, unbiased and fact-finding manner that will support accurate and fair decision making by the involved multidisciplinary team in the criminal justice and child protection systems. The status of the individual conducting the forensic interview may vary, depending on the case circumstances and location, but in all situations, it is recommended that the forensic interviewer have initial and ongoing formal forensic interviewer training. The interviewer may be a CAC employee, law enforcement officer, OCS worker, medical provider, federal law enforcement officer or other MDT members, depending on the situation and who is available.

Key elements of a child forensic interview include the following:

- Introductions and rapport building
- Assessment of developmental and cultural factors influencing communication
- Age appropriate language and formulation of questions
- Explanation of rules of the interview
- Exploring the potential for abuse in as non-leading a manner as possible
- Gathering details surrounding any disclosure
- Screening for other types of abuse, neglect or mental injury
- Use of aids such as free hand drawing and body diagrams as needed to help child communicate

The CAC/MDT protocol should set out the required qualifications of the forensic interviewer, including minimum specialized training, the method for sharing among MDT members information collected in the forensic interview, and the mechanisms for collaboration and peer review.

Ongoing education in the field of child maltreatment and/or forensic interviewing is essential for those conducting forensic interviews of children. Additionally, the importance of peer review cannot be overstated. As noted by Michael Lamb, "interviewers continue to maintain or improve their skills only when they regularly review their own and others' interviews closely, discussing their strategies, successes and mistakes with other interviewers"[12] .

In response to concerns about defense attorney attacks on peer review, Victor Vieth states: "Simply put, whatever the MDT does or does not do as part of the forensic interviewing process, including peer review, will be attacked by defense counsel." "The MDT should not focus on avoiding a defense attack

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10 Based on the Accreditation Standards of the National Children's Alliance, which all CACs in Alaska are required to strive to meet

11 Victor Vieth, Director, National Child Protection Training Center, Winona State University

12 Lamb, et al, A structured forensic interview protocol improves the quality and informativeness (sic) of investigative interviews with children: A review of research using the NICHD Investigative Interview Protocol, 31 CHILD ABUSE & NEGLECT 1201, 1210 (2007).

of the peer review process, any more than the MDT should focus on conducting a forensic interview in a manner to avoid a defense attack. [13]

Cultural Considerations in Forensic Interviewing of Children

"It should never be assumed that English is a universal language understood by all children."

Research indicates that members of different cultural groups may respond differently to children's disclosure of sexual abuse.[14] A child's cultural background may also impact upon the child's appraisal of the abusive experiences (e.g., level of self-blame) and the level of social support that the child may receive. In addition, the way emotions may or may not be expressed is also related to culture and ethnicity. In the investigative process, the interviewer should explore as appropriate:

- family structure (e.g. extended, nuclear, single), gender role expectations,
- child care practices,
- financial management of the household,
- community/country of origin and reasons for immigration or transfer to urban areas (if Alaska Native),
- any contact with family in the village/country of origin, religious belief systems, social networks, and
- attitudes about sexual violence.

Interviewers should integrate these cultural concerns into the interview process. Furthermore, the factors that make it more difficult for some children to disclose sexual abuse are culturally related (e.g., gender role expectations), and cultural issues may also contribute to the possibility of recantation.

Language proficiency is another important consideration for the interviewer. It should never be assumed that English is a universal language understood by all children. Ideally, children should be asked what language they speak at home, as well as what language they would prefer to use in talking to investigators. Children may use language terms for body parts, for certain actions, for relationships and for certain individuals, and they may not know the English word for these things or people. There may be a taboo about saying words for private parts or sex acts, especially with people outside of the family. Nicknames are widely used in some cultures, and children may not know a person's formal name, only their nickname such as "Junior" or "Chubby".

Non-verbal expression, body language and posture are interpreted differently in different cultures with great variation as to the meaning. The interviewer should not presume that a bent-over posture or a lack of eye contact, for instance, means a person is not truthful, or that alert posture and direct eye-contact means the person is truthful. Understanding the child's specific cultural norms for non-verbal expression is an important aspect of the forensic interview.

Translation/interpretation, whether of spoken language or of non-verbal communication, in and of itself, raises additional considerations, and it is important that the MDT include individuals with knowledge and understanding of the unique cultural aspects of the child and family/caregivers or who are willing and able to access such expertise when needed.

13 *Victor Vieth, In the Shadow of Defense Council: Conducting Peer Reviews of Forensic Interviews in an Age of Discovery*

14 *Feiring, C., Coates, D.L., & Taska, L.S. (2001). Ethnic status, stigmatization, support and symptom development following sexual abuse. J. of Interpersonal Violence.16: 1307-1329*

Medical Evaluation for Child Maltreatment

All CACs in Alaska evaluate children for sexual abuse; many also offer the ability to evaluate children for physical abuse, neglect and drug endangerment.

Purpose of the Medical Evaluation
The majority of children for whom sexual abuse is a concern will have normal or non-specific anal-genital exams. There are a number of reasons for this, including:

- Late disclosure
- Delays in seeking care
- Types of sexual abuse that do not cause significant physical trauma: fondling, oral-genital contact, rubbing, touching over clothes
- Elasticity of vaginal and anal openings
- Rapid healing in children
- Medical conditions that can be confused with sexual abuse

Also, research shows that that it is unusual to find any forensic evidence in pre-pubertal children, especially if they are seen more than 24 hours after the abuse has occurred.[15], [16]

Even in physical abuse cases, exams can be non-diagnostic because of delays in evaluation, medical conditions that can be confused with abuse and the overlap in findings that can occur in inflicted and accidental injuries.

Therefore the purposes of the medical evaluation include the following:

- Help ensure the health, safety and well being of the child
- Diagnose, document, and address medical conditions resulting from abuse and neglect
- Differentiate medical findings that are indicative of abuse from those which may be explained by other medical conditions
- Diagnose, document, and address medical conditions unrelated to abuse (within the scope of practice of the individual provider)
- Assess the child for any developmental, emotional, or behavioral problems needing further evaluation and treatment including referrals as necessary
- Collection, preservation and documentation of forensic material if indicated by history and timing
- Reassure and educate the child and family to assist in emotional healing

Indications for a Medical Evaluation
All children who are suspected victims of child sexual and/or physical abuse should be offered a medical evaluation.[17] Health care providers working with the CAC and MDT should determine those situations (indicators) in which medical evaluations should be "required" (with the provision that children are never forced to have any portion of an exam unless medical/surgical intervention is necessary). These indicators should be part of the CAC's written protocols.

Indicators to consider include:

- Any child who discloses direct oral, anal or genital contact (skin to skin) by a suspect's body part or an object
- Any child with anal or genital pain, bleeding, or abnormal discharge
- Any child with a non-neonatal transmission of a sexually-transmitted infection
- Any child disclosing physical abuse or observed to have possible signs of non-accidental injury, including
    - Unexplained or unwitnessed injuries to a young child
    - Injuries inconsistent with history or age and development
    - Patterned injuries
- Any child with significant signs of neglect

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15 Christian et al; Pediatrics July 2007
16 Young et al; Archives Pediatric & Adolescent Medicine June 2006
17 Medical Standard from the National Children's Alliance

- Any child where there is a concern of endangerment due to drug exposure
- Any child who is highly suspected of being recently abused, or who may be reluctant to disclose abuse, or who is preverbal
- Other considerations for medical exams include:
    - Young children exhibiting significant sexualized behavior
    - History or exam findings of concern for abuse noted by another health care provider
    - Adolescents disclosing "consensual sex" if the teen is under 16 years of age

Access for Medical Evaluations

The National Children's Alliance Medical Standard states that: **"Specialized medical evaluation and treatment services are routinely made available to all CAC clients and coordinated with the multidisciplinary team response."**

In Alaska, some CACs offer on-site medical evaluations through employed or contract medical providers. Others arrange for medical exams to be conducted at the local hospital, clinic, or at another CAC with medical providers on staff.

CACs need to make arrangements for those situations where children require evaluation after regular business hours or at Emergency Department or in-patient hospital care – for example, a child with serious injuries requiring diagnostic testing and treatment beyond the scope of the CAC. Policies should be in place for transport to the nearest hospital if the child first presents to the CAC, as well as for examination of the child, documentation of injuries, and forensic evidence gathering as appropriate.

Medical evaluations arranged through the CAC should always be available regardless of the child's and family's ability to pay. In Alaska it is possible to bill third party payers including private insurance and Medicaid for exams conducted on children under the age of 16. In some situations and areas, such as sexual abuse exams conducted as part of a criminal investigation (or on children 16 and older), law enforcement may pay for the exam. The Alaska Violent Crimes Compensation Board is another potential resource for assisting with the costs of exams, diagnostic testing, and transportation to and from the CAC when other resources are not available.

Process for the Medical Evaluation

General Principles

Duplicative exams should be avoided whenever possible. If feasible, the child's exam should be conducted by someone with specialized training and experience in conducting medical evaluations for abuse and neglect. In addition, photo-documentation of exam findings allows for peer review and expert consultation, which also helps obviate the need for another exam.

All abuse exams should generally consist of a complete head-to-toe physical. Diagnostic testing (i.e., radiological and laboratory testing) is obtained and/or ordered by the medical provider as clinically indicated.

Every effort should be made to avoid duplicative interviewing. If the medical provider is unable to observe the child's forensic interview, then a summary of pertinent information should be provided prior to the exam. The medical provider will need to obtain a medical history, including chronic health conditions, prior injuries, surgeries or procedures (especially those that may affect interpretation of findings), medications, allergies, and relevant family medical history (such as bleeding disorders in a child with bruises, or warts in a child with possible HPV). Clarification questions about the abuse may also be necessary, such as asking the cause of a particular injury found on the child's body. Every effort should be made to ask non-leading questions, and any questions asked along with the child's responses should be noted in the medical report. Whenever possible, the child's exact words should be used and identified with quotation marks.

Consent

Ideally, there will be a non-offending legal guardian available to give consent for the child's medical exam. Alaska law does allow for the medical evaluation, x-rays and photographs to be taken of children for whom there is a concern for abuse without parental consent;[18] however parents should be notified as soon as reasonably possible, and the team should discuss how and when this will happen. In addition, Alaska law also allows adolescents to seek medical care related to sexually transmitted infections, pregnancy, and contraception without parental consent. In those instances where the medical evaluation is part of a criminal investigation, the health care provider should encourage the adolescent to talk to their parents and should coordinate with law enforcement concerning parental notification.

Exam Steps

The exam for child maltreatment is a comprehensive head-to-toe evaluation, including height, weight, and head circumference for children less than two years of age, and vital signs. The child's head, eyes, ears (including external ears, canals and ear drums), nose, mouth, neck, heart, lungs, abdomen, back, extremities, and buttocks should all be evaluated. All skin surfaces should be visualized, with careful attention to those areas which can easily be missed such as behind the ears. Oral frenula should be examined for evidence of trauma as well. A colposcope is ideal for examination of the anal-genital region; however, it may not always be available. Any source of magnification can be used if necessary, including an otoscope. Speculum exams are reserved for post-pubescent children. There are rare situations in which a medical need exists for internal visualization of the anal or vaginal canal beyond what can normally be seen with positioning and gentle external traction. Examples include the need for surgical repair or unexplained vaginal or anal bleeding. In this case, the medical provider will work with the local hospital to arrange an exam under sedation.

Diagnostic Testing

A complete description of diagnostic testing for child sexual and physical abuse is beyond the scope of this document. It is vitally important for health care providers to stay up to date with the literature on this topic, and to consult with more experienced providers as needed. Of note, however, is that Alaska has high rates of Chlamydia trachomatis and rising rates of gonorrhea. In addition, nucleic acid amplification testing (commonly called "PCR") for both of these infections can be obtained easily through a non-invasive, non-clean catch urine sample for pre-pubertal children and on the same sample as liquid cytology pap smear samples from adolescents – thus providers should have a low threshold to screen for at least these two infections on child sexual abuse cases where indicated by history or exam.

Exam Documentation

Photographic documentation of examination findings is the standard of care. Photo-documentation enables peer review, continuous quality improvement, and consultation. It may also prevent the need for a repeat examination. Photo-colposcopy is normally used for documentation of the anal-genital area; however, in the event a colposcope with camera is not available, a digital camera maybe used to document exam findings. Digital photo-documentation should be used for visible physical abuse or neglect findings.

Written documentation may involve dictated notes, forms or an electronic medical record if required by the hospital or clinic providing medical exam services for the CAC. The Children's Justice Act Task Force, in collaboration with the Alaska Children's Alliance, has developed standardized forms which may be used electronically and are currently used in a number of the CACs in the state.

Treatment

The medical provider works with other team members to develop an appropriate treatment plan for the child and family, which may include but is not limited to any of the following:

- Further diagnostic testing
- Follow-up exams and photos

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18 AS 25.20.025

- Prescriptions and medical treatment either ordered or administered at the CAC
- Follow-up care and referrals, including:
    - Counseling
    - Primary and/or specialty medical care

Provisions must also be made for evaluation, treatment and/or referral for medical conditions found at the time of the exam.

Sharing of Exam Findings with the Team

The CAC's written protocols should describe how medical exam findings will be shared with MDT members in a timely manner, and in what format. Remember that the duty to report suspected child abuse is a clear exception to HIPPA privacy requirements.[19]

Training Criteria for Medical Providers

Medical evaluations should be conducted by health care providers with specialized training and experience in child abuse. This can include physicians, nurse practitioners, physician assistants, and sexual assault nurse examiners with pediatric training and expertise. All medical providers should operate within the scope of their practice as outlined by their state license.

Acquisition of adequate training can be through any of the following:

- Board certification in Child Abuse Pediatrics
- Child Abuse Fellowship training or child abuse Certificate of Added Qualification
- Documentation of satisfactory completion of competency-based training in the performance of child abuse evaluations
- Documentation of completion of at least 16 hours of formal medical training in child sexual abuse evaluation (the absolute minimum as recommended by the National Children's Alliance)

Continuous Quality Improvement

The National Children's Alliance Medical Standard states that the CAC must provide opportunities for ongoing training and peer review. In Alaska, most medical providers will not be conducting hundreds of child abuse exams each year. Therefore, ongoing training and peer review as well as the ability to access expert opinions are critical to develop and maintain competency.

The National Children's Alliance Medical Standard recommends that ongoing education in the field of child sexual abuse should consist of a minimum of 3 hours of CEU/CME credits every 2 years. A number of viable options are open for Alaskan medical providers for training, including:

- The biennial Alaska Child Maltreatment Conference, organized by the Alaska Children's Alliance with sponsorship from the Alaska Children's Justice Act Task Force and Western Regional Child Advocacy Center
- The National Children's Alliance Medical Training Academy (basic and advanced), held at least twice yearly through a partnership with Midwest Regional Child Advocacy Center
- The San Diego International Conference on Child and Family Maltreatment, sponsored by the Chadwick Center for Children and Families, usually held in January each year (a nice break for we Alaskans!)
- The National Symposium on Child Abuse, sponsored by The National Children's Advocacy Center (the very first CAC) and held in Huntsville, Alabama, in March each year (also a nice break for Alaskans!)
- The American Professional Society on the Abuse of Children Annual Colloquium, held each summer in various locations

Membership in the American Professional Society on the Abuse of Children (APSAC) and the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) both include the benefit of their respective journals as well as access to their websites and resources.

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19 http://aappolicy.aappublications.org/cgi/reprint/pediatrics;125/1/197.pdf

All medical providers affiliated with Alaskan CACs have the opportunity to become members of the Alaska Children's Alliance (ACA) Medical Peer Review Group and participate in monthly peer review as well as access expert consultation. Further information may be obtained through the local CAC or from the chapter coordinator for the ACA.

Cultural Considerations Regarding Medical Evaluations for Child Abuse

Many of the same concerns arise here as were discussed in the Forensic Interview section regarding cultural considerations. In addition to those areas discussed, the child's cultural beliefs may require that the medical evaluation be conducted by a person from the same gender as the child. Children may have been taught not to speak to a person of the opposite gender regarding private parts or sexual issues.

The child's cultural practices and teachings about the privacy or lack of privacy about their own body can impact how the child tolerates and cooperates with the medical evaluation. The medical evaluator needs to ensure that this step does not cause further trauma to the child because of cultural beliefs and practices.

Victim Advocacy

Victim Support and Advocacy within a CAC[20]

Child victims and their non-offending family members have a constitutional right to be treated with dignity, respect and fairness throughout the criminal justice process.[21] Victim support and advocacy should reduce trauma for the child and non-offending family members and thus strengthen the victim's involvement in the investigation and prosecution, improving overall outcomes for child victims. Victim and non-offending caregiver support from the time of disclosure throughout the case and beyond sentencing is a necessary component in the MDT's response. By keeping the child and family informed and focusing on their needs during the investigation and justice process, the victim advocate empowers the child and family to focus on well-being and healing. Victim advocacy has also been proven to increase guilty verdicts in sexual abuse cases, suggesting that better prepared and relaxed child victims and witnesses are more credible.[22]

> "By keeping the child and family informed and focusing on their needs during the investigation and justice process, the victim advocate empowers the child and family to focus on well-being and healing."

At the CAC, more than one person may serve as victim advocate, and it is important that this role/function is defined clearly within the CAC/MDT's written documents as to how the needs will be met. Some CACs have staff (e.g. family advocates, care coordinators, victim advocates, and child life specialists) that handle advocacy functions, and some CACs have a cooperative arrangement with a local victim advocacy agency (e.g., domestic violence advocates, rape crisis counselors, Court Appointed Special Advocates), and/or system-based advocates (e.g., victim witness coordinators, law enforcement victim's advocates). Some CACs use more than one of these resources.

Procedures should be in place to provide initial and on-going support and advocacy for the child and non-offending caregiver. At a minimum, victim support and advocacy should include the following services:

- Providing crisis response and preparing child for interview, medical evaluation
- Supporting non-offending caregiver during investigation, forensic interview, medical evaluation
- Explaining legal process to caregiver and child
- Providing education to caregiver and extended family members regarding the impact of abuse, dynamics of child sexual abuse and ways to support child, promote healing
- Providing logistical support for child and non-offending family, including arranging transportation, assistance with appointments for services, etc.
- One-on-one preparation of child for testimony in court at age-level
- Conveying non-offending caregiver and child concerns and abilities to prosecutor and MDT members
- Explaining victim rights and helping child and/or caregiver to complete Victim Impact Statements
- Supporting child and non-offending caregiver during trial
- Serving as a resource and possible expert witness on dynamics of abuse, responses of children, child development and psycho-social needs of child victims
- Making referrals for services to child and/or non-offending family members

Cultural Considerations Regarding Victim Advocacy

The victim advocate will likely have the most contact with the child and caregiver following the initial investigation and thus is in the strongest position to identify cultural issues and needs that impact the child's and family's cooperation with the system. It is essential that the victim advocate diligently learn about the child's lifestyle and culture (in the broadest sense)

20 *Based on the Accreditation Standards of the National Children's Alliance, which all CACs in Alaska are required to strive to meet (see Appendix 2)*

21 *State of Alaska Constitution, Article I, Section 24*

22 *Child Victims and Witnesses: A Handbook for Criminal Justice Professionals, USDOJ 1998*

to identify values and practices that may offer support and healing strategies throughout the case. The victim advocate also advises other MDT members regarding these issues to promote continuity of response for the victim.

The victim advocate needs to be aware of the role that extended family and the child's "community" (whether a whole village or a neighborhood in the city) has in the child's life and educate/inform those in the child's environment about abuse dynamics as well as ways to support this child in her/his healing journey. This may involve working with cultural authority figures such as elders, spiritual leaders, shaman, priests, etc.

Communication and Information Sharing

State law requires OCS, as a general rule, to keep confidential information that it has obtained from a report of harm (Protective Services Report) and any investigation or services arising out of that report.[23] However, an exception to this general rule requires OCS to provide appropriate confidential information to members of the investigation MDT as necessary for the MDT member to perform the member's duties.[24] OCS may not share the reporter's name but may share the contents of the report with the MDT members.[25]

Other members of the MDT may also have confidentiality restrictions applicable to them; for example, physicians must follow the federal Health Insurance Portability and Accountability Act (HIPAA)[26]. However, HIPAA's general rule (that protected health information may not be released by a covered entity without the patient's consent or court order) does not apply during these parts of the initial response: (1) when child abuse or neglect is suspected, the medical provider is a mandatory reporter and may disclose a child's protected health information to OCS in the course of reporting the suspected child abuse or neglect and (2) during an investigation of the report, the medical provider may disclose protected health information about the child to OCS without parental notification or authorization.

HIPAA also allows disclosure of protected health information (1) to other health care professionals if necessary for treatment of the patient and (2) to law enforcement if (a) the information is necessary for immediate law enforcement or for a criminal investigation in which the investigation would be compromised if the information was not immediately provided and (b) the health care provider determines, using his/her best professional judgment, that the disclosure is in the best interest of the victim.[27]

Records and information collected by the MDT are not subject to discovery or subpoena in connection with a civil or criminal proceeding and not subject to public disclosure.[28]

Cultural Considerations Regarding Information Sharing

Confidentiality can be a challenge in small communities. It is common in rural Alaska communities for health care providers, public safety officers, service providers and ICWA workers to be related to many individuals in the village. Thus it is extremely important that procedures are in place for releasing and sharing information that will assure those closely related to the child or the suspect cannot access any information on the child's disclosure or other investigative information. Medical, social services and school records that might normally be released to the parent/caregiver should be kept in a separate, secure location in the village as well as the hub when child maltreatment is suspected.

23 *AS 47.10.093(a) and (f); 7 AAC 54.040(a)*
24 *AS 47.10.093(b)(7).*
25 *7 AAC 54.040(c)*
26 *45 CFR 160, 162, and 164*
27 *45 CFR 164.512*
28 *AS 47.14.300(d) & (f)*

SECTION THREE: CULTURE AND DIVERSITY CONSIDERATIONS IN CHILD ABUSE EVALUATIONS

Culture is one of the filters that people use to interpret life experiences. Culture is different from race or ethnicity. It is not based on the color of our skin but on our accumulative life experiences. Culture encompasses many different factors: language, family structure, socioeconomic status, gender and gender roles, moral and religious values, traditions, history, parenting practices, sexual attitudes, tolerance level for emotionalism, and individual vs. group orientation.[29] MDTs need to maintain vigilance on matters of culture in every case; it is not acceptable to apply one's own cultural values standards and beliefs in these cases, nor is it appropriate to presume that only people of color have "culture."

Diversity influences nearly every aspect of child maltreatment response in Alaska. The concept of diversity encompasses acceptance and respect, and includes an understanding that each individual is unique and recognition of our individual differences. These differences can be along the dimensions of culture, race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies. Practicing diversity is the exploration of these differences in a safe, positive, and nurturing environment. In the MDTs setting this means understanding each other and moving beyond simple tolerance to embracing and celebrating the rich dimensions of diversity contained within each individual.

"MDTs must be willing to become educated and competent in adjusting to the diverse world views in order to successfully investigate and prosecute in a respectful manner."

These considerations, along with developmental considerations, bring a variety of unique circumstances to most investigations. MDTs must be willing to become educated and competent in adjusting to the diverse world views in order to successfully investigate and prosecute in a respectful manner.

Addressing cultural differences and respecting diversity in the CAC and MDTs means that members should seek guidance from appropriate and knowledgeable sources when responding to child victims from an experience or context that is not familiar to the MDT member. The MDT must be deliberate and introspective during the initial investigation, including determining who will conduct the forensic interview and what questioning techniques will be used, and when drawing conclusions regarding the occurrence of abuse. Furthermore, whether the child is from a remote rural community or from a cultural context within an urban setting, the MDT must not make assumptions as to the history and comfort of the child with the response system, but rather must diligently assess the child's context and history.

Language – both verbal and non-verbal – has many interpretations. A child may live in dominant society, attend school and speak English fluently yet still be more comfortable within their own cultural context and communication norms. Research indicates that members of different cultural groups may respond differently to children's disclosure of sexual abuse.[30] A child's cultural background may also impact the child's appraisal of the abusive experiences (e.g., level of self-blame) and the level of social support that the child may receive. In addition, the way emotions may or may not be expressed is also related to culture and ethnicity. In the investigative process, the interviewer should explore:

- family structure (e.g., extended, nuclear, single),
- gender role expectations, child care practices,
- financial management of the household,
- community/country of origin and reasons for immigration or transfer to urban areas (if Alaska Native),
- any contact with family in the village/country of origin,
- religious belief systems, social networks, and
- attitudes about sexual violence.

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29 *New York State Children's Justice Task Force "Forensic Interviewing Best Practices", 2003*

30 *Feiring, C., Coates, D.L., & Taska, L.S. (2001). Ethnic status, stigmatization, support and symptom development following sexual abuse. J. of Interpersonal Violence 16:1307-1329.*

Advocacy for children must naturally begin where the child is physically, emotionally and developmentally, and thus be accountable for creating comfort and safety for the child while they are dealing with the system, drawing on the strengths and familiarity of the child's own cultural environment. It is incumbent on the victim advocate to adapt their advocacy skills and exercise creativity in addressing the child/family needs, providing support that will enable the child to cooperate with the investigation and prosecution.

SECTION FOUR: FOLLOW-UP ROLES AND RESPONSIBILITIES

MDT Follow-Up Roles and Responsibilities

After the initial response outlined in Section Two, representatives from the following disciplines are typically part of the ongoing MDT that meet for the purpose of case review and follow up.

Role of the Office of Children's Services (OCS)

If the initial assessment of alleged child maltreatment determines that further OCS action is warranted, such action may include:

- Case management of on-going family cases
- Facilitation of services for prevention of removal
- Facilitation of reunification services to families with children in out-of-home placement
- Permanency planning services up to and including adoption and guardianship

Regardless of OCS involvement in a case, an OCS representative continues to be a member of the MDT and provides expertise and input when cases are brought before the MDT.

Role of Law Enforcement

The law enforcement agency may be involved with additional investigation tasks at the direction of the prosecutor and/or if a child makes additional disclosures or provides more detailed information after the case has been accepted for prosecution. The investigating officer will also be called upon to testify at Grand Jury and at the trial.

Role of the Child Advocacy Center

As part of their follow up role, the CAC staff provides:

- Follow-up support and case management services
- Referrals for other services within the child's community
- Maintenance of statistical case information including case disposition tracking
- Assist with scheduling and creating and providing an agenda for MDT case review meetings

Role of State of Alaska Department of Law – District Attorney's Office (DAO)

The DAO may become involved in the investigation of any possible criminal case. After an investigation is complete, the DAO determines whether or not the case can be proven beyond a reasonable doubt. If the determination is to proceed with prosecution, the DAO is responsible for filing criminal charges and moving the case through the formal legal system. The goal is to prosecute all provable cases. The final authority concerning prosecution rests with the DAO.

In addition, a DAO representative is usually a member of the MDT and provides expertise and input when cases are brought before the MDT.

Role of State of Alaska Department of Law – Attorney General's Office (AGO)

The AGO may become involved in the assessment of possible child abuse or neglect. If the decision is made to file a child-in-need-of-aid petition, the AGO responsibilities include:

- Providing legal advice and representation to the Office of Children's Services in civil child protection proceedings
- Working with OCS and other team members to hold offenders accountable in the civil justice system and provide protection for the child

In addition, an AGO representative is usually a member of the MDT and provides expertise and input when cases are brought before the MDT.

Role of Medical Provider

As part of their follow-up role, the medical provider:

- Ensures medical test results are communicated to the patient/family/caregiver and (as appropriate) MDT members
- Provides treatment as indicated
- Provides expert testimony as needed
- Provides education and training for other MDT members
- Participates in the Multidisciplinary Team
- Networks with child abuse groups and organizations

For further information, see specific section on Medical Evaluation.

Role of Victim Advocate

As part of their follow-up role, the victim advocate may assist with some or all of the following tasks:

- One-on-one preparation of child for testimony in court at age-level
- Helping child and/or caregiver to complete Victim Impact Statements
- Support for child and non-offending caregiver during trial
- Serving as a resource and possible expert witness on dynamics of abuse, responses of children, child development and psycho-social needs of child victims

For further information, see specific section on Victim Advocacy.

Role of Mental Health Provider

As part of their follow-up role, the mental health provider:

- Provides treatment planning that identifies and incorporates patient clinical problems
- Facilitates groups and individual treatment sessions
- Continuously monitors patient progress in treatment and outcomes as a result of interventions
- Makes ongoing assessment of patient mental health status and assist in crisis management
- Documents a thorough assessment, including mental status exam, interventions and activities related to the patient's plan of care
- Provides expert witness testimony as needed
- Participates in the MDT

Role of Tribes and Tribal Organizations

When a child is eligible for Tribal programs and services from a Tribal organization, the Tribe or Tribal organization may assist with some or all of the following tasks:

- Provide supplemental face-to-face support/liaison function when the victim advocate, prosecutor and law enforcement agencies are located elsewhere
- Assist agencies in making contact with the child and family residing in the village
- Provide follow-up medical monitoring and treatment
- Assist victim advocate with obtaining pertinent Victim Impact Statements
- Provide cultural and language interpreter
- Provide community and family dynamics updates for prosecutor in preparation for trial
- Support for child and non-offending caregiver during trial
- Serving as a resource and possible expert witness on cultural issues including cultural norms and consequences, cultural needs of child victims

Role of Guardian Ad Litem (GAL)

The GAL represents the best interest of the child in a CINA proceeding in those cases where OCS has taken legal custody of a child. The GAL determines and advocates for the best interest of the child given the child's situation, taking into account the child's age, maturity, culture, and ethnicity, and public laws and policies regarding family preservation and timely permanency planning. The GAL's responsibilities are to:

- Conduct ongoing independent investigations, including as reasonable and appropriate in person visits with the child, review of records, interviews with parents, social workers, teachers, and other persons as necessary to assess the child's situation and observations of the child's interactions with parents or other potential caregivers
- Consult professionals as necessary to determine the best interest of the child
- Monitor the provision and utilization of family support services
- Monitor services to the child provided by educational, medical, mental health, and other community systems and ensure these services are promoting the best interest of the child
- Explain the court proceedings, the role of a GAL, and the child's rights to the child when appropriate, in language and terms the child can understand; encourage older children to attend and participate in court hearings as appropriate and determine whether and under what conditions younger children should attend court hearings
- Determine whether to seek appointment of a GAL or attorney in related legal proceedings
- Determine whether to call the child as a witness or determine appropriate action if others seek the child's testimony, and familiarize the child with the process of testifying

Other individuals with specific expertise or knowledge may participate in the ongoing MDT according to local protocols or the needs of the specific case.

Role of State of Alaska Division of Juvenile Justice (DJJ)

DJJ is responsible for both reporting child abuse and neglect of its clients and for prosecution of juveniles who have allegedly committed offenses that would be crimes if committed by an adult, including sexual abuse offenses. DJJ will review sexual abuse offenses committed by juveniles to determine whether there is sufficient admissible evidence to support a formal adjudication. DJJ will also consider the minor's age, maturity level, emotional and intellectual capacity, family circumstances, and prior personal victimization, among other factors, to determine whether formal or informal action should be taken. The goals of DJJ are to hold these juveniles accountable for their behavior, provide for their victims, and assist the juveniles and their family to gain skills to prevent further offenses.

DJJ will also provide information to the MDT to assist in the investigation of child abuse and neglect cases.

Unique Challenges for Mental Health Service Provision in Alaska

Mental health services may be provided on site at CACs or through collaboration with community mental health providers; however, many challenges face Alaska in delivering these services. With a lack of resources along with the difficulties in recruiting, retraining and retaining qualified mental health personnel, many rural areas have no local mental health services other than the occasional itinerant provider. And of those rural areas that do have mental health services, many personnel are serving on a part-time basis, making it difficult to provide consistent and recommended follow-up services. A qualified workforce is needed to meet the needs of these children and families. Greater travel distance to outpatient services is common in rural settings and is associated with fewer mental health follow-up visits by patients as well as a lesser likelihood of receiving care in accordance with mental health services prescribed through an initial assessment.

Cultural Considerations Regarding Mental Health Evaluation and Treatment

Any mental health evaluation should include consideration of the child's cultural context and diversity factors within the family and community. Standard Western evaluation methods may not be comprehensive enough to encompass the strengths of the child's culture or the depth of impacts from historical trauma on the family and community. During the early contacts with the child and caregiver, mental health providers should identify culture and diversity dynamics and tailor treatment recommendations and plans to assure effective and appropriate services are offered. It is essential that mental health service providers diligently learn about the child's lifestyle and culture (in the broadest sense) to identify values and practices that may offer support and healing strategies throughout the case. The mental health provider also advises other MDT members regarding these issues to promote continuity of response for the child.

The mental health provider may not have a service role if the child and family are not willing. However, the mental health provider should also assist in educating and informing those in the child's environment about abuse dynamics as well as ways to support this child in her/his healing journey. This may involve working with cultural authority figures such as elders, spiritual leaders, shaman, priests, etc.

Records Handling and Storage

Protection & maintenance of records

Each CAC should develop policies and procedures for what records will be kept on site and how to maintain the confidentiality of those records. Confidentiality policies and procedures for the multidisciplinary team should be in place to insure client privacy while allowing for the sharing of relevant information consistent with legal, ethical, and professional standards of practice as determined by AS 47.14.300.

MDT protocols should also establish guidelines for how and when records may be released. Medical records are subject to HIPAA guidelines; however, federal and state law do allow for information sharing as part of the investigation for suspected child abuse. The child's parent or legal guardian normally has the right to a copy of the child's medical record; an exception is made if sharing that information may pose risk to the child.[31] Examples include cases where a parent is the alleged offender, or a non-offending parent is non-protective and likely to share the information with the offender. When medical exams are performed at the local hospital facility, requests for such records should be referred to the hospital. If concerns are present about releasing such records to the parent, this information should be shared with the hospital.

Requests for a copy of the forensic interview tape (or viewing of the tape) should be referred to the agency with primary responsibility for the investigation (OCS or law enforcement).

Mental health records, even if the mental health services are provided at the CAC, should be kept in a separate confidential file which is not released except with court order.

It is essential that each MDT discuss and develop protocols to address issues such as:

- Ownership of information stored at the CAC
- Control and release of records stored at the CAC
- Data custody

The following statutes should be considered:
AS 40.25.120(a)(2) (Public records exception for juveniles)
AS 47.10.093 (OCS records)
AS 47.12.310 (Division of Juvenile Justice records)
AS 47.14.300(d) & (f) (MDT records)
AS 47.17.040(b) (OCS investigation records)
7 AAC 54.020 – 7 AAC 54.150 (OCS records)
45 CFR 160 and 164 (HIPAA regulations)
AS 18.66.200 (protection of disclosure of communications in certain situations)

Protection of evidence

Evidence collected at a CAC as part of a child abuse investigation may include the recording of the child's forensic interview; a copy of exam photos; a copy of the forensic medical report; and forensic evidence collected from the child's body. Such documentation and collection/preservation of evidence should be conducted according to CAC and MDT policies and procedures, as well as current Alaska Sexual Assault Evidence Collection Kit guidelines. A Chain of Custody[32] should be followed for all evidence gathered as part of a Sexual Assault Evidence Collection kit. In addition, it is recommended that a Chain of Custody be used for copies of exam photographs and forensic medical reports. The CAC should have a secure locked location for forensic evidence to be stored if law enforcement is not immediately available to take possession of the evidence.

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31 *45 CFR 164.502(G)(5)*

32 *Chronological documentation that ensures the physical security of samples, data and records in a criminal investigation from identification and collection through presentation to the court*

SECTION FIVE: RESOURCES FOR MDTS

This is a list of helpful resources for MDTs; some were also used in the development of this document.

General MDT

- *The APSAC Handbook on Child Maltreatment, Third Edition* -- Edited by John E. B. Myers, available at http://www.apsac.org/mc/page.do?sitePageId=54511
- *Child Abuse and Neglect User Manuals* – available at http://www.childwelfare.gov/pubs/umnew.cfm
- *Child Abuse Protocol Development Guide* – available at http://www.tribal-institute.org/download/Completed%20Protocol%20Guide%202003.pdf
- *Resource Guide For Parents, Caregivers and Service Providers Working With Alaska Native Children* – available at http://www.providence.org/resources/alaska/tchap/ak_cares.pdf
- *State of New Hampshire Attorney General's Task Force on Child Abuse and Neglect Protocols 3rd Edition 2008* – available at http://doj.nh.gov/victim/documents/lawenforcement.pdf

Forensic Interviewing of Children

- *Basic Guidelines for Forensic Interviewers in Child Sexual Abuse Cases in Indian Country and Alaska Native Communities* – available at http://www.tribal-institute.org/download/Guidelines%20for%20the%20Forensic%20Interview.pdf
- *The Forensic Interviewer at Trial: Guidelines for the Admission and Scope of Expert Witness Testimony Concerning an Investigative Interview in a Case of Child Abuse* – – available at http://www.wmitchell.edu/lawreview/documents/8.Veith.pdf
- *In The Shadow of Defense Counsel: Conducting Peer Reviews of Forensic Interviews in an Age of Discovery* – available at http://www.ncptc.org/vertical/Sites/{8634A6E1-FAD2-4381-9C0D-5DC7E93C9410}/uploads/{5C3E2603-E1FB-4EB1-8369-E5549FE62EFA}.PDF
- *New York State Children's Justice Task Force FORENSIC INTERVIEWING BEST PRACTICES*—available on request at http://www.nyscarcc.org/index.php

Investigation

- Crime Scene Investigations http://www.crime-scene-investigator.net
- *Portable Guides to Investigating Child Abuse* – available at http://ojjdp.ncjrs.gov/publications/PubResults.asp
- *Severe Child Injury Investigation and Review* – available at http://ican-ncfr.org/hmSevereInjuryReview.asp

Medical Evaluation for Child Abuse

- American Academy of Pediatrics policy statements and clinical guidelines – search by topic at http://aappolicy.aappublications.org/
- Child Abuse and Children with Disabilities http://childabuse.tc.columbia.edu/
- Child Abuse Evaluation and Treatment for Medical Providers – http://childabusemd.com/
- *Tips for Non-Native Medical Providers Working in Alaska Native Communities* – available at http://www.tribal-institute.org/download/Working_Native_Communities_03.pdf

Victim Advocacy

- Alaska Violent Crimes Compensation Board http://www.state.ak.us/admin/vccb/
- National Court Appointed Special Advocates (CASA) http://www.nationalcasa.org
- Office of Victims of Crime http://www.ojp.usdoj.gov/ovc

Mental Health

- *Child Physical and Sexual Abuse: Guidelines for Treatment* – available at http://academicdepartments.musc.edu/ncvc/resources_prof/ovc_guidelines04-26-04.pdf
- Indian Country Child Trauma Center Native -- specific treatment models for trauma, children with sexual behavior problems, and parent-child interaction therapy www.icctc.org
- National Child Traumatic Stress Network http://www.nctsn.org
- Sidran Traumatic Stress Foundation -- Provides education, training, research and information about abuse and healing www.sidran.org

- Trauma Information Page -- Treatment resources (free) and research www.trauma-pages.com

Legal

- The American Bar Association (ABA) Center on Children and the Law http://www.abanet.org/child/home.html
- National Association of Counsel for Children http://naccchildlaw.org
- National District Attorney Association http://www.ndaa.org/
- *THE IMPACT OF HIPAA ON CHILD ABUSE AND NEGLECT CASES* – available at http://www.pcsao.org/HIPAA/HIPAAChildAbuse.pdf

Other Website Resources

- Adverse Childhood Experiences studies http://www.cdc.gov/nccdphp/ace/
- American Humane Association http://www.americanhumane.org
- American Professional Society on the Abuse of Children www.apsac.org
- Bureau of Indian Affairs Alaska http://www.bia.gov/WhoWeAre/RegionalOffices/Alaska/index.htm
- Childabuse.com -- This site's mission is to provide information and raise awareness about child abuse http://www.childabuse.com
- ChildHelp USA www.childhelpusa.org
- Child Welfare Information Gateway -- A national resource for information on child abuse, neglect and welfare http://www.childwelfare.gov
- Child Welfare League of America http://cwla.org/
- International Society for Prevention of Child Abuse and Neglect http://ispcan.org/
- National Children's Alliance (NCA) http://www.nca-online.org/pages/page.asp?page_id=4028
- National Center for Missing and Exploited Children http://www.missingkids.com
- National Center on Shaken Baby Syndrome http://www.dontshake.org
- National Data Archive on Child Abuse and Neglect http://www.ndacan.cornell.edu
- Office for Victims of Crime
- Office of Justice Programs U.S. Department of Justice http://www.ojp.usdoj.gov/ovc/welcome.html
- Office of Children's Services Program statements & Practice model links -- http://www.hss.state.ak.us/ocs/
- Shaken Baby Alliance http://www.shakenbaby.com
- Tribal Law & Policy Institute www.tlpi.org

FOR ADDITIONAL RESOURCES AND UPDATES, PLEASE VISIT OUR WEBSITE AT

http://hss.state.ak.us/ocs/ChildrensJustice/

APPENDIX 1

Pertinent Statutes

Note: The following statutes are current at the time of publication. To verify the most recent version of statutes relevant to child abuse, please visit the following website: http://www.legis.state.ak.us/basis/folio.asp

Alaska Criminal Laws Relating to Child Sexual and Physical Abuse

Sexual offenses:

Sexual Abuse of a Minor: (AS 11.41.434, 11.41.436, 11.41.438, and 11.41.440) Sexual contact or penetration (putting something into the vagina, rectum or any genital-mouth contact) between a minor and an adult, a person in a position of authority, someone who is at least 4 years older than the child or by another child if that child was forced or coerced into the sexual activity by someone 16 or older. Depending upon the actions, this can be an unclassified felony, a class B felony, a class C felony, or a class A misdemeanor.

Incest: (AS 11.41.450) When a biological relative of full or half blood, puts something into the vagina or rectum of a child. Incest is a class C felony.

Online enticement of a minor: (AS. 11.41.452) using a computer to communicate with a person who is (or who is believed to be) under 16 to entice, solicit, or encourage the person to engage in an act described in AS 11.41.455(a)(1) - (7) This is a class B or class C felony, depending on whether the defendant was required to register as a sex offender or child kidnapper.

Unlawful Exploitation of a Minor: (AS 11.41.455) using a person under the age of 18 in books, stories, videos, or pictures about sex. This is a class B felony or a class A felony for repeat offenders.

Indecent Exposure: (AS 11.41.458, AS 11.41.460) showing one's penis or vagina to another person on purpose. This is a class B misdemeanor if the victim is over 16, a class A misdemeanor if the victim is under 16 and a class C felony if the victim is under 16 and the person is a repeat offender or masturbates during the exposure.

Disorderly Conduct: (AS 11.61.110(7)) showing one's buttock or anus to another person.

Sexual Harassment: (AS 11.61.120) making rude or sexual gestures, pulling another person's clothing down, up, or off to expose their private parts, making sexual jokes that are offensive, making obscene phone calls.

Endangering the Welfare of a Child: (AS 11.51.100(a)(2)) a parent, guardian, or lawful custodian leaving a child under the age of 16 with another person, who is *not a parent, guardian, or lawful custodian*, knowing that the person is either (1) a registered sex offender or required to be registered in this state or another jurisdiction; (2) has been charged with a sex offense; or (3) has been charged with an attempt, solicitation, or conspiracy to commit a sex offence." This is a class C felony.

Indecent viewing or photography: (11.61.123) knowingly viewing, or producing a picture of the private exposure of the genitals, anus, or female breast of a child under 16 and the view or production is without the knowledge or consent of the parent or guardian of the child viewed or shown in the picture and without the knowledge or consent of the child, if that child is at least 13 years of age.

Distribution of child pornography: (AS 11.61.125) bringing or causing to be brought into the state for distribution, or in the state distributing, or in the state possessing, preparing, publishing, or printing with intent to distribute, any material that visually or aurally depicts conduct described in AS 11.41.455(a), knowing that the production of the material involved the use of a child under 18 years of age who engaged in the conduct. This is a class B felony or a class A felony for repeat offenders.

Electronic distribution of indecent material to minors: (AS 11.61.128) an adult knowingly distributing to a child under 16 by computer any material that depicts certain sexual conduct, whether actual or simulated. This is a class B or class C felony, depending on whether the defendant was required to register as a sex offender or child kidnapper.

Promoting prostitution in the first degree: (AS 11.66.110(a)(2) inducing or causing a person under 18 years of age to engage in prostitution. This is an unclassified felony.

Physical offenses:

Assault: (AS 11.41.200, 11.41.210, 11.41.220 11.41.230) causing physical injury to another. Depending upon the actions or harm caused, this can be a class A felony, a class B felony, a class C felony, or a class A misdemeanor. Also, it is a class C felony If the offender (a) recklessly causes physical injury to a child under 10 and the injury would (1) cause a reasonable caregiver to seek medical attention from a health care professional in the form of diagnosis or treatment or (2) if the offender has done this repeatedly or (b) knowingly causes physical injury to a child under 16 years of age but at least 10 years of age and the injury reasonably requires medical treatment;

Endangering the Welfare of a Child: (AS 11.51.100(a)(3)) for a parent, guardian, or lawful custodian of a child under the age of 16 to leave the child with another person knowing the other person has *previously* physically mistreated or had sexual contact with *any* child *and* the other person causes physical injury or has sexual contact with the present child. "Physically mistreated" includes unreasonably excessive discipline. This is a class C felony or a class A misdemeanor, depending on the injuries to the child.

Alaska Civil Law Regarding MDT Roles and Responsibilities

AS 47.14.300. Multidisciplinary child protection teams.

(a) The department shall create multidisciplinary child protection teams to assist in the evaluation and investigation of reports made under AS 47.17 and to provide consultation and coordination for agencies involved in child protection cases under AS 47.10.

(b) A team created under (a) of this section may invite other persons to serve on the team who have knowledge of and experience in child abuse and neglect matters. These persons may include

(1) mental and physical health practitioners licensed under AS 08;

(2) child development specialists;

(3) educators;

(4) peace officers as defined in AS 11.81.900;

(5) victim counselors as defined in AS 18.66.250;

(6) experts in the assessment and treatment of substance abuse;

(7) representatives of the district attorney's office and the attorney general's office;

(8) persons familiar with 25 U.S.C. 1901 - 1963 (Indian Child Welfare Act);

(9) guardians ad litem; and

(10) staff members of a child advocacy center if a center is located in the relevant area.

(c) A team created under (a) and (b) of this section shall review records on a case referred to the team by the department. The department shall make available to the team its records on the case and other records compiled for planning on the case by other agencies at the request of the department. The team may make recommendations to the department on appropriate planning for the case.

(d) Except for a public report issued by a team that does not contain confidential information, records or other information collected by the team or a member of the team related to duties under this section are confidential and not subject to public disclosure under AS 40.25.100 and 40.25.110.

(e) Meetings of a team are closed to the public and are not subject to the provisions of AS 44.62.310 and 44.62.312.

(f) The determinations, conclusions, and recommendations of a team or its members are not admissible in a civil or criminal proceeding. A member may not be compelled to disclose a determination, conclusion, recommendation, discussion, or thought process through discovery or testimony in a civil or criminal proceeding. Records and information collected by the team are not subject to discovery or subpoena in connection with a civil or criminal proceeding.

(g) Notwithstanding (f) of this section, an employee of the department may testify in a civil or criminal proceeding concerning cases reviewed by a team even though the department's records were reviewed by a team and formed the basis of that employee's testimony and the team's report.

(h) A person who serves on a multidisciplinary child protection team is not liable for damage or other relief in an action brought by the reason of the performance of a duty, a function, or an activity of the team.

(i) In this section, "team" means a multidisciplinary child protection team created under (a) and (b) of this section.

Alaska Civil Law Regarding Child Advocacy Centers and Forensic Interviewing of Children
AS 47.17.033 Investigations and interviews.
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(c) An investigation by the department of child abuse or neglect reported under this chapter shall be conducted by a person trained to conduct a child abuse and neglect investigation and without subjecting a child to more than one interview about the abuse or neglect except when new information is obtained that requires further information from the child.

(d) An interview of a child conducted as a result of a report of harm may be audiotaped or videotaped. If an interview of a child concerns a report of sexual abuse of the child by a parent or caretaker of the child, the interview shall be videotaped, unless videotaping the interview is not feasible or will, in the opinion of the investigating agency, result in trauma to the child.

(e) An interview of a child that is audiotaped or videotaped under (d) of this section shall be conducted

(1) by a person trained and competent to conduct the interview;

(2) if available, at a child advocacy center; and

(3) by a person who is a party to a memorandum of understanding with the department to conduct the interview or who is employed by an agency that is authorized to conduct investigations.

(f) An interview of a child may not be videotaped more than one time unless the interviewer or the investigating agency determines that one or more additional interviews are necessary to complete an investigation. If additional interviews are necessary, the additional interviews shall be conducted, to the extent possible, by the same interviewer who conducted the initial interview of the child.

(g) A recorded interview of a child shall be preserved in the manner and for a period provided by law for maintaining evidence and records of a public agency.

(h) A recorded interview of a child is subject to disclosure under the applicable court rules for discovery in a civil or criminal case.

(i) The training required under (c) of this section must address the constitutional and statutory rights of children and families that apply throughout the investigation and department intervention. The training must inform department representatives of the applicable legal duties to protect the rights and safety of a child and the child's family.

(j) During a joint investigation by the department and a law enforcement agency, the department shall coordinate an investigation of child abuse or neglect with the law enforcement agency to ensure that the possibility of a criminal charge is not compromised.

(k) Unless a law enforcement official prohibits or restricts notification under (j) of this section, at the time of initial contact with a person alleged to have committed child abuse or neglect, the department shall notify the person of the specific complaint or allegation made against the person, except that the identity of the complainant may not be revealed.

(l) In this section, "child advocacy center" means a facility operated with a child-focused, community partnership committed to a multidisciplinary team approach that includes representatives from law enforcement, child protection, criminal prosecution, victim advocacy, and the medical and mental health fields who collaborate and assist in investigating allegations of sexual or other abuse and neglect of children.

Alaska Civil Laws regarding disclosure of public records
AS 40.25.120. Public records; exceptions; certified copies.
(a) Every person has a right to inspect a public record in the state, including public records in recorders' offices, except

(1) records of vital statistics and adoption proceedings, which shall be treated in the manner required by AS 18.50;

(2) records pertaining to juveniles unless disclosure is authorized by law;

(3) medical and related public health records;

(4) records required to be kept confidential by a federal law or regulation or by state law;

(5) to the extent the records are required to be kept confidential under 20 U.S.C. 1232g and the regulations adopted under 20 U.S.C. 1232g in order to secure or retain federal assistance;

(6) records or information compiled for law enforcement purposes, but only to the extent that the production of the law enforcement records or information

(A) could reasonably be expected to interfere with enforcement proceedings;

(B) would deprive a person of a right to a fair trial or an impartial adjudication;

(C) could reasonably be expected to constitute an unwarranted invasion of the personal privacy of a suspect, defendant, victim, or witness;

(D) could reasonably be expected to disclose the identity of a confidential source;

(E) would disclose confidential techniques and procedures for law enforcement investigations or prosecutions;

(F) would disclose guidelines for law enforcement investigations or prosecutions if the disclosure could reasonably be expected to risk circumvention of the law; or

(G) could reasonably be expected to endanger the life or physical safety of an individual;

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AS 47.10.093. Disclosure of [OCS] records.

(b) A state or municipal agency or employee shall disclose appropriate confidential information regarding a case to ***

(7) a member of a multidisciplinary child protection team created under AS 47.14.300 as necessary for the performance of the member's duties;

(f) The department may release to a person with a legitimate interest confidential information relating to children not subject to the jurisdiction of the court under AS 47.10.010 .

AS 47.17.040. Central registry; confidentiality.

(a) The department shall maintain a central registry of all investigation reports but not of the reports of harm.

(b) Investigation reports and reports of harm filed under this chapter are considered confidential and are not subject to public inspection and copying under AS 40.25.110 and 40.25.120. However, in accordance with department regulations, investigation reports may be used by appropriate governmental agencies with child-protection functions, inside and outside the state, in connection with investigations or judicial proceedings involving child abuse, neglect, or custody. A person, not acting in accordance with department regulations, who with criminal negligence makes public information contained in confidential reports is guilty of a class B misdemeanor.

7 AAC 54.040. Release of child protection information to persons with legitimate interests

(a) The department has exclusive control and custody of the child protection information collected by the department. Any request for disclosure of child protection information not covered by this chapter, or requiring a special determination, must be sent to the central office of the unit of the department that handles child protection services programs.

(b) Protected health information contained in child protection files may only be released under this section to a public health authority.

(c) The department may release child protection information, on a form provided by the department, concerning a minor child that is not subject to the jurisdiction of a court under AS 47.10.010 , to a person with legitimate interest if the department has reason to believe that the release of the information will prevent physical harm to the child. The information that may be released under this subsection includes reports of harm under AS 47.17 without the name of the person making the report, the results of investigations on those reports of harm, information on protective services reports, and additional child protection information.

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(f) A person with sufficient legitimate interest who receives child protection information from the department shall safeguard the information.

Alaska Statutes Regarding Mandatory Reporting

AS 47.17.020. Persons required to report.

(a) The following persons who, in the performance of their occupational duties, or with respect to (8) of this subsection, in the performance of their appointed duties, have reasonable cause to suspect that a child has suffered harm as a result of child abuse or neglect shall immediately report the harm to the nearest office of the department:

(1) practitioners of the healing arts;

(2) school teachers and school administrative staff members of public and private schools;

(3) peace officers and officers of the Department of Corrections;

(4) administrative officers of institutions;

(5) child care providers;

(6) paid employees of domestic violence and sexual assault programs, and crisis intervention and prevention programs as defined in AS 18.66.990;

(7) paid employees of an organization that provides counseling or treatment to individuals seeking to control their use of drugs or alcohol;

(8) members of a child fatality review team established under AS 12.65.015(e) or 12.65.120 or the multidisciplinary child protection team created under AS 47.14.300 .

(b) This section does not prohibit the named persons from reporting cases that have come to their attention in their nonoccupational capacities, nor does it prohibit any other person from reporting a child's harm that the person has reasonable cause to suspect is a result of child abuse or neglect. These reports shall be made to the nearest office of the department.

(c) If the person making a report of harm under this section cannot reasonably contact the nearest office of the department and immediate action is necessary for the well-being of the child, the person shall make the report to a peace officer. The peace officer shall immediately take action to protect the child and shall, at the earliest opportunity, notify the nearest office of the department.

(d) This section does not require a religious healing practitioner to report as neglect of a child the failure to provide medical attention to the child if the child is provided treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by an accredited practitioner of the church or denomination.

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(g) A person required to report child abuse or neglect under (a) of this section who makes the report to the person's job supervisor or to another individual working for the entity that employs the person is not relieved of the obligation to make the report to the department as required under (a) of this section.

(h) This section does not require a person required to report child abuse or neglect under (a)(6) of this section to report mental injury to a child as a result of exposure to domestic violence so long as the person has reasonable cause to believe that the child is in safe and appropriate care and not presently in danger of mental injury as a result of exposure to domestic violence.

(i) This section does not require a person required to report child abuse or neglect under (a)(7) of this section to report the resumption of use of an intoxicant as described in AS 47.10.011(10) so long as the person does not have reasonable cause to suspect that a child has suffered harm as a result of the resumption.

Alaska Statutes Regarding Medical and Mental Health Evaluations for Child Abuse

AS 25.20.025. Examination and treatment of minors.

(a) Except as prohibited under AS 18.16.010(a)(3),

(1) a minor who is living apart from the minor's parents or legal guardian and who is managing the minor's own financial affairs, regardless of the source or extent of income, may give consent for medical and dental services for the minor;

(2) a minor may give consent for medical and dental services if the parent or legal guardian of the minor cannot be contacted or, if contacted, is unwilling either to grant or withhold consent; however, where the parent or legal guardian cannot be contacted or, if contacted, is unwilling either to grant or to withhold consent, the provider of medical or dental services shall counsel the minor keeping in mind not only the valid interests of the minor but also the valid interests of the parent or guardian and the family unit as best the provider presumes them;

(3) a minor who is the parent of a child may give consent to medical and dental services for the minor or the child;

(4) a minor may give consent for diagnosis, prevention or treatment of pregnancy, and for diagnosis and treatment of venereal disease;

(5) the parent or guardian of the minor is relieved of all financial obligation to the provider of the service under this section.

(b) The consent of a minor who represents that the minor may give consent under this section is considered valid if the person rendering the medical or dental service relied in good faith upon the representations of the minor.

c) Nothing in this section may be construed to remove liability of the person performing the examination or treatment for failure to meet the standards of care common throughout the health professions in the state or for intentional misconduct.

HIPAA Guidelines Regarding Child Abuse and Neglect Reports

Code of Federal Regulations, Title 45, Parts 160 & 164

§ 160.203 General rule and exceptions.

A standard, requirement, or implementation specification adopted under this subchapter that is contrary to a provision of State law preempts the provision of State law. This general rule applies, except if one or more of the following conditions is met:

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(c) The provision of State law, including State procedures established under such law, as applicable, provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation, or intervention.

§ 164.502 Uses and disclosures of protected health information: general rules.

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(g)

(5) ***Implementation specification:*** Abuse, neglect, endangerment situations. Notwithstanding a State law or any requirement of this paragraph to the contrary, a covered entity may elect not to treat a person as the personal representative of an individual if:

(i) The covered entity has a reasonable belief that:

(A) The individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or

(B) Treating such person as the personal representative could endanger the individual; and

(ii) The covered entity, in the exercise of professional judgment, decides that it is not in the best interest of the individual to treat the person as the individual's personal representative.

§ 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required.

A covered entity may use or disclose protected health information without the written authorization of the individual, as described in Sec. 164.508, or the opportunity for the individual to agree or object as described in Sec. 164.510, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity's information and the individual's agreement may be given orally.

(a) ***Standard: Uses and disclosures required by law.***

(1) A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

(2) A covered entity must meet the requirements described in paragraph (c), (e), or (f) of this section for uses or disclosures required by law.

(b) ***Standard: uses and disclosures for public health activities***

(1) Permitted disclosures. A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to:

(i) A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority;

(ii) A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

(c) ***Standard: Disclosures about victims of abuse, neglect or domestic violence***

(1) ***Permitted disclosures.*** Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a

social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

(i) To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law;

(ii) If the individual agrees to the disclosure; or

(iii) To the extent the disclosure is expressly authorized by statute or regulation and:

(A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or

(B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

(2) ***Informing the individual.*** A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

(d) ***Standard: Uses and disclosures for health oversight activities***

(1) ***Permitted disclosures.*** A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

(i) The health care system;

(ii) Government benefit programs for which health information is relevant to beneficiary eligibility;

(iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or

(iv) Entities subject to civil rights laws for which health information is necessary for determining compliance.

(2) ***Exception to health oversight activities.*** For the purpose of the disclosures permitted by paragraph (d)(1) of this section, a health oversight activity does not include an investigation or other activity in which the individual is the subject of the investigation or activity and such investigation or other activity does not arise out of and is not directly related to:

(i) The receipt of health care;

(ii) A claim for public benefits related to health; or

(iii) Qualification for, or receipt of, public benefits or services when a patient's health is integral to the claim for public benefits or services.

(3) ***Joint activities or investigations.*** Notwithstanding paragraph (d)(2) of this section, if a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation is considered a health oversight activity for purposes of paragraph (d) of this section.

(4) Permitted uses. If a covered entity also is a health oversight agency, the covered entity may use protected health information for health oversight activities as permitted by paragraph (d) of this section.

(e) ***Standard: Disclosures for judicial and administrative proceedings***

(1) ***Permitted disclosures.*** A covered entity may disclose protected health information in the course of any judicial or administrative proceeding:

(i) In response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order; or

(ii) In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if:

(A) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iii) of this section, from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request; or

(B) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iv) of this section, from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order that meets the requirements of paragraph (e)(1)(v) of this section.

(iii) For the purposes of paragraph (e)(1)(ii)(A) of this section, a covered entity receives satisfactory assurances from a party seeking protecting health information if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The party requesting such information has made a good faith attempt to provide written notice to the individual (or, if the individual's location is unknown, to mail a notice to the individual's last known address);

(B) The notice included sufficient information about the litigation or proceeding in which the protected health information is requested to permit the individual to raise an objection to the court or administrative tribunal; and

(C) The time for the individual to raise objections to the court or administrative tribunal has elapsed, and:

(1) No objections were filed; or

(2) All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.

(iv) For the purposes of paragraph (e)(1)(ii)(B) of this section, a covered entity receives satisfactory assurances from a party seeking protected health information, if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or

(B) The party seeking the protected health information has requested a qualified protective order from such court or administrative tribunal.

(v) For purposes of paragraph (e)(1) of this section, a qualified protective order means, with respect to protected health information requested under paragraph (e)(1)(ii) of this section, an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:

(A) Prohibits the parties from using or disclosing the protected health information for any purpose other than the litigation or proceeding for which such information was requested; and

(B) Requires the return to the covered entity or destruction of the protected health information (including all copies made) at the end of the litigation or proceeding.

(vi) Notwithstanding paragraph (e)(1)(ii) of this section, a covered entity may disclose protected health information in response to lawful process described in paragraph (e)(1)(ii) of this section without receiving satisfactory assurance under paragraph (e)(1)(ii)(A) or (B) of this section, if the covered entity makes reasonable efforts to provide notice to the individual sufficient to meet the requirements of paragraph (e)(1)(iii) of this section or to seek a qualified protective order sufficient to meet the requirements

of paragraph (e)(1)(iv) of this section.

(2) Other uses and disclosures under this section. The provisions of this paragraph do not supersede other provisions of this section that otherwise permit or restrict uses or disclosures of protected health information.

(f) ***Standard: Disclosures for law enforcement purposes.*** A covered entity may disclose protected health information for a law enforcement purpose to a law enforcement official if the conditions in paragraphs (f)(1) through (f)(6) of this section are met, as applicable.

(1) ***Permitted disclosures:*** Pursuant to process and as otherwise required by law. A covered entity may disclose protected health information:

(i) As required by law including laws that require the reporting of certain types of wounds or other physical injuries, except for laws subject to paragraph (b)(1)(ii) or (c)(1)(i) of this section; or

(ii) In compliance with and as limited by the relevant requirements of:

(A) A court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer;

(B) A grand jury subpoena; or

(C) An administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:

(1) The information sought is relevant and material to a legitimate law enforcement inquiry;

(2) The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and

(3) De-identified information could not reasonably be used.

(2) ***Permitted disclosures: Limited information for identification and location purposes.*** Except for disclosures required by law as permitted by paragraph (f)(1) of this section, a covered entity may disclose protected health information in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, provided that:

(i) The covered entity may disclose only the following information:

(A) Name and address;

(B) Date and place of birth;

(C) Social security number;

(D) ABO blood type and Rh factor;

(E) Type of injury;

(F) Date and time of treatment;

(G) Date and time of death, if applicable; and

(H) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

(ii) Except as permitted by paragraph (f)(2)(i) of this section, the covered entity may not disclose for the purposes of identification or location under paragraph (f)(2) of this section any protected health information related to the individual's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue.

(3) ***Permitted disclosure: Victims of a crime.*** Except for disclosures required by law as permitted by paragraph (f)(1) of this section, a covered entity may disclose protected health information in response to a law enforcement official's request for such information about an individual who is or is suspected to be a victim of a crime, other than disclosures that are subject to paragraph (b) or (c) of this section, if:

(i) The individual agrees to the disclosure; or

(ii) The covered entity is unable to obtain the individual's agreement because of incapacity or other emergency circumstance, provided that:

(A) The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the

victim;

(B) The law enforcement official represents that immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure; and

(C) The disclosure is in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

(4) ***Permitted disclosure: Decedents.*** A covered entity may disclose protected health information about an individual who has died to a law enforcement official for the purpose of alerting law enforcement of the death of the individual if the covered entity has a suspicion that such death may have resulted from criminal conduct.

(5) ***Permitted disclosure: Crime on premises.*** A covered entity may disclose to a law enforcement official protected health information that the covered entity believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the covered entity.

(6) ***Permitted disclosure: Reporting crime in emergencies.***

(i) A covered health care provider providing emergency health care in response to a medical emergency, other than such emergency on the premises of the covered health care provider, may disclose protected health information to a law enforcement official if such disclosure appears necessary to alert law enforcement to:

(A) The commission and nature of a crime;

(B) The location of such crime or of the victim(s) of such crime; and

(C) The identity, description, and location of the perpetrator of such crime.

(ii) If a covered health care provider believes that the medical emergency described in paragraph (f)(6)(i) of this section is the result of abuse, neglect, or domestic violence of the individual in need of emergency health care, paragraph (f)(6)(i) of this section does not apply and any disclosure to a law enforcement official for law enforcement purposes is subject to paragraph (c) of this section.

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(j) ***Standard: Uses and disclosures to avert a serious threat to health or safety***

(1) ***Permitted disclosures.*** A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure:

(i) (A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

(B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or

(ii) Is necessary for law enforcement authorities to identify or apprehend an individual:

(A) Because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim; or

(B) Where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody, as those terms are defined in Sec. 164.501.

(2) ***Use or disclosure not permitted.*** A use or disclosure pursuant to paragraph (j)(1)(ii)(A) of this section may not be made if the information described in paragraph (j)(1)(ii)(A) of this section is learned by the covered entity:

(i) In the course of treatment to affect the propensity to commit the criminal conduct that is the basis for the disclosure under paragraph (j)(1)(ii)(A) of this section, or counseling or therapy; or

(ii) Through a request by the individual to initiate or to be referred for the treatment, counseling, or therapy described in paragraph (j)(2)(i) of this section.

(3) ***Limit on information that may be disclosed.*** A disclosure made pursuant to paragraph (j)(1)(ii)(A) of this section shall contain only the statement described in paragraph (j)(1)(ii)(A) of this section and the protected health information described in paragraph (f)(2)(i) of this section.

(4) ***Presumption of good faith belief.*** A covered entity that uses or discloses protected health information pursuant to paragraph (j)(1) of this section is presumed to have acted in good faith with regard to a belief described in paragraph (j)(1)(i) or (ii) of this section, if the belief is based

upon the covered entity's actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority.

(k) ***Standard: Uses and disclosures for specialized government functions***

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(5) ***Correctional institutions and other law enforcement custodial situations.***

(i) ***Permitted disclosures.*** A covered entity may disclose to a correctional institution or a law enforcement official having lawful

custody of an inmate or other individual protected health information about such inmate or individual, if the correctional institution or such law enforcement official represents that such protected health information is necessary for:

(A) The provision of health care to such individuals;

(B) The health and safety of such individual or other inmates;

(C) The health and safety of the officers or employees of or others at the correctional institution;

(D) The health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another;

(E) Law enforcement on the premises of the correctional institution; and

(F) The administration and maintenance of the safety, security, and good order of the correctional institution.

(ii) ***Permitted uses.*** A covered entity that is a correctional institution may use protected health information of individuals who are inmates for any purpose for which such protected health information may be disclosed.

(iii) No application after release. For the purposes of this provision, an individual is no longer an inmate when released on parole, probation, supervised release, or otherwise is no longer in lawful custody.

(6) ***Covered entities that are government programs providing public benefits.***

(i) A health plan that is a government program providing public benefits may disclose protected health information relating to

eligibility for or enrollment in the health plan to another agency administering a government program providing public benefits if the sharing of eligibility or enrollment information among such government agencies or the maintenance of such information in a single or combined data system accessible to all such government agencies is required or expressly authorized by statute or regulation.

(ii) A covered entity that is a government agency administering a government program providing public benefits may disclose protected health information relating to the program to another covered entity that is a government agency administering a government program providing public benefits if the programs serve the same or similar populations and the disclosure of protected health information is necessary to coordinate the covered functions of such programs or to improve administration and management relating to the covered functions of such programs.

APPENDIX 2

National Standards for Child Advocacy Centers

Multidisciplinary Team
A multidisciplinary team for response to child abuse allegations includes representation from the following: law enforcement, child protective services, prosecution, medical, mental health, victim advocacy and Children's Advocacy Center.

Cultural Competency and Diversity
Culturally competent services are routinely made available to all CAC clients and coordinated with the multidisciplinary team response.

Forensic Interviews
Forensic interviews are conducted in a manner that is legally sound, of a neutral, fact finding nature, and are coordinated to avoid duplicative interviewing.

Victim Support and Advocacy
Victim support and advocacy services are routinely made available to all CAC clients and their non-offending family members as part of the multidisciplinary team response.

Medical Evaluation
Specialized medical evaluation and treatment services are routinely made available to all CAC clients and coordinated with the multidisciplinary team response.

Mental Health
Specialized trauma-focused mental health services, designed to meet the unique needs of the child and non-offending family members, are routinely made available as part of the multidisciplinary team response.

Case Review
A formal process in which multidisciplinary discussion and information sharing regarding the investigation, case status and services needed by the child and family is to occur on a routine basis.

Case Tracking
Children's Advocacy Centers must develop and implement a system for monitoring case progress and tracking case outcomes for all MDT components.

Organizational Capacity
A designated legal entity responsible for program and fiscal operations has been established and implements basic sound administrative policies and procedures.

Child Focused Setting
The child-focused setting is comfortable, private, and both physically and psychologically safe for diverse populations of children and their non-offending family members.

MULTIDISCIPLINARY TEAM (MDT)
Essential components:

A. The CAC/MDT has a written interagency agreement signed by authorized representatives of all MDT components that clearly commits the signed parties to the CAC model for its multidisciplinary child abuse intervention response.
B. All members of the MDT including appropriate CAC staff, as defined by the needs of the case, are routinely involved in investigations and/or MDT interventions.
C. The CAC/MDT's written documents address information sharing that ensures the timely exchange of relevant information among MDT members, staff and volunteers and is consistent with legal, ethical and professional standards of practice.

Rated criteria:

D. The CAC provides routine opportunities for MDT members to provide feedback and suggestions regarding procedures/operations of the CAC/MDT.
E. The CAC/MDT participates in ongoing and relevant training and educational opportunities, including cross-discipline, team and skills-based learning.

CULTURAL COMPETENCY AND DIVERSITY

Essential components:

A. The CAC has a cultural competency plan that includes community assessment, goals, and strategies.
B. The CAC must ensure that provisions are made for non-English speaking and deaf or hard of hearing children and their non-offending family members throughout the investigation process.
C. The CAC and MDT members ensure that all services are provided in a manner that addresses culture and development throughout the investigation, intervention, and case management process.

Rated criteria:

D. The CAC engages in community outreach with underserved populations.
E. The CAC actively recruits staff, volunteers, and board members that reflect the demographics of the community
F. The CAC's cultural competency plan has been implemented and evaluated.

FORENSIC INTERVIEWS

Essential components:

A. Forensic interviews are provided by MDT/CAC staff that have specialized training in conducting forensic interviews of children.
B. The CAC/MDT's written documents describe the general forensic interview process including pre- and post-interview information sharing and decision making, and interview procedures.
C. Forensic interviews are conducted in a manner that is legally sound, non-duplicative, non-leading and neutral.
D. MDT members with investigative responsibilities are present for the forensic interview(s).
E. Forensic interviews are routinely conducted at the CAC.

Rated criteria:

F. The CAC/MDT's written documents include:
    - selection of an appropriate, trained interviewer;
    - sharing of information among team members; and
    - a mechanism for collaborative case planning.
G. The CAC and/or MDT provide opportunities for professionals who conduct forensic interviews to participate in ongoing training and peer review.
H. The CAC/MDT coordinate information gathering whether through history taking, assessment of forensic interview(s) to avoid duplication.

VICTIM SUPPORT AND ADVOCACY

Essential components:

A. Crisis intervention and ongoing support services are routinely made available for children and their non-offending family members on-site or through linkage agreements with other appropriate agencies or providers.
B. Education regarding the dynamics of abuse, the coordinated multidisciplinary response, treatment, and access to services is routinely available for children and their non-offending family members.
C. Information regarding the rights of a crime victim is routinely available to children and their non-offending family members and is consistent with legal, ethical and professional standards of practice.
D. The CAC/MDT's written documents include availability of victim support and advocacy services for all CAC clients.

Rated criteria:

E. A designated, trained individual(s) provides comprehensive, coordinated victim support and advocacy services including, but not limited to:
    - Information regarding the dynamics of abuse and the coordinated multidisciplinary response;
    - updates on case status;
    - assistance in accessing/obtaining victims' rights as outlined by law;
    - court education, support and accompaniment; and
    - assistance with access to treatment and other services such as protective orders, housing, public assistance, domestic violence intervention and transportation.

F. Procedures are in place to provide initial and on-going support and advocacy with the child and/or non-offending family members.

MEDICAL EVALUATION

Essential components:

A. Medical evaluations are provided by health care providers with pediatric experience and child abuse expertise.

B. Specialized medical evaluations for the child client are routinely made available on-site or through linkage agreements with other appropriate agencies or providers.

C. Specialized medical evaluations are available and accessible to all CAC clients regardless of ability to pay.

D. The CAC/MDT's written documents include access to appropriate medical evaluation and treatment for all CAC clients.

Rated criteria:

E. The CAC/MDT's written documents include:
    - the circumstances under which a medical evaluation is recommended;
    - the purpose of the medical evaluation;
    - how the medical evaluation is made available;
    - how medical emergency situations are addressed;
    - how multiple medical evaluations are avoided;
    - how medical care is documented;
    - how the medical evaluation is coordinated with the MDT in order to avoid duplication of interviewing and history taking; and
    - procedures are in place for medical intervention in cases of suspected physical abuse and maltreatment, if applicable.

A. The CAC and/or MDT provide opportunities for those who conduct medical evaluations to participate in ongoing training and peer review.

B. MDT members and CAC staff are trained regarding the purpose and nature of the evaluation and can educate clients and/or non-offending caregivers regarding the medical evaluation.

C. Findings of the medical evaluation are shared with the MDT in a routine and timely manner.

MENTAL HEALTH

Essential components:

A. Mental health services are provided by professionals with pediatric experience and child abuse expertise.

B. Specialized trauma-focused mental health services for the child client are routinely made available on-site or through linkage agreements with other appropriate agencies or providers.

C. Mental health services are available and accessible to all CAC clients regardless of ability to pay.

D. The CAC/MDT's written documents include access to appropriate mental health evaluation and treatment for all CAC clients.

Rated criteria:

E. The CAC/MDT's written documents include:
    - the role of the mental health professional on the MDT including provisions for attendance at case review;
    - provisions regarding sharing relevant information with the team while protecting

the clients' right to confidentiality; and
    - how the forensic process is separate from mental health treatment.

F. The CAC and/or MDT provide opportunities for those who provide mental health services to participate in ongoing training and peer review.
G. Mental health services for non-offending family members and/or caregivers are routinely made available on-site or through linkage agreements with other appropriate agencies or providers

CASE REVIEW

Essential components:

A. The CAC/MDT's written documents include criteria for case review and case review procedures.
B. A forum for the purpose of reviewing cases is conducted on a regularly scheduled basis.
C. Case review is an informed decision making process with input from all necessary MDT members based on the needs of the case.
D. A designated individual coordinates and facilitates the case review process, including notification of cases that will be reviewed.

Rated criteria:

E. Representatives routinely participating in case review include, at a minimum:
    - Law Enforcement
    - Child Protective Services
    - Prosecution
    - Medical
    - Mental Health
    - Victim Advocacy and
    - Children's Advocacy Center.

F. Recommendations from case review are communicated to appropriate parties for implementation.
G. Case review meetings are utilized as an opportunity for MDT members to increase understanding of the complexity of child abuse cases.

CASE TRACKING

Essential components:

A. The CAC/MDT's written documents include tracking case information until final disposition.
B. The CAC tracks and minimally is able to retrieve NCA Statistical Information.

Rated criteria:

C. An individual is identified to implement the case tracking process.
D. All MDT partner agencies provide their specific case information and disposition.
E. MDT partner agencies have access to information as defined by the CAC/MDT's written documents.

ORGANIZATIONAL CAPACITY

Essential components:

A. The CAC is an incorporated, private non-profit organization or government-based agency or a component of such an organization or agency.
B. The CAC maintains, at a minimum, current general commercial liability*, professional liability, and Directors and Officers liability as appropriate to its organizational structure.
C. The CAC has written administrative policies and procedures that apply to staff, MDT members, board members, volunteers and clients.
D. The CAC has an annual independent financial audit.
E. The CAC has personnel responsible for its operations and program services.
F. The CAC has, and demonstrates compliance with, written screening policies for staff that includes criminal background and child abuse registry checks and provides training and supervision.
G. The CAC has, and demonstrates compliance with, written screening policies for on-site volunteers that include criminal background and child abuse registry checks and provides training and supervision.

Rated criteria:

H. The CAC provides education and community awareness on child abuse issues.
I. The CAC has addressed its sustainability through the development of a strategic plan that includes a funding component.

CHILD FOCUSED SETTING

Essential components:

A. The CAC setting is a designated, well-defined, task appropriate facility or contiguous space within an existing structure.
B. The CAC has written policies and procedures that ensure separation of victims and alleged offenders.
C. The CAC makes reasonable accommodations to make the facility physically accessible.
D. The facility allows for live observation of interviews by MDT members.

Rated criteria:

E. The CAC is maintained in a manner that is physically safe and "child proof".
F. Children and families are observed or supervised by staff, volunteer, and/or MDT members.
G. Separate and private area(s) are available for those awaiting services, for case consultation and discussion, and for meetings or interviews.
H. The location of the CAC is convenient and accessible to clients and MDT members.

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Alaska Children's
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CHILDREN'S JUSTICE ACT TASK FORCE MEMBERS
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Alaska Children's Justice Act Task Force

The Honorable Kevin Meyer

716 West 4th Avenue Suite 410

Anchorage, AK 99501

December 9, 2011

Dear Representative Meyer:

The Alaska Children's Justice Act Task Force (CJA) respectfully requests that you sponsor and introduce the attached bill to improve and remedy some deficiencies within the criminal statutes.

The CJA, funded in FY 1999, is a federally-mandated, state-wide multi-disciplinary group charged with evaluating the state system response to child abuse, making recommendations for system improvement, and implementing projects that improve the system's response.

Last year the CJA made a presentation to the House HSS Committee concerning a problem that the task force had identified. After the presentation, the task force was asked to present our recommendations.

At our scheduled meeting on December 20, 2011 at 12:30 p.m., we will present a proposal for a bill that our committee members have developed over the past several months. We are asking that you sponsor this bill. We will be prepared to answer any questions that you or your staff may have at that time.

I am including with this letter our statement regarding the proposed legislation, a copy of our member list, and a copy of the proposed legislative changes.

We look forward to our meeting with you and to your support for this important change to the statutes which we believe will further our goal of protecting Alaska's children.

Thank you for your consideration.

Respectfully yours,

Thom F. Janidlo

Vice-Chair

Alaska Children's Justice Act Task Force

Alaska Children's Justice Act Task Force (CJA)
Statement Regarding Proposed Legislation

About the CJA

The current CJA was founded in FY1999. We are a federally-mandated, state-wide multidisciplinary group, with representatives from law enforcement, medicine, child protection, law (both prosecution and defense), child advocacy centers, judiciary, mental health, CASA, schools, and parents. The CJA is charged with evaluating the state system response to child abuse, especially child sexual abuse and serious physical abuse; making recommendations for system improvement; and implementing projects that improve the system response. For a current list of CJA members, see attachment "CJA member list 11-11."

Recommendations for system improvement through criminal legislation

As we pointed out in last year's presentation to the House HESS Committee, we have become aware of some shortcomings in the current criminal laws regarding the prosecution of harm to children. After researching laws in other states, analyzing the Alaska criminal statutes, and running our ideas past prosecutors and law enforcement, we have drafted the attached "CJA proposed legislation 11-18-11."

What follows is a description of the problem and how this legislation proposes to fix the problem, with section numbers provided to locate the fix in the proposed legislation.

This legislation would seek to:

- **Modify the assault statutes to create broader criminal liability for assaults to children**

Problem: Young children or mentally/physically impaired older children sometimes experience harm that deserves greater penalties to the offender than are currently available. One reason is because the harm may not fit into the "serious

physical injury" definition[1], a required element in many of the felony assault statutes, and yet the harm caused to the child is serious enough to deserve a penalty greater than a misdemeanor. For example, a person who intentionally burns a child but not to the point of the child needing medical treatment could be charged only with a misdemeanor. Another example is that a person who spanks a child so hard that it results in severe bruising but not protracted disfigurement could be charged only with a misdemeanor.

Solutions:

A. Create a new definition of harm for child assaults, "serious bodily injury to the child" (See section 10.) This definition was modeled after a Tennessee criminal statute, 39-15-402(d).[2]

B. Apply the "serious bodily injury" definition to children under 12 or children under age 16 who are mentally or physically impaired. (See section 4 for definition of mental and physical impairment.)

C. Add new causes of action in all three felony assault statutes so that the penalty for an assault to a child corresponds with the person's mental state and the harm caused. For example, this legislation would add two new causes of action to 11.41.200, assault in the first degree (a class A felony), to punish the intentional, one-time serious bodily injury (to a young or impaired older child) and the reckless, repeated serious bodily injury to such children. (See section 1.) This legislation also would add causes of action to assault in the second degree (a class B felony) to cover less serious mental states and/or less serious injuries to such children. (See section 2.)

D. Modify assault in the third degree (a class C felony) to increase the age of the injured child from under 10 to under 12 and to also apply to a child under 16 who is mentally or physically impaired, in order to make the ages in the assault statutes the same.[3] (See section 3.)

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[1] 11.81.900(56) defines "serious physical injury" as "**(A)** physical injury caused by an act performed under circumstances that create a substantial risk of death; or **(B)** physical injury that causes serious and protracted disfigurement, protracted impairment of health, protracted loss or impairment of the function of a body member or organ, or that unlawfully terminates a pregnancy."

[2] 39-15-402(d) defines "Serious bodily injury to the child" as including, "but is not limited to, second- or third-degree burns, a fracture of any bone, a concussion, subdural or subarachnoid bleeding, retinal hemorrhage, cerebral edema, brain contusion, injuries to the skin that involve severe bruising or the likelihood of permanent or protracted disfigurement, including those sustained by striking children with objects, or other physical injury that results in significant physical or emotional injury to the child."

E. Create a sentencing aggravator if the serious bodily injury caused to a child resulted in significant mental injury to the child. (See section 11.) The definition of "mental injury" is taken from AS 47.17.290(9).[4]

- **Create new criminal theories regarding exposure of children to drugs**

Problem: It is difficult to prosecute a person who has exposed a child to drugs and, because of that exposure, the child tests positive for that drug. For example, the District Attorney's Office currently can prosecute someone under Misconduct Involving Controlled Substance I for purposefully giving a child under 16 drugs such as methamphetamine but can't prosecute someone who is indirectly exposing a child to such drugs, such as by having a meth lab in the home. Nor can a person be prosecuted for exposing a child to serious chemicals used in meth labs, which can be highly dangerous to a child. Also, 11.51.130(a)(2) (contributing to the delinquency of a minor) -- which makes it a misdemeanor to recklessly allow a child to be in presence of the unlawful manufacture, use, display, or delivery of a controlled substance – seemed to fit better in the endangering the welfare of a minor statute.

Solution: Modify AS 11.51.100 (endangering the welfare of a minor in the first degree) by creating 3 new subsections to:

A. Penalize the reckless exposure of a child to a controlled substance and, because of that exposure, the child tests positive for the controlled substance. Exposure could include having a meth lab in the home or doing drugs in the child's presence, or leaving drugs around the house, in harms way. The penalties range from a misdemeanor to a Class B felony, depending on the dangerousness of the drug. (See section 5, subsection (b)(2).) The level of penalty, from a class B felony to a class A misdemeanor, depends on the seriousness of the class of drugs. For example, exposure to meth would be a class A felony, whereas exposure to marijuana would be a misdemeanor. (See section 5, subsection (g).)

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[3] The CJA felt that under 12 was a better age cut-off than 10; children under 12 are usually still in elementary school, so the under 10 category seemed too restrictive.

[4] AS 47.17.290(9) states: "mental injury" means a serious injury to the child as evidenced by an observable and substantial impairment in the child's ability to function in a developmentally appropriate manner and the existence of that impairment is supported by the opinion of a qualified expert witness."

B. Move the provision in 11.51.130(a)(2) (recklessly allowing a child to be in presence of the unlawful manufacture, use, display, or delivery of a controlled substance) to AS 11.51.100. (See section 5, subsection (b)(3).)

C. Penalize the reckless exposure of a child to serious chemicals used in meth labs. (See section 5, subsection (b)(4).)

- **Increase penalties when a parent intentionally withholds adequate food or liquids**

Problem: The current punishment for criminal neglect is a misdemeanor. The CJA believes that a felony is a more apt punishment for a parent or guardian who intentionally withholds adequate food or liquids to a child, perhaps as a form of punishment or deliberate cruelty.

Solution: Modify AS 11.51.120 so that it is a class C felony for a parent to intentionally fail, without lawful excuse, to provide adequate food and liquids to the child. (See sections 6 and 7.) The standard for determining what is an inadequate amount of food is that "a reasonable person would conclude the child was not receiving adequate food or liquids."

- **Create a criminal law when an incarcerated person contacts a victim or witness in violation of a court order**

Problem: Current law prevents a defendant out on bail or on parole or probation from having contact with a victim or witness if so ordered by the court, but if that defendant is incarcerated on a no bail order, it is not a crime for him to be contacting the victim or a witness (unless he threatens her or encourages her to change her story, which is a violation of the witness tampering or interference with the judicial process law). So, for example, if an incarcerated sex offender contacts his under-age victim to tell her that he loves her and wants to marry her, no crime has been committed. Also, there is nothing law enforcement can do to the person who forwards the phone call or letters to the incarcerated offender.

Solution: Add two new theories to the unlawful contact statute to: (1) penalize an incarcerated person for contacting a victim or witness after being ordered not to and (2) penalize a person who assists the defendant who's been ordered to have no contact to have such contact. (See section 9.)

CJA Task Force Proposed Legislative changes 12/6/11

"An Act relating to the crimes of assault, endangering the welfare of a child, and criminal nonsupport contributing to the delinquency of a minor, unlawful contact; relating to criminal definitions; relating to sentencing; and providing for an effective date."

* **Sec. 1.** AS 11.41.200(a) is amended to read:

(a) A person commits the crime of assault in the first degree if

(1) that person recklessly causes serious physical injury to another by means of a dangerous instrument;

(2) with intent to cause serious physical injury to another, **that** [THE] person causes serious physical injury to any person;

(3) **that** [THE] person knowingly engages in conduct that results in serious physical injury to another under circumstances manifesting extreme indifference to the value of human life; or

(4) that person recklessly causes serious physical injury to another by repeated assaults using a dangerous instrument, even if each assault individually does not cause serious physical injury.

(5) while being 18 years of age or older, that person

(i) intentionally causes serious bodily injury to a child under 12 years of age or to a child under the age of 16 who is mentally or physically impaired.

(ii) recklessly causes serious bodily injury to a child under 12 years of age or to a child under the age of 16 who is mentally or physically impaired on more than one occasion.

* **Sec. 2.** AS 11.41.210(a) is amended to read:

(a) A person commits the crime of assault in the second degree if

(1) with intent to cause physical injury to another person, that person causes physical injury to another person by means of a dangerous instrument;

(2) that person recklessly causes serious physical injury to another person; or

(3) that person recklessly causes serious physical injury to another by repeated assaults, even if each assault individually does not cause serious physical injury.

(4) while being 18 years of age or older, that person

(i) recklessly causes serious bodily injury to a child under 12 years of age or to a child under the age of 16 who is mentally or physically impaired;

(ii) intentionally causes physical injury to a child under 12 years of age or to a child under the age of 16 who is mentally or physically impaired and the injury would cause a reasonable caregiver to seek medical attention from a health care professional in the form of diagnosis or treatment;

(iii) intentionally causes physical injury to a child under 12 years of age or a child under the age of 16 who is mentally or physically impaired on more than on occasion.

* **Sec. 3.** AS 11.41.220(a) is amended to read:

(a) A person commits the crime of assault in the third degree if that person

(1) recklessly

(A) places another person in fear of imminent serious physical injury by means of a dangerous instrument;

(B) causes physical injury to another person by means of a dangerous instrument; or

(C) while being 18 years of age or older

(i) causes physical injury to a child under **12** [10] years of age **or to a child under the age of 16 who is mentally or physically impaired** and the injury would cause a reasonable caregiver to seek medical attention from a health care professional in the form of diagnosis or treatment;

(ii) causes physical injury to a child under **12** [10] years of age **or to a child under the age of 16 who is mentally or physically impaired** on more than one occasion;

(2) with intent to place another person in fear of death or serious physical injury to the person or the person's family member makes repeated threats to cause death or serious physical injury to another person;

(3) while being 18 years of age or older, knowingly causes physical injury to a child under 16 years of age but at least **12** [10] years of age and the injury reasonably requires medical treatment;

(4) with criminal negligence causes serious physical injury under AS 11.81.900(b)(56)(B) to another person by means of a dangerous instrument; or

(5) commits a crime that is a violation of AS 11.41.230(a)(1) or (2) and, within the preceding 10 years, the person was convicted on two or more separate occasions of crimes under

(A) AS 11.41.100 - 11.41.170;

(B) AS 11.41.200 - 11.41.220, 11.41.230(a)(1) or (2), 11.41.280, or 11.41.282;

(C) AS 11.41.260 or 11.41.270;

(D) AS 11.41.410, 11.41.420, or 11.41.425(a)(1); or

(E) a law or ordinance of this or another jurisdiction with elements similar to those of an offense described in (A) - (D) of this paragraph.

* **Sec. 4.** AS 11.41 is amended by adding a new section to read:

Sec. 11.41.225. Definitions

In AS 11.41.200-220:

a) mentally impaired means a person who suffers from diminished cognitive function or capacity or a mental disorder that temporarily or permanently renders the person substantially incapable of appraising the nature of his or her conduct or the conduct of others.

b) Physically impaired includes, but is not limited to, all of the following: having any physiological disease, disorder, condition, cosmetic disfigurement, or anatomical loss that does both of the following:

(1) Affects one or more of the following body systems: neurological, immunological, musculoskeletal, special sense organs, including speech organs, respiratory, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine.

(2) Limits an individual's ability to participate in major life activities.

* **Sec. 5.** AS 11.51.100 is amended to read:

Sec. 11.51.100. Endangering the welfare of a child in the first degree.

(a) A person commits the crime of endangering the welfare of a child in the first degree if, being a parent, guardian, or other person legally charged with the care of a child under 16 years of age, the person

(1) intentionally deserts the child in a place under circumstances creating a substantial risk of physical injury to the child;

(2) leaves the child with another person who is not a parent, guardian, or lawful custodian of the child knowing that the person

(A) is registered or required to register as a sex offender under AS 12.63 or a law or ordinance in another jurisdiction with similar requirements;

(B) has been charged by complaint, information, or indictment with a violation of AS 11.41.410 - 11.41.455 or a law or ordinance in another jurisdiction with similar elements; or

(C) has been charged by complaint, information, or indictment with an attempt, solicitation, or conspiracy to commit a crime described in (B) of this paragraph; or

(3) leaves the child with another person knowing that the person has previously physically mistreated or had sexual contact with any child, and the other person causes physical injury or engages in sexual contact with the child.

(b) A person commits the crime of endangering the welfare of a minor in the first degree if

(1) the person transports a child in a motor vehicle, aircraft, or watercraft while in violation of AS 28.35.030**;**

(2) the person recklessly exposes a child to an IA, IIA, IIIA, IVA, VA, or VIA controlled substance, and as a result of that exposure the child tests positive for a IA, IIA, IIIA, IVA, VA, or VIA controlled substance. In this section, exposure includes but is not limited to the manufacture of a controlled substance or the consumption of a controlled substance by smoking or inhalation while in the presence of a child.

(3) recklessly allows the child to enter or remain in the immediate physical presence of the unlawful manufacture, use, display, or delivery of a controlled substance knowing that the manufacture, use, display, or deliveryis occurring, unless the child's disabilities of minority have been removed for general purposes under AS 09.55.590; or

(4) recklessly causes or allows a child to enter or remain in a dwelling or vehicle in which on occupant of the dwelling or vehicle possesses an immediate precursor of methamphetamine, or the salts, isomers, or salts of isomers of the immediate precursor of methamphetamine, or possesses a listed chemical with the intent to manufacture any material, compound, mixture, or preparation that contains methamphetamine, or its salts, isomers, or salts of isomers or an immediate precursor of methamphetamine, or its salts, isomers, or salts of isomer; in this section, "listed chemical" means a chemical described under AS 11.71.200.

(c) In this section, "physically mistreated" means

(1) having committed an act punishable under AS 11.41.100 - 11.41.250; or

(2) having applied force to a child that, under the circumstances in which it was applied, or considering the age or physical condition of the child, constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation because of the substantial and unjustifiable risk of

(A) death;

(B) serious or protracted disfigurement;

(C) protracted impairment of health;

(D) loss or impairment of the function of a body member or organ;

(E) substantial skin bruising, burning, or other skin injury;

(F) internal bleeding or subdural hematoma;

(G) bone fracture; or

(H) prolonged or extreme pain, swelling, or injury to soft tissue.

(d) Endangering the welfare of a child in the first degree under (a)(3) of this section is a

(1) class B felony if the child dies;

(2) class C felony if the child suffers sexual contact, sexual penetration, or serious physical injury; or

(3) class A misdemeanor if the child suffers physical injury.

(e) Endangering the welfare of a child under (b)**(1), (3) or (4)** of this subsection is a class A misdemeanor.

(f) Endangering the welfare of a child in the first degree under (a)(1) or (2) of this section is a class C felony.

(g) Endangering the welfare of a child under (b)(2) of this subsection is a

(1) class B felony if the controlled substance was a schedule IA, or IIA controlled substance;

(2) class C felony if the controlled substance was a schedule IIIA, or IVA controlled substance;

(3) class A misdemeanor of the controlled substance was a schedule VA, VIA controlled substance.

* **Sec. 6.** AS 11.51 is amended by adding a new section to read:

Sec. 11.51.115. Criminal nonsupport in the First Degree.

(a) A person commits the crime of criminal nonsupport if, being a person legally charged with the support of a child the person intentionally fails, without lawful excuse, to provide adequate food and or liquids for the child and a reasonable person would conclude the child was not receiving adequate food or liquids.

(b) Criminal nonsupport in the first degree is a class C felony.

(c) In this section, "child" is defined in AS 11.51.120(f)(1).

* **Sec. 7.** AS 11.51.120 is amended to read:

Sec. 11.51.120. Criminal nonsupport in the Second Degree.

(a) A person commits the crime of criminal nonsupport if, being a person legally charged with the support of a child the person knowingly fails, without lawful excuse, to provide support for the child.

(b) As used in this section "support" includes necessary food, care, clothing, shelter, medical attention, and education. There is no failure to provide medical attention to a child if the child is provided treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by an accredited practitioner of the church or denomination.

(c) Except as provided in (d) of this section, criminal nonsupport is a class A misdemeanor.

(d) Criminal nonsupport is a class C felony if the support the person failed to provide is monetary support required by a court or administrative order from this or another jurisdiction and, at the time the person knowingly failed, without lawful excuse, to provide the support,

(1) the aggregate amount of accrued monetary child support arrearage is $20,000 or more;

(2) no child support payment has been made for a period of 24 consecutive months or more; or

(3) the person had been previously convicted under this section or a similar provision in another jurisdiction and

(A) the aggregate amount of accrued monetary child support arrearage is $5,000 or more; or

(B) no child support payment has been made for a period of six months or more.

(e) In addition to the provisions of (c) and (d) of this section, criminal nonsupport is punishable by loss or restriction of a recreational license as provided in AS 12.55.139_.

(f) In this section,

(1) "child" means a person

(A) under 18 years of age; or

(B) 18 years of age or older for whom a person is ordered to pay support under a valid court or administrative order;

(2) "child support" means support for a child;

(3) "without lawful excuse" means having the financial ability to provide support or having the capacity to acquire that ability through the exercise of reasonable efforts.

* **Sec. 8.** AS 11.51.130(a) is amended to read:

(a) A person commits the crime of contributing to the delinquency of a minor if, being 19 years of age or older or being under 19 years of age and having the disabilities of minority removed for general purposes under AS 09.55.590, the person aids, induces, causes, or encourages a child

(1) under 18 years of age to do any act prohibited by state law unless the child's disabilities of minority have been removed for general purposes under AS 09.55.590;

[(2) UNDER 18 YEARS OF AGE OR ALLOWS A CHILD UNDER 18 YEARS OF AGE TO ENTER OR REMAIN IN THE IMMEDIATE PHYSICALL PRESENCE OF THE UNLAWFUL MANUFACTURE, USE, DISPAY, OR DELIVERY OF A CONTROLLED SUBSTANCE KNOWING THAT THE MANUFACTURE, USE, DISPAY, OR DELIVERY IS OCCURING, UNLESS THE CHILD'S DISABILITIES OF MINORITY HAVE BEEN REMOVED FOR GENERAL PURPOSES UNDER AS 09.55.590 ;]

(2)[3] under 16 years of age to be repeatedly absent from school, without just cause; or

(3)[4] under 18 years of age to be absent from the custody of a parent, guardian, or custodian without the permission of the parent, guardian, or custodian or without the knowledge of the parent, guardian, or custodian, unless the child's disabilities of minority have been removed for general purposes under AS 09.55.590 or the person has immunity under AS 47.10.350 or 47.10.398(a); it is an affirmative defense to a prosecution under this paragraph that, at the time of the alleged offense, the defendant

(A) reasonably believed that the child was in danger of physical injury or in need of temporary shelter; and

(B) within 12 hours after taking the actions comprising the alleged offense, notified a peace officer, a law enforcement agency, or the Department of Health and Social Services of the name of the child and the child's location.

* **Sec. 9.** AS 11.56.750(a) is amended by adding a new section to read:

(a) A person commits the crime of unlawful contact in the first degree if the person

(1) has been ordered not to contact a victim or witness of the offense [AS]

(A) **as** part of a sentence imposed under AS 12.55.015 ; or

(B) **as** a condition of

(i) release under AS 12.30;

(ii) probation under AS 12.55.101; or

(iii) parole under AS 33.16.150; **or**

(C) while incarcerated; and

(2) either directly or indirectly, knowingly contacts or attempts to contact the victim or witness in violation of the order**; or**

(3) knowingly assists a person in violating section (a)(1 & 2) of this statute.

* **Sec. 10.** AS 11.81.900(a) is amended by adding a new subsection to read:

"Serious bodily injury to the child" includes, but is not limited to, second- or third-degree burns, a fracture of any bone, a concussion, subdural or subarachnoid bleeding, retinal hemorrhage, cerebral edema, brain contusion, strangulation, injuries to the skin that involve severe bruising or the likelihood of permanent or protracted disfigurement, including those sustained by striking children with objects, or other physical injury that results in significant physical injury to the child.

* **Sec. 11.** AS 12.55.155(18) is amended to read:

Sec. 12.55.155. Factors in aggravation and mitigation.

(18) the offense was a felony

(A) specified in AS 11.41 and was committed against a spouse, a former spouse, or a member of the social unit made up of those living together in the same dwelling as the defendant;

(B) specified in AS 11.41.410 - 11.41.458 and the defendant has engaged in the same or other conduct prohibited by a provision of AS 11.41.410 - 11.41.460 involving the same or another victim;

(C) specified in AS 11.41 that is a crime involving domestic violence and was committed in the physical presence or hearing of a child under 16 years of age who was, at the time of the offense, living within the residence of the victim, the residence of the perpetrator, or the residence where the crime involving domestic violence occurred;

(D) specified in AS 11.41 and was committed against a person with whom the defendant has a dating relationship or with whom the defendant has engaged in a sexual relationship; [OR]

(E) specified in AS 11.41.434 - 11.41.458 or AS 11.61.128 and the defendant was 10 or more years older than the victim; **or**

(F) specified in AS 11.41.200 – 11.41.220 and the serious bodily injury caused to a child resulted in significant mental injury to the child. In this section, "mental injury" is defined as a serious injury to the child as evidenced by an observable and substantial impairment in the child's ability to function in a developmentally appropriate manner and the existence of that impairment is supported by the opinion of a qualified expert witness.

* **Sec. 12.** This Act takes effect *, 2012.

CHILDREN'S JUSTICE ACT TASK FORCE MEMBERS
(Updated November 2011)

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The economic burden of child maltreatment in the United States and implications for prevention☆,☆☆

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ABSTRACT

Objectives: To present new estimates of the average lifetime costs per child maltreatment victim and aggregate lifetime costs for all new child maltreatment cases incurred in 2008 using an incidence-based approach.
Methods: This study used the best available secondary data to develop cost per case estimates. For each cost category, the paper used attributable costs whenever possible. For those categories that attributable cost data were not available, costs were estimated as the product of incremental effect of child maltreatment on a specific outcome multiplied by the estimated cost associated with that outcome. The estimate of the aggregate lifetime cost of child maltreatment in 2008 was obtained by multiplying per-victim lifetime cost estimates by the estimated cases of new child maltreatment in 2008.
Results: The estimated average lifetime cost per victim of nonfatal child maltreatment is $210,012 in 2010 dollars, including $32,648 in childhood health care costs; $10,530 in adult medical costs; $144,360 in productivity losses; $7,728 in child welfare costs; $6,747 in criminal justice costs; and $7,999 in special education costs. The estimated average lifetime cost per death is $1,272,900, including $14,100 in medical costs and $1,258,800 in productivity losses. The total lifetime economic burden resulting from new cases of fatal and nonfatal child maltreatment in the United States in 2008 is approximately $124 billion. In sensitivity analysis, the total burden is estimated to be as large as $585 billion.
Conclusions: Compared with other health problems, the burden of child maltreatment is substantial, indicating the importance of prevention efforts to address the high prevalence of child maltreatment.

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Introduction

Child maltreatment (CM) is a serious and prevalent public health problem in the United States, responsible for substantial morbidity and mortality. The 4 major types of CM are physical abuse, sexual abuse, psychological abuse, and neglect (Leeb et al., 2007). In fiscal year 2008, US state and local child protective services (CPS) received 3.3 million

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reports of children being abused or neglected and an estimated 772,000 children were classified by CPS authorities as being maltreated (USDHHS, 2010). The number of confirmed cases has decreased over the past several years (USDHHS, 2010), but researchers argue that CPS data grossly underestimate the total incidence of CM (Haugaard & Emery, 1989; Hussey, Chang, & Kotch, 2006; Swahn et al., 2006; Waldfogel, 1998). A nationally representative study of children aged 0–17 reported that 10.2% of US children experienced some form of maltreatment in 2008 (Finkelhor, Turner, Ormrod, & Hamby, 2009).

CM has been shown to have lifelong adverse health, social, and economic consequences for survivors, including behavioral problems (Felitti et al., 1998; Repetti, Taylor, & Seeman, 2002); mental health conditions such as posttraumatic stress disorder (Browne & Finkelhor, 1986; Holmes & Sammel, 2005; Moeller, Bachmann, & Moeller, 1993); increased risk for delinquency, adult criminality, and violent behavior (Fang & Corso, 2007; Widom & Maxfield, 2001); increased risk of chronic diseases (Browne & Finkelhor, 1986; Felitti et al., 1998); lasting impacts or disability from physical injury (Dominguez, Chalom, & Costarino, 2001); reduced health-related quality of life (Corso, Edwards, Fang, & Mercy, 2008); and lower levels of adult economic well-being (Currie & Widom, 2010). Given the high prevalence of CM and the many negative short- and long-term consequences of CM, the economic costs of CM may be substantial. Estimating the economic burden of CM is important for several reasons. Economic estimates can help to increase awareness of the current severity of CM, place the problem in the context of other public health concerns, and may be used in economic evaluation of interventions to reduce or prevent CM.

Several studies have drawn attention to the problem of CM by producing estimates of the national economic burden of CM (Conrad, 2006; Daro, 1988; Fromm, 2001; Miller, Cohen, & Wiersema, 1996; Wang & Holton, 2007). These studies made important contributions and advanced awareness, but shortcomings have been identified (Corso & Fertig, 2010), which should be addressed if burden estimates are to be used for health policy analysis. Problems include the "(1) lack of transparency in inputs used in the estimation procedure, (2) calculation mistakes, and (3) methodological errors" (p. 297) (Corso & Fertig, 2010). Correcting for these flaws is crucial to producing higher quality future estimates of the economic burden of CM. Furthermore, since the last estimate of the economic burden of CM conducted in 2007 (Wang & Holton, 2007), researchers have found additional quantified evidence regarding the health care costs associated with CM during childhood and adulthood (Bonomi et al., 2008; Florence et al., 2012) and the long-term consequence of CM on adult earnings (Currie & Widom, 2010). Including these latest study results should improve understanding of the economic burden of CM.

Economic burden estimates generally take 1 of 2 perspectives to quantifying a health problem: a prevalence-based approach or an incidence-based approach. Both are relevant to CM. Prevalence-based economic burden provides an estimate of the direct and indirect costs incurred in a period (most often 1 year) as a result of the prevalence of CM during this same period (or this given year), regardless of the onset of CM. Thus, in a prevalence-based study of the economic burden of CM with a time frame of, say, 1 year, costs associated with all cases of CM (including cases with the onset in or at any time before the base year) would be included; however, only costs incurred during the 1-year period would be counted (Haddix, Teutsch, & Corso, 2003).

In contrast, incidence-based economic burden represents the total lifetime costs resulting from new cases of CM that occur within a set time period (most often 1 year) (Haddix, Teutsch, & Corso, 2003). Incidence-based costs are more difficult to estimate because they require data on short- and long-term costs and consequences of CM, such as its chronic sequelae on health, employment, and earnings over the lifetime of an individual. However, incidence-based costs are more useful for the economic evaluation of CM prevention/intervention activities (Haddix, Teutsch, & Corso, 2003). For example, the lifetime costs avoided could be compared with the costs of preventing 1 case of CM in a benefit-cost analysis of prevention. Both direct and indirect costs are included in an incidence-based costing perspective.

All of the previous estimates of the economic burden of CM that we are aware of are not estimated on a cost-per-case basis, except for the Conrad (2006) study. Similar to other studies, Conrad's study has a number of methodological shortcomings. For example, for the effect of CM on juvenile delinquency, Conrad uses the raw number of how many abused children become juvenile offenders as reported in a study by Widom and Maxfield (2001). This number does not take into account how many of these children would have been offenders if they had not been abused and therefore overestimates the effect of CM on juvenile delinquency. Widom and Maxfield (2001) report that about 27% of abused and neglected children have had a juvenile arrest, compared with 17% of non-abused children. This 10% marginal (or incremental) effect would have provided a more accurate estimate of the effect of CM on delinquency. There are similar problems with the estimates of effect of CM on adult criminality and lifetime productivity. In addition, for some of the cost estimates (such as the use of health care and mental health services), annual costs (prevalence-based estimates) of CM were calculated. Because the study was designed to estimate the incidence-based lifetime health care costs, the stream of incremental health care costs associated with CM over the lifetime should be used, discounted, and summed to net present value in the base year of analysis (Haddix, Teutsch, & Corso, 2003).

In this paper, we present new estimates of the average lifetime cost per CM victim and aggregate lifetime costs for all new cases of CM incurred in 2008 using an incidence-based approach. This study extends previous research in this area by correcting methodological flaws of previous studies; incorporating more recent and comprehensive studies of the epidemiology, consequences, and costs of CM; and providing a framework for using the findings in the literature to estimate the incidence-based economic burden of CM.

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Methods

General overview

This study measured costs from the societal perspective. All costs were estimated in US dollars and adjusted to the reference year 2010 using the gross domestic product (GDP) deflator (available from http://www.gpoaccess.gov/usbudget/fy12/pdf/BUDGET-2012-TAB.pdf, Table 10.1). Future costs associated with CM accumulating over time were discounted at 3% to reflect their present value, as recommended by the US Panel on Cost-Effectiveness in Health and Medicine (Gold et al., 1996). Although 3% is often recommended as the base rate for cost-effectiveness analysis of health and medical interventions, a more conservative discount rate of 7% was used as a further sensitivity analysis as recommended by the Committee to Evaluate Measures of Health Benefits for Environmental, Health, and Safety Regulations (Miller, Robinson, & Lawrence, 2006).

Based on previous research (Corso & Fertig, 2010), this study focuses on the following major types of costs that are associated with CM: health care costs (short- and long-term, including physical and mental health), productivity losses, child welfare costs, criminal justice costs, and special education costs. For each category, we used the best available secondary data to develop cost per case estimates. First, a general literature review was performed to identify published, peer-reviewed studies on all outcomes related to CM with a potential economic cost or consequence. Articles were identified by keyword searching in a variety of databases, including PubMed, PsycInfo, EconLit, and Google Scholar. In addition to keyword searches, the bibliographies of all relevant articles were scanned to identify additional relevant studies. Whenever possible, published peer-reviewed studies were used to estimate the costs. However, in cases where the data on costs or effects were particularly sparse, we included non-peer-reviewed reports or white papers containing relevant economic outcomes of CM. Reports and white papers were identified by examining the citations of peer-reviewed studies identified in the general literature review and through searches of EconLit, the Social Science Research Network, and Google and Google Scholar.

The median age for CM victims in 2008 was 6 years old (USDHHS, 2010). We used the median age to calculate the average lifetime cost per victim, which was defined as the sum of short-term health care costs, long-term health care costs, productivity losses, child welfare costs, criminal justice costs, and special education costs. In other words, the present value of all future costs is estimated starting at age 6. For each category, we used attributable costs whenever possible (e.g., health care costs); these estimates reflect econometric procedures to statistically identify the difference between the costs of CM victims and non-maltreated controls, adjusting for observed differences between the 2 groups. Attributable cost data were not available for some categories; in these, costs were estimated as the product of incremental effect of CM on a specific outcome multiplied by the estimated cost associated with that outcome. For example, the cost of adult criminality due to CM is estimated as the product of the incremental probability of being an adult criminal by the average cost per adult criminal career. The estimate of the aggregate lifetime cost of CM in 2008 was obtained by multiplying per-victim lifetime cost estimates by the estimated cases of new CM in 2008.

Incidence rate

To generate incidence-based estimates, we begin with an estimate of CM cases and deaths during 2008. For cases, an estimated 772,000 children were determined by CPS agencies to be victims of abuse or neglect during 2008 (USDHHS, 2010). Three-quarters of victims (75%) had no history of prior victimization (USDHHS, 2010), yielding an estimated 579,000 new cases in 2008. Although researchers have argued that CPS data underestimate the total incidence of CM (Haugaard & Emery, 1989; Hussey, Chang, & Kotch, 2006; Swahn et al., 2006; Waldfogel, 1998), to be conservative, this study uses the CPS estimate of 579,000 new cases as the baseline for our estimation of the aggregate lifetime cost of CM in 2008.

Given that definitions of CM and criteria for substantiation vary between states and that previous research has shown that children in unsubstantiated cases have similar maltreatment experiences and developmental outcomes to children in substantiated cases (Drake, 1996; Hussey, Marshall, & English, 2005; Kohl, Jonson-Reid, & Drake, 2009; Leiter, Myers, & Zingraff, 1994), a sensitivity analysis on the aggregate lifetime cost of CM was conducted using the investigated incidents of CM. In 2008, nearly 3.7 million children received an investigation or assessment (USDHHS, 2010); assuming that 75% of these investigated children were also new reports, this suggests about 2,775,000 new victims of CM as an alternative estimate of CM incidence for sensitivity analysis.

The other major source of national estimates of the incidence of nonfatal CM is the periodic National Incidence Study (NIS), which combines information about reported cases with data on maltreated children identified by community professionals who are likely to come into contact with maltreated children such as child care providers, teachers, and hospital staff. There have been 4 cycles of NIS conducted in the United States: NIS-1 (1979–1980); NIS-2 (1986); NIS-3 (1993) and NIS-4 (2005–2006). According to NIS-4, the most recent NIS data available, an estimated 1,256,600 children experienced maltreatment using the "Harm Standard," and an estimated 2,905,800 children experienced maltreatment using the broader "Endangerment Standard" during the 2005–2006 study year (Sedlak et al., 2010). Assuming that 75% of these cases were new reports, this suggests an estimated 942,450 new cases using the "Harm Standard" and 2,179,350 new cases using the "Endangerment Standard." Both numbers were included as alternative estimates of CM incidence in 2008 in the sensitivity analysis.

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An incidence-based accounting of the costs of CM must also include the value of mortality for fatal cases of maltreatment. An estimated 1,740 children nationally died from abuse or neglect in 2008 (USDHHS, 2010). About 80% of all fatalities were children younger than 4 years old. Valuation is described in detail below.

Average lifetime cost per victim of nonfatal child maltreatment

Short-term health care costs. Short-term health care costs of CM in this study refer to the health care costs resulting from a new case of CM that occurred in childhood. Because the median CM case is a child aged 6 years, short-term health care costs include the incremental health care costs attributable to CM from age 6 to age 17.

A literature review identified a set of 8 articles on pediatric, short-term medical costs of CM. However, all of the studies are based on inpatient hospital data and limit their per-case reporting time period to a single inpatient episode (Brown, Fang, & Florence, 2011). Estimating the average annual medical costs of CM requires capturing increased expenditures outside of hospital settings. For example, CM may lead to increased costs for mental health services, prescription drugs, or chronic disease care, which are not captured in the inpatient studies. Furthermore, only the most severe instances of CM require inpatient care, and therefore these studies capture a non-representative sample of abused children.

In the absence of appropriate estimates in the literature, we have, in separate analyses, estimated the medical costs of maltreatment during childhood using linked survey and Medicaid claims (Florence et al., 2012). Specifically, we linked a sample of 1,151 children with cases investigated by CPS, drawn from the National Survey of Child and Adolescent Well-Being, to individual 2000–2003 Medicaid claims. We formed a comparison group of Medicaid children based on propensity score matching. The attributable difference in annual medical costs between the case and control groups is $2,703 (2003 dollars) per victim. Full details of methods and results for this analysis can be found elsewhere (Florence et al., 2012). Adjusted by GDP deflator, the cost difference measured in 2010 dollars is $3,184, or $32,648 per victim of nonfatal CM for the present value of medical costs from ages 6 through 17.

Long-term medical costs. A few sources of data exist for adult estimates of the long-term medical costs of CM (Bonomi et al., 2008; Hulme, 2000; Walker et al., 1999). Based on a review (Brown et al., 2011), we determined that Bonomi et al.'s (2008) estimates were most suitable for this study. They examined long-term health care costs associated with physical, sexual, or both physical and sexual childhood abuse using data from 3,333 women (ages 18–64) enrolled in a large health care delivery system. Total annual health care costs were 21% higher (about $507) in 2004 for women with a history of physical or sexual childhood abuse compared to women without these abuse histories. Based on Bonomi et al.'s (2008) findings and acknowledging that the study only included women (as did the 2 other adult estimates), we assume that the average annual incremental health care costs for a CM victim from age 18 through age 64 are $507 (2004 dollars), or $582 in 2010 dollars. The present value of a stream of these incremental health care costs over the period from age 18 through age 64 is $10,530 per case.

We did not locate any studies that report incremental health care costs associated with CM for adults older than age 65. As a result, the long-term medical costs of CM included in this study only account for the incremental health care costs from age 18 to 64.

Productivity losses. Lifetime productivity losses associated with CM were estimated using the human capital approach, which measures the potential loss of earnings due to being maltreated during childhood. Currie and Widom (2010) assessed the economic consequences in individuals with documented histories of childhood neglect and physical and sexual abuse and a matched comparison group who were followed up into adulthood (mean age = 41). They found that individuals with documented histories of neglect and/or abuse earned about $5,000 less per year on average than controls, controlling for background characteristics. Based on their findings, we assume that experience of CM reduces victim earnings by $5,000 (2003 dollars) per year from ages 18 to 64, assuming that productivity losses are negligible beyond 65 when most retire. Adjusted to 2010 dollars, the earning gap is $5,890, and assuming a long-term growth in labor productivity of 1% per year (Grosse, 2003), the present discounted value of these earnings losses from age 6 would be $144,360. We do not include the value of lost tax receipts from reduced earnings. Although these are a cost to the government, from a social perspective, this is a transfer from individuals to the public sector, and there is no net loss.

Child welfare costs. Given that some of the child welfare services provided to CM victims last more than 1 year (e.g., long-term foster care), the ideal way to estimate lifetime child welfare costs associated with CM would be to track the CM victims and their child welfare costs over their entire childhood. To date, there have been no such longitudinal studies. However, according to the Administration for Children and Families, the number of children investigated for CM and the cross-section of the investigated sample with respect to age and services provided to the children (e.g., substantiated vs. unsubstantiated; in-home services vs. out-of-home placement) remained relatively constant between 2004 and 2008 (USDHHS, 2010), which satisfies the assumptions for the steady-state methodology used by other researchers to estimate the lifetime costs of disease when direct or longitudinal data on lifetime costs are not available (Barnett, Birnbaum, Cremieux, Fendrick, & Slavin, 2000; Birnbaum, Leong, & Kabra, 2003). Following their methodology, by making steady-state assumptions, the total annual child welfare costs in 1 year serve as a proxy for the lifetime welfare costs of victims investigated in that year.

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The most recent national estimate of child welfare costs available is from 2006. Overall, states spent $25.7 billion in federal, state, and local funds on child welfare activities in fiscal year 2006, and an estimated 3,578,000 children received a CPS investigation in 2006 (DeVooght, Allen, & Geen, 2008). This yields an estimated $7,183 in child welfare costs per investigated child, or $7,728 per child in 2010 dollars.

Criminal justice costs. Criminal justice costs associated with CM were determined based on the effects of CM on juvenile and adult arrests. Widom and Maxfield (2001) analyzed data from a longitudinal study that followed a group of 908 substantiated cases of CM and a comparison group of 667 children through adulthood; they reported that 27.4% of maltreated children had a juvenile arrest, compared with 17.2% of non-abused children. We used the simple difference in these, 10.2%, as our estimate for the incremental effect of CM on the likelihood of arrest. Regarding the associated costs, Reynolds, Temple, Robertson, and Mann (2002) estimated that expenditures to the criminal justice system for juveniles with court petitions were $18,950 per participant in 1998 dollars, including the administrative expenditures associated with the juvenile arrest and the weighted national average of the proportion of cases that led to residential treatment, community treatment or probation services, and release. Updated to 2010 dollars, the criminal justice costs per juvenile arrest are $24,513. Based on the mean age of juvenile arrest of 14 (Reynolds et al., 2002) and the incremental increase of 10.2%, the present value of future expenditures to the criminal justice system associated with juvenile arrest evaluated at age 6 is $1,974 (2010 dollars) per CM victim.

For adult criminal justice costs, we used additional data from Widom and Maxfield (2001), who reported that CM increases the likelihood of having an adult criminal record by 9.1 percentage points (41.6% for the maltreated group vs. 32.5% for the comparison group). Reynolds et al. (2002) estimated that the average social cost of an adult crime — including the costs of arrest, judicial processing, and treatment — is $69,038 in 1998 dollars or $89,304 in 2010 dollars. Based on the assumed mean age of first adult arrest at 23 and an incremental increase of 9.1%, the present value of future expenditures to the criminal justice system associated with adult arrest is $4,773 (2010 dollars) per CM victim. Given the incidence-based costing framework we are using, this estimate reflects the average costs of all criminals, including chronic re-offenders.

Special education costs. Maltreated children are more likely to receive special education. Jonson-Reid, Drake, Kim, Porterfield, and Han (2004) found that 24.2% of maltreated children received special education at a mean age of 8 years, compared with 13.7% of children with no maltreatment record. Again, based on a simple difference, we assumed that the incremental effect due to CM is 10.5%. Reynolds et al. (2002) estimated that the average annual cost per child for special education services was $7,791 (1998 dollars) above and beyond regular instruction. Assuming that the average number of years receiving special education services is 9 years (from age 8 to 17) and the incremental increase is 10.5%, the present value of future special education costs associated with CM is estimated to be $7,999 (2010 dollars) per victim.

Average lifetime cost per victim of fatal child maltreatment

According to Corso, Mercy, Simon, Finkelstein, and Miller's (2007) work, for children aged 0–4, the average cost per case for a fatal assault was $11,300 (in 2000 dollars) in medical costs and $1,005,650 (in 2000 dollars) for lost productivity. Adjusted to 2010 dollars, the medical costs and productivity losses are $14,100 and $1,258,812, respectively.

Results

Table 1 presents the average lifetime cost of nonfatal CM per victim. Discounted at 3%, we estimated the average lifetime cost per victim of nonfatal CM to be $210,012 in 2010 dollars. The cost includes discounted present values of $32,648 in childhood health care costs, $10,530 in adulthood medical costs, $144,360 in productivity losses, $7,728 in child welfare costs, $6,747 in criminal justice costs, and $7,999 in special education costs. Because cost estimates vary as a function of the discount rate, we also estimated the average lifetime cost per case of nonfatal CM using the discount rate of 7% (Miller et al., 2006). Based on a 7% annual discount rate, the average lifetime cost per nonfatal victim was estimated to be $97,952 (see Table 1). For fatal CM, the average lifetime cost per death was estimated to be $1,272,900 in 2010 dollars, including $14,100

Table 1
The average lifetime cost per victim of nonfatal child maltreatment.

Source of cost	Reference	Average lifetime cost per victim (in 2010 dollars)	
		Discounted at 3%	Discounted at 7%
Short-term health care costs	Florence et al. (2012)	$32,648	$27,063
Long-term health care costs	Bonomi et al. (2008)	$10,530	$3,789
Productivity losses	Currie and Widom (2010)	$144,360	$49,068
Child welfare costs	DeVooght et al. (2008)	$7,728	$7,728
Criminal justice costs	Widom and Maxfield (2001) Reynolds et al. (2002)	$6,747	$3,860
Special education costs	Jonson-Reid et al. (2004) Reynolds et al. (2002)	$7,999	$6,443
Total		$210,012	$97,952

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Table 2
The average lifetime cost per case of fatal child maltreatment.

Source of cost	Average lifetime cost per victim (in 2010 dollars)	Average lifetime cost per victim (in 2010 dollars)
	Discounted at 3%	Discounted at 7%
Medical costs	$14,100	$14,100
Productivity losses	$1,258,800	$325,267
Total	$1,272,900	$339,367

Table 3
Total lifetime costs of child maltreatment, 2008, United States (based on substantiated cases of child maltreatment).

Source of cost	Total lifetime costs (in 2010 dollars)	
	Discounted at 3%	Discounted at 7%
Nonfatal		
Incidence (cases)	579,000	579,000
Short-term health care costs	$18,903,192,000	$15,669,477,000
Long-term health care costs	$6,096,870,000	$2,193,831,000
Productivity losses	$83,584,440,000	$28,410,372,000
Child welfare costs	$4,474,512,000	$4,474,512,000
Criminal justice costs	$3,906,513,000	$2,234,940,000
Special education costs	$4,631,421,000	$3,730,497,000
Total	$121,596,948,000	$56,714,208,000
Fatal		
Incidence (cases)	1,740	1,740
Medical costs	$24,534,000	$24,534,000
Productivity losses	$2,190,312,000	$565,964,580
Total	$2,214,846,000	$590,498,580
Total costs (including both fatal and nonfatal cases)	$123,811,794,000	$57,304,706,580

in medical costs and $1,258,800 in productivity losses (Table 2). The average lifetime cost per death would be $339,367 if using the discount rate of 7%.

Table 3 presents the total lifetime economic burden of CM in 2008 based on the baseline estimate of 579,000 new cases of nonfatal CM. For these cases, the aggregate lifetime costs were estimated to be $121.6 billion. Of the total costs, childhood health care costs accounted for $18.9 billion, adulthood medical costs accounted for $6.1 billion, productivity losses accounted for $83.6 billion, child welfare costs accounted for $4.5 billion, criminal justice costs accounted for $3.9 billion, and special education costs accounted for $4.6 billion. The aggregate lifetime costs associated with the 1,740 deaths resulting from CM were estimated to be $2.21 billion, with medical costs accounting for $25 million and lost productivity accounting for $2.19 billion. Adding together the fatal and nonfatal costs gave us the total lifetime costs associated with new cases of fatal and nonfatal CM in 2008, approximately $124 billion. When using the more conservative discount rate of 7%, the total lifetime costs of CM in 2008 still exceed $57 billion (Table 3).

In sensitivity analysis (Table 4), when we assumed that all investigated children were victims of CM (i.e., 2,775,000 new victims in 2008), the total lifetime costs associated with new cases of fatal and nonfatal CM in 2008 would increase to $585 billion using the discount rate of 3% and to $272 billion using the discount rate of 7%. When incidence estimates using the NIS "Harm Standard" (i.e., 942,450 new victims per year) and "Endangerment Standard" (i.e., 2,179,350 new victims per year) were applied to the sensitivity analysis, the total lifetime costs of CM in 2008 were approximately $200 billion and $460 billion, respectively, using the discount rate of 3%. When using the discount rate of 7%, the total lifetime costs of CM were $93 billion and $214 billion respectively.

Table 4
Sensitivity analysis of total lifetime costs of child maltreatment, 2008, United States.

Source of incidence data	Incidence (cases)	Total lifetime costs (in 2010 dollars) discounted at 3%	Total lifetime costs (in 2010 dollars) discounted at 7%
Nonfatal			
NIS harm standard	942,450	$197,925,809,400	$92,314,862,400
NIS endangerment standard	2,179,350	$457,689,652,200	$213,471,691,200
CPS investigated cases	2,775,000	$582,783,300,000	$271,816,800,000
Fatal			
CPS data	1,740	$2,214,846,000	$590,498,580
Total costs (including both fatal and nonfatal cases)			
NIS harm standard		$200,140,655,400	$92,905,360,980
NIS endangerment standard		$459,904,498,200	$214,062,189,780
CPS investigated cases		$584,998,146,000	$272,407,298,580

Abbreviations: NIS, National Incidence Study; CPS, child protective services.

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Discussion

Using an incidence-based approach, the lifetime economic burden of CM resulting from an estimated 579,000 new cases of nonfatal CM and 1,740 cases of fatal CM that occurred in the United States in 2008 is approximately $124 billion. On average, the lifetime cost is estimated to be $210,012 per victim of nonfatal CM and $1,272,900 per victim of fatal CM. These estimates are significant new contributions that use a consistent, robust approach in incidence-based costing methods, which improve significantly upon the limitations of past estimates of the burden of CM. Our estimates also represent the most recent and up-to-date figures for accurate, contemporary policy analysis. Furthermore, our use of a consistent, incidence-based approach directly facilitates comparisons with other health conditions and enables economic analyses of CM-specific policies. Such evaluation was impossible in the past based on previous work. We also provide sensitivity analyses on our estimates to reflect the facts that the measure of burden is dependent on assumptions about discounting for present value and CPS data underestimate the total incidence of CM.

Our new estimates cannot be compared directly to previous estimates of the economic impact of CM because of significant differences in our methods, as discussed earlier. However, for context, we cautiously make comparisons to the most widely cited report and to estimated costs of some other public health problems, which are measured using incidence-based costing approaches. Using a mix of methods, but primarily a prevalence-based approach, Wang and Holton (2007) report an estimate of $103.8 billion (2007 dollars) in annual costs; because it is primarily prevalence-based, their estimate is approximately the burden in a single year. In contrast, our estimate of $124 billion (2010 dollars)—while seemingly similar—represents the lifetime cost of new CM cases that occur in a single year.

We also estimated the lifetime burden of a new case of nonfatal CM to be $210,012 per victim. This estimate is comparable to that of many other high profile public health problems, indicating the impact and seriousness of the issue of CM. For example, the discounted lifetime costs (discounted at a 5% rate) of stroke per person were estimated at $159,846 (2010 dollars) (Taylor et al., 1996), whereas the total lifetime costs (discounted at a 3% rate) associated with type 2 diabetes were estimated between $181,000 and $253,000 (2010 dollars) per case (Zhuo, Zhang, & Hoerger, 2010). Although stroke and diabetes are clearly different from CM, we reference them to indicate that CM costs and prevalence are high enough for policy makers to justify allocating resources to effective prevention and mitigation strategies for CM.

Like any estimates of economic burden, our study has several limitations. First, we used an estimate of 579,000 new substantiated cases per year as the baseline to calculate the total lifetime economic burden of CM. This number underestimates the total incidence of CM because some of the maltreated cases may not have been reported to CPS or were reported but not substantiated for various reasons, implying that our baseline results are probably conservative, lower-bound estimates of the total lifetime economic burden of CM. Since many states are now facing fiscal crises and significantly trimming social service budgets, it is possible that budget cuts may have artificially reduced the number of substantiated cases. If so, our estimates based on substantiated cases may not represent a "steady state" burden of CM as much as estimates based on investigated cases, which may be less affected by budget cuts than substantiation. A number of papers (e.g., Drake, 1996; Fallon et al., 2011; Hussey et al., 2005; Kohl, Jonson-Reid, & Drake, 2009; Leiter, Myers, & Zingraff, 1994) have shown that risk of maltreatment, which we capture more broadly through investigations, is strongly associated with adverse CM-related outcomes, including risk of CM fatalities (Putnam-Hornstein, 2011). Second, the costs of several adverse outcomes associated with CM were not measured. Research has suggested that CM may be associated with reduced life expectancy, decreased quality of life, and negative parenting behaviors, which can lead to negative intergenerational outcomes, including conduct, peer, and emotional problems (Brown et al., 2011; Corso & Fertig, 2010; Corso et al., 2007; Roberts, O'Connor, Dunn, & Golding, 2004). We were unable to locate sufficient data on the magnitude of these effects or their costs and were therefore unable to include them in this study. As a result, our findings undercount the full costs of CM. Third, the assessment and definitions of CM differed somewhat among the studies we used to estimate different categories of costs. Some used CPS substantiated cases to identify CM (e.g., Currie & Widom, 2010; Widom & Maxfield, 2001), whereas others used CPS investigations (e.g., Florence et al., 2012) to measure CM or used self-reported surveys and questionnaires (e.g., Bonomi et al., 2008) to measure the retrospective abuse history. Fourth, most of the studies we used for component costs did not estimate the impact of psychological abuse because of the lack of data on psychological abuse. The long-term medical cost estimates in Bonomi et al. (2008) do not include psychological abuse or neglect. Excluding psychological abuse or neglect from some cost areas associated with CM may lead to an underestimation of the economic burden of CM.

Fifth, we did not estimate the economic burden of CM by type and severity of maltreatment because several of the cost studies we used (e.g., Currie & Widom, 2010; Widom & Maxfield, 2001) did not provide the effects of CM by type of maltreatment and none of the studies have estimated the effects by severity of CM. However, for the studies which *did* investigate the effects by type, results indicate that different types of maltreatment may be associated with different magnitude of these effects. For example, Jonson-Reid et al. (2004) found that children reported for physical abuse had nearly a 50% higher risk of later special education entry than those reported for sexual abuse. Bonomi et al. (2008) estimated that long-term annual health care costs were 22% higher for women with a history of physical abuse and 16% higher for women with a history of sexual abuse compared to women without physical or sexual childhood abuse. In contrast, sexual abuse can be more significantly associated with some other health consequences such as reproductive and sexual health problems. A literature review indicates that childhood sexual abuse can be associated with a myriad of serious reproductive and sexual health problems including unplanned or adolescent pregnancies, infertility, menstrual problems, and painful intercourse (Bohn & Holz, 1996). Severity of maltreatment is another important factor that may affect economic costs. Some

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previous studies have shown a relationship between severity of CM and psychological and/or functional outcomes (e.g., Manly, Cicchetti, & Barnett, 1994; Romans, Martin, Anderson, O'Shea, & Mullen, 1995), but little has been done to examine the associations of CM severity with the outcomes included in this study for the estimation of CM costs. Furthermore, the field has not achieved consensus on how to best measure the severity of CM. The lack of the studies and consensus on the operational definitions of severity did not allow us to conduct finer calculations by severity.

Sixth, we were unable to include any long-term medical costs for adults aged 65 or older. Because other research has shown that health consequences of CM may continue beyond age 65 (Felitti et al., 1998), any associated costs in this age group further imply that we underestimate total costs of CM. Seventh, productivity losses for CM morbidity were not adjusted to include household productivity, although for mortality, household productivity losses were included in the Corso et al. (2007) estimates. Short-term productivity losses such as missed school days due to CM were excluded as well. Excluding these losses implies that our estimates underestimate the actual burden of CM. Eighth, we used the median age (6 years) in CPS reports (USDHHS, 2010) to calculate the average lifetime cost per victim. More severe cases of CM tend to occur in early childhood, so the unbalanced age distribution in terms of the severity of CM could bias our estimates. (For example, in most cases of abusive head trauma, victims are infants younger than 1-year old (Brown et al., 2011).) Ninth, most of our component costs estimates were based on data from single studies. In most cases there were few alternatives from which to choose. Given the sensitive nature of CM, we did not find any relevant studies of CM costs that were based on an experimental design. Instead, as a second best approach with the available data, we relied on studies which applied quasi-experimental longitudinal, prospective designs whenever possible. For almost all the cost categories for which existing data are available, only one study with prospective quasi-experimental design has been found for each category. Given the lack of additional valid studies in these areas, we were not able to use methods like meta-analysis or a sensitivity analysis of high and low estimates to arrive at more valid estimates for each cost category. Finally, although we include a range of estimates based on discount rate and incidence rate sensitivity analysis, we are unable to provide statistical confidence intervals in this study because of the large number of input sources used and the fact that several estimates included in our study did not report standard errors.

Although our study provides several important innovations over past estimates, a few areas should be highlighted for future research. First, as discussed above, we were unable to include economic estimates of a few impacts, which may have monetary costs. Future studies that quantify the costs of reduced life expectancy, decreased quality of life, or negative parenting behaviors and negative intergenerational outcomes could be included as updates to our estimates as they are available using the same framework. Second, if additional data on unsubstantiated cases were to be made available by CPS agencies or other sources, we could expand our sensitivity analysis and the potential range of estimates in this study. Developing more consistent definitions of CM and adding confidence intervals to inputs would strengthen our findings. Third, we were unable to estimate the economic burden of CM by type and severity of maltreatment due to the lack of sufficient data. This gap inhibits the evaluation of interventions which may be specific to certain types of maltreatment and our understanding of cost impacts of maltreatment. Where possible, we recommend that future researchers make efforts to investigate the costs of maltreatment by type and severity, as this will facilitate improved economic evaluations.

In summary, we estimate that the approximately 579,000 new substantiated cases of nonfatal CM and 1,740 cases of fatal CM per year in the United States result in a total economic burden of $124 billion. This estimate is based on discounted lifetime costs of $210,012 per victim of nonfatal CM and $1,272,900 per victim of fatal CM. These estimates are based on an incidence-based approach, which facilitates economic analysis for public health interventions. Compared with other health problems, the burden of CM is substantial, even after conservative assumptions are used, indicating the importance of preventing and treating CM. Although the evidence base for effective strategies to address CM is limited, a promising array of prevention and response programs have great potential to reduce the economic burden of CM. Included among effective programs are Nurse-Family Partnership, Early Start, and Triple P System (Macmillan et al., 2009; Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009). For such programs to be successful, an ongoing commitment to implementation science will be needed to ensure that the full programs—upon which the positive results rest—are imparted with fidelity and include ongoing monitoring and supervision, and sustained resourcing (Cohen, Mannarino, & Murray, 2011; Toth & Manly, 2011). Given the substantial economic burden of CM, the benefits of prevention will likely outweigh the costs for effective programs.

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Cindy Smith

From: Rutherdale, Jan A (LAW) <jan.rutherdale@alaska.gov>
Sent: Wednesday, February 08, 2012 10:20 AM
To: Cindy Smith; Lyons, Michelle G (HSS)
Cc: Celeste Hodge
Subject: Re: Materials are coming

Will do, Cindy, and thanks again for your patience with yesterday's glitches.
Jan

----- Original Message -----
From: Cindy Smith <Cindy_Smith@legis.state.ak.us>
To: Rutherdale, Jan A (LAW); Lyons, Michelle G (HSS)
Cc: Hodge, Celeste (LAA)
Sent: Wed Feb 08 08:03:21 2012
Subject: RE: Materials are coming

For today, we will have a laptop and screen set up so all you need to bring is a jump drive with your presentation and we can plug you right in! If you can be there about 10 minutes before start time -- so around 1:20 -- that would helpful so we can make sure the presentation is up, loaded and ready to go when the committee begins.

All the printed material has been distributed, and we look forward to seeing you!

Cindy Smith
Office of Senator Hollis French
(907) 465-3892
www.senate.org

-----Original Message-----
From: Rutherdale, Jan A (LAW) [mailto:jan.rutherdale@alaska.gov]
Sent: Tuesday, February 07, 2012 2:58 PM
To: Cindy Smith; Lyons, Michelle G (HSS)
Subject: RE: Materials are coming

Cindy,
Sorry about the delay; Michelle ran into OCS firewall problems so we're sending this from my computer.

-----Original Message-----
From: Cindy Smith [mailto:Cindy_Smith@legis.state.ak.us]
Sent: Tuesday, February 07, 2012 12:21 PM
To: Rutherdale, Jan A (LAW); Lyons, Michelle G (HSS)
Subject: RE: Materials are coming

OK, thanks!

Cindy Smith
Office of Senator Hollis French
(907) 465-3892
www.senate.org

-----Original Message-----
From: Rutherdale, Jan A (LAW) [mailto:jan.rutherdale@alaska.gov]
Sent: Tuesday, February 07, 2012 12:20 PM
To: Cindy Smith; Lyons, Michelle G (HSS)
Subject: Materials are coming

Hi Cindy,
Michelle Lyons-Brown will be sending you within the hour the following for the presentation:
-Power point (3 slides to a page, B&W, w/o photos -hand-out of a national study (I can't remember the same) -a slightly corrected version of the CJA member list (if you've already distributed this, don't worry about redistributing)
- the statement regarding the proposed legislation -the proposed legislation

(Note: you already have a copy of the last two items -- we haven't changed them.)

We'll bring with us the 3 other reference handoutsthat are in hard copy form and not needed for the presentation (mandatory reporter training CD, MDT Guideline publication, and ACA brochure).
Jan

Cindy Smith

From: Lyons, Michelle G (HSS) <michelle.lyons@alaska.gov>
Sent: Tuesday, February 07, 2012 1:03 PM
To: Cindy Smith
Subject: Materials may come in two batches
Attachments: CJA statement regarding proposed legislation 11-18-11.doc; CJA member list 11-11.docx; CJA proposed legisation jan's FINAL 12-6-11.doc

Importance: High

As we are having technological issues with the presentation and cannot get it forwarded at this time....

Michelle Lyons-Brown
Child Advocacy Center/
Child Justice Act Task Force Coordinator
State of Alaska
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What is the Alaska Children's Alliance?

The Alaska Children's Alliance (ACA) is a non-profit coalition of established and developing children's advocacy centers (CAC's), multi-disciplinary teams (MDT's), and child protection teams (CPT's) dedicated to improving community responses to child maltreatment.

ACA is a state chapter of the National Children's Alliance (NCA). NCA is a non-profit accrediting organization that was developed to support and sustain the continued evolution of the CAC model. NCA provided Chapter Grant funding for the development of ACA and its publications, such as this brochure.

The Mission of the Alaska Children's Alliance

The mission of the Alaska Children's Alliance is to promote a culturally appropriate multidisciplinary response to child maltreatment throughout Alaska.

What is a Children's Advocacy Center?

A Children's Advocacy Center (CAC) provides a child-friendly environment that allows law enforcement, child protection workers, prosecutors, medical providers, victim/family advocacy, tribal representatives, and mental health providers to work together when there are allegations of child abuse. Referrals are accepted from the Office of Children's Services, law enforcement agencies (Alaska State Troopers, local police departments) and medical providers.

Why does Alaska need Children's Advocacy Centers?

- Alaska continues to have very high rates of child abuse and neglect, particularly child sexual abuse
- Child maltreatment is strongly linked to juvenile and adult crime, teen pregnancy, alcohol & drug abuse, suicide, and future family violence
- Child maltreatment has also been shown to be major contributors to poor adult medical and mental health
- Studies show that the annual economic impact of child abuse is $182,000 per maltreated child.
- Children are less fearful when investigations are conducted using CACs
- Parents & caregivers are more satisfied with the investigations when CACs are used

What happens at a Children's Advocacy Center?

- Comprehensive, multidisciplinary evaluation for child abuse concerns
- Specialized forensic interview in a child-oriented interview room which is video-taped and monitored by other members of the team
- Thorough, non-invasive medical exam by specially trained medical professionals
- Support, referrals, and follow up for children and families

Goals of CAC's, MDT's, & CPT's

- Assure that children are not further victimized by the systems designed to protect them
- Assure the child is safe
- Reduce the long term affects associated with trauma for the child and family
- Enhance and coordinate the investigation so that the accuracy of the concern is quickly and reliably determined
- Promote successful prosecution of criminal child abuse
- Encourage support and treatment for abused children and their families

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The Alaska Children's Alliance

"Let us pray and work diligently,
and not take our ease,
until every Alaskan child
is safe, loved, and nurtured
every day of his or her life."

~ Senator Fred Dyson

A Chapter of the National Children's Alliance