

**02/07/13**  
**OVERVIEW:**  
**ALASKA**  
**CHILDREN'S**  
**JUSTICE ACT**  
**TASK FORCE**

<TARGET><BILL></BILL><SUBJECT>02-07-13 OVERVIEW ALASKA  
CHILDREN'S JUSTICE ACT TASK  
FORCE</SUBJECT><COMM>HHSS28</COMM></TARGET>



## **Overview of the Alaska Children's Justice Act Task Force ("Alaska CJATF")**

Alaska CJATF, founded in FY1999, is a federally-mandated, state-wide multidisciplinary group mandated to evaluate the state system response to child abuse, make recommendations for system improvement, and implement projects that improve system response. The Task Force is comprised of representatives from law enforcement, medicine, child protection, law (both prosecution and defense), child advocacy centers (CACs), judiciary, mental health, court-appointed special advocates/guardians ad litem, schools, tribal organizations and parent groups. (See attached list of current members.)

Our limited federal funding (approximately \$85,000 annually), which requires the backing of the Governor through a letter of support each annual grant cycle, pays for our part-time coordinator, our quarterly meetings, and all of the projects outlined below. We are very careful stewards of these funds.

Our projects over the past two years focus on three areas: gathering better data, improving the system response to child abuse and making recommendations for changes in law.

We have consistently focused on the need to gather better data. Without good data, it is difficult to assess how the system is working, identify needed improvements, and evaluate whether those changes succeed. To this end, the Task Force has used child maltreatment data compiled by the Alaska Surveillance of Child Abuse and Neglect Program (SCAN) to provide a baseline for evaluating the efficacy of intervention and prevention programs. Some of the most striking findings are that on an average day up to 34 Alaskan children may experience some sort of maltreatment, including 7 who may be physically abused and 5 who may be sexually abused. The estimated economic burden on victims and the state related to all types of child maltreatment exceeds \$500 million annually in Alaska. (Please see source document enclosed.)

Our focus on improving the system response to child abuse falls into three main categories. First, we actively support the development of CACs and Multi-Disciplinary Teams (MDTs).

- Development and publication of the "Guidelines for Multidisciplinary Response to Child Abuse in Alaska" based on best practices recommendations
- Sponsorship of a statewide Child Forensic Interviewing Roundtable, conducted three years ago, led to the selection of the ChildFirst Forensic Interviewing model. The first of three trainings to develop a core of Alaska trainers will occur in late February 2013. This model will standardize forensic interviewing statewide and across disciplines.
- Ongoing distribution of the training CD we developed for mandated reporters (several thousand have been sent state-wide, to the Lower 48, and overseas). The CD is also available on line at our website along with a new Guide for instructors:  
<http://www.hss.state.ak.us/ocs/ChildrensJustice/default.htm>

Second, CJA supports education and training in the following ways:

- Annual presentations to the Legislature with an educational focus on child maltreatment data and issues to help guide Alaska's legislative decisions;
- Providing training scholarships to multidisciplinary team members in the field to help them keep abreast of the latest research and best practices;

- Sponsorship of the biennial Alaska Child Maltreatment Conference, presented by the Alaska Children's Alliance.

Third, we support innovative programs by reviewing successful pilot or regional programs and determining whether such programs can be expanded for statewide use. We also provide financial support to such programs, for example, by paying for training materials in the Pathway to Hope program, a culturally sensitive victim and community recovery model. In addition, members of the CJATF are involved with the Governor's Choose Respect Initiative.

We have also made recommendations for law changes. In the 2012 legislative session, in response to gaps in our laws resulting in inadequate sentences for offenders that lessen their accountability for harming children, we drafted legislation and presented it to the Senate Judiciary Committee meeting on February 8, 2012. Aspects of the proposed legislation became part of Senate Bill 210, which passed during this legislative session. For the 2013 legislative session, we have drafted legislation to amend the mandatory reporting statutes, and provide more protection for abuse victims. We will be presenting this legislation to the House Health and Social Services Committee on February 7, 2013, and the Senate Judiciary Committee on February 8, 2013.

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Appendix—Detailed Listing of Health and Social Problems Shown to Have a Graded Relationship to the ACE Score.\*

Type of Problem	Outcomes Associated with Adverse Childhood Experiences
Prevalent Diseases	Ischemic heart disease <sup>14,28</sup> cancer, <sup>38</sup> chronic lung disease, <sup>38</sup> skeletal fractures, <sup>38</sup> sexually transmitted diseases, <sup>35,38</sup> and liver disease <sup>11,38</sup>
Risk Factors for Common Diseases/Poor Health	Smoking <sup>1,36,38</sup> alcohol abuse, <sup>1,2,11,19,25,38</sup> promiscuity, <sup>1,29,35,38</sup> obesity, <sup>26,38</sup> illicit drug use, <sup>1,16,38</sup> injected drug use, <sup>1,26,38</sup> multiple somatic symptoms, <sup>1</sup> poor self-rated health, <sup>38</sup> high perceived risk of AIDS <sup>29</sup>
Poor Mental Health	Depressive disorders, <sup>1,14,15,36,38</sup> anxiety, <sup>1</sup> hallucinations, <sup>1,8</sup> panic reactions, <sup>1</sup> sleep disturbances, <sup>1</sup> memory disturbances, <sup>1,31</sup> poor anger control, <sup>1</sup> risk of perpetrating or being a victim of domestic violence <sup>1,17</sup>
Sexual and Reproductive Health	Early age at first intercourse, <sup>1,38</sup> sexual dissatisfaction, <sup>1</sup> teen pregnancy, <sup>9</sup> unintended pregnancy, <sup>27</sup> teen paternity, <sup>27,32</sup> fetal death <sup>9</sup>
General Health and Social Problems	High perceived stress, <sup>1</sup> difficulty with job performance, <sup>10</sup> relationship problems, <sup>10</sup> marriage to an alcoholic <sup>25</sup>

\* A complete bibliography of ACE Study publications listed by topic area is available online at <http://www.cdc.gov/nccdphp/ace/>

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## Implications

The effects of ACEs are long-term, powerful, cumulative, and likely to be invisible to health care providers, educators, social service organizations, and policy makers because the linkage between cause and effect is concealed by time, the inability to “see” the process of neurodevelopment, and because effects of the original traumatic insults may not become manifest until much later in life.<sup>1,3,36,38</sup> When a child is wounded, the pain and negative long-term effects reverberate as an echo of the lives of people they grew up with—and then they grow up, at risk for taking on the same characteristics and behaviors—thereby sustaining the cycle of abuse, neglect, violence and substance abuse, and mental illness. For example, ACEs greatly increase the risk of adult alcohol abuse or marriage to an alcoholic,<sup>25</sup> perpetuating the adversities and their consequences.<sup>28</sup> Thus, growing up with alcohol abuse contributes to many of the leading chronic health and social problems in the United States.

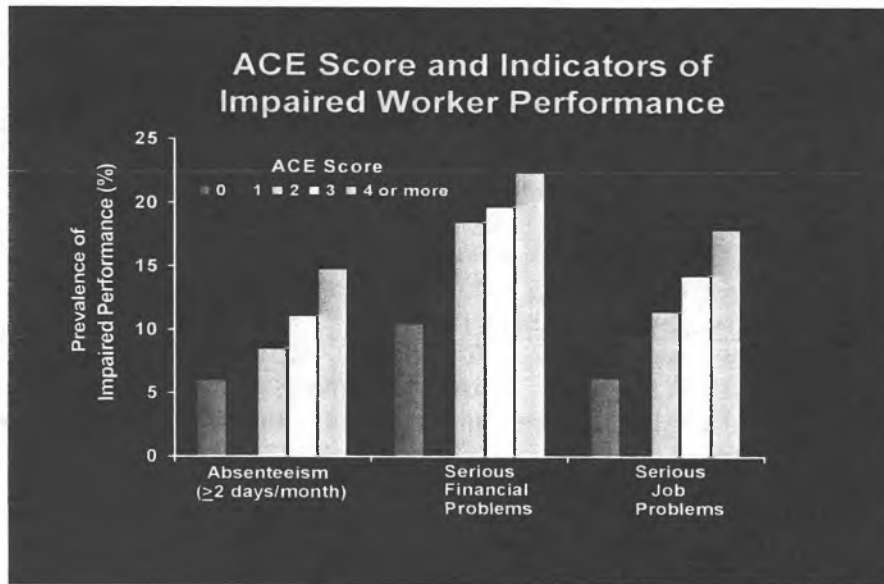
Information from the ACE Study suggests that traumatic stressors during childhood and adolescence represent a common pathway to a variety of important long-term behavioral, health, and social problems (see Appendix, page 22). Thus, an integrated rather than a separate or categorical, perspective on the origins of health and social problems throughout the lifespan is needed. This approach to alcohol abuse and related ACEs, and to the consequences of exposure to them, may unify and improve our understanding of many seemingly unrelated health and social problems that tend to be identified and treated as categorically separate issues in Western culture.

The ACE Score appears to be a robust of the cumulative, lifetime impact of traumatic stress on neurodevelopment in childhood. Stressful and traumatic childhood and adolescent experiences literally become “biology” affecting brain structure and function (as well as endocrine, immune, and other biologic functions) thus leading to persistent effects. Until now, these persistent effects were “hidden” from the view of both neuroscientists and public health researchers. **This is no longer the case. In fact, with this information comes *the responsibility to use it.***<sup>40</sup>

These links between childhood experience and adult health and social function have significant implications for health and social services. We found that adults who reported any single category of adverse childhood experience were likely to have suffered multiple other categories during childhood. Therefore, assessment of exposure to other ACEs is important when working with children or adults identified as having had any single type of ACE. Children experiencing alcohol abuse in the home should be screened for other types of maltreatment and traumatic stressors—and vice versa! This information, if routinely gathered will likely contribute to more meaningful diagnoses, earlier and improved treatment of exposed *children and their caretakers*, and better integration of prevention, social services, and legal venues.

Facing the high prevalence and interrelatedness of ACEs is going to be tough. Categorical approaches to the individual ACEs as well as the health and social problems strongly related to them tend to be “siloed”. However, the professions, research priorities, organizations, and resources that are necessary to healing frequently exist in “silos”—separate, often competitive rather than collaborative, entities, each preserving and advancing the resources and work that is historically “theirs”. While this is understandable, to succeed, we must make this “ours”, a team effort that reaches beyond traditional boundaries and borders.

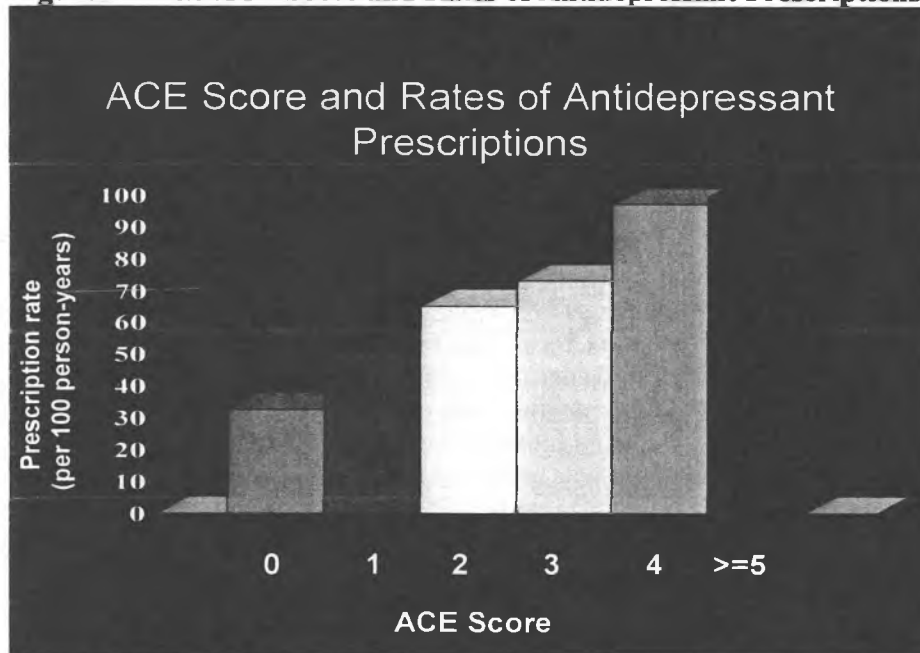
*Prevention and remediation of our nation’s leading health and social problems are likely to benefit from integrated approaches that incorporate information about their common origins in the enduring neurodevelopmental consequences of growing up with alcohol abuse and related adverse experiences during childhood.*



**ACEs and Direct Health Care Costs—Prescription Pharmaceuticals**

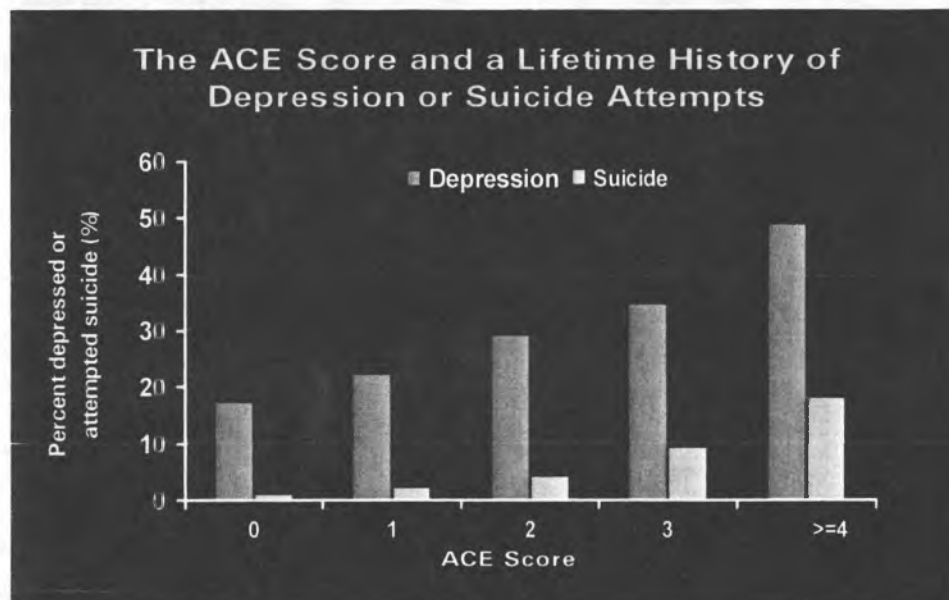
Nearly \$180 billion were spent on prescription drugs in the United States in 2003. This represents approximately 11% of total national health expenditures and was more than four times the amount spent in 1990.<sup>62</sup> One of the most rapidly rising set of prescribed drugs is antidepressants; how do ACEs affect their use?

**Figure 11.-The ACE Score and Rates of Antidepressant Prescriptions<sup>4</sup>**



**Given the results of the ACE Study, what are the human, social, and economic costs of the high prevalence, interrelatedness, and long-term consequences of Adverse Childhood Experiences?**

**Figure 9, - Relationship of the ACE Score to Depression and Suicide Attempts**



By now it should be obvious that the long term human costs of ACEs are enormous and that the problems associated with these problems also translate into costs of health care, disability, and social services. Now, let's turn to two examples where the costs—in economic terms—are most obvious.

#### **ACEs Affect Worker Performance**

Inasmuch as ACEs affect the health and well-being of the workforce, they are a hidden drain on profitability for corporate America. The human and economic costs of the long-term effects of adverse childhood experiences on the workforce are likely major and merit attention by the business community in concert with the modern practice of medicine and public health. Recent studies estimated annual costs as high as \$28 billion for chronic back pain for US businesses,<sup>58</sup> \$30-\$44 billion for depression and related absenteeism, reduced productivity, and medical expenses,<sup>59</sup> and \$246 billion for chemical dependency in the workforce.<sup>60</sup> These massive losses occur despite safety programs and the most expensive medical care system in the world.<sup>61</sup> If these areas are indeed related to the performance of the workforce, profitability of businesses and even national productivity are likely to be affected as well.

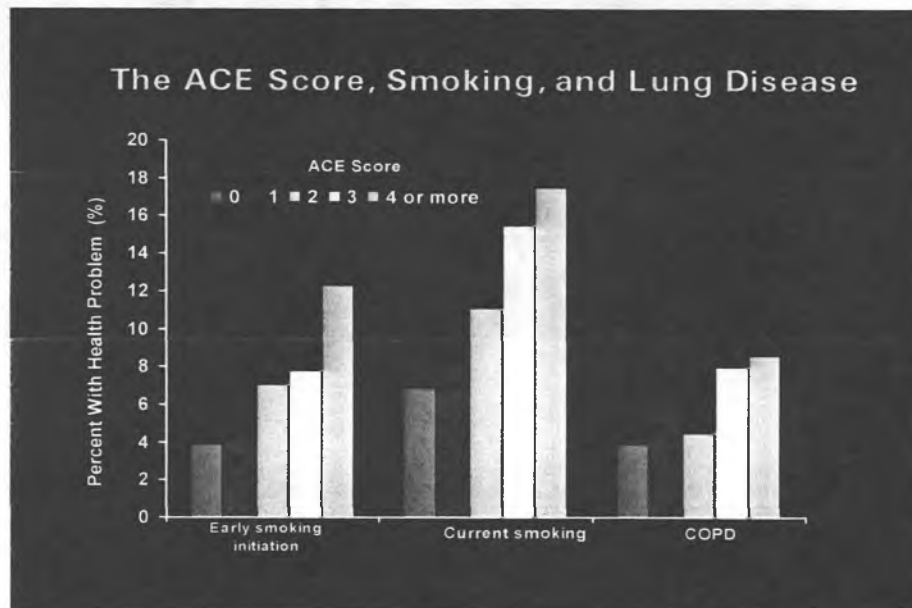
Absenteeism, financial problems, and self-reported problems on the job are all indicators of impaired productivity that are expensive and are also indicators of ACE related problems such as alcohol abuse, chronic pain, mental health disorders, and others. Figure 9 displays the relationship of ACEs to these indicators of reduced worker productivity.<sup>10</sup>

**Figure 10.-ACEs and Indicators of Impaired Worker Performance**

### The ACE Score, Smoking, and Chronic Obstructive Pulmonary Disease

Cigarette smoking is the leading cause of preventable morbidity and mortality in the United States. Unfortunately, as with initiation of alcohol use, ACEs increase the likelihood of early smoking initiation.<sup>36</sup> Moreover, ACEs lead to continued smoking and the risk of Chronic Obstructive Pulmonary Disease (COPD; one of the 10 leading causes of death in the US).<sup>36,38</sup>

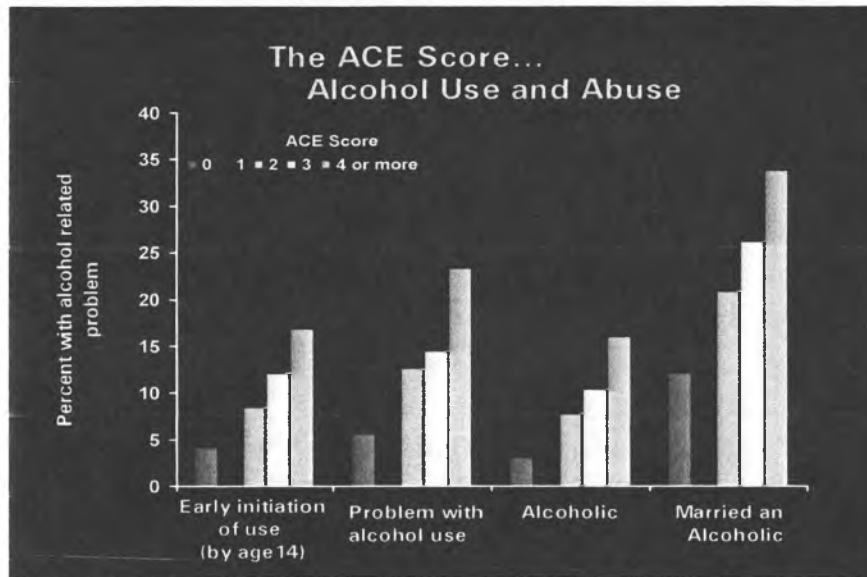
**Figure 8.--Relationship of the ACE Score to Smoking and COPD**



### ACEs, Depression, and Suicide Attempts (Figure 8)

Depression is now recognized to be a leading cause of disability worldwide, and ACEs bear a strong relationship to this common mental health problem; the relationship is equally strong for both men and women.<sup>15</sup> Suicide is a leading cause of death in the US with a “bimodal” age pattern of attempts—one peak in adolescence and one in middle age. Here also, ACEs have a powerful graded relationship to the risk of suicide attempts; this holds for attempts by men and women and attempts during adolescence or adulthood.<sup>34</sup>

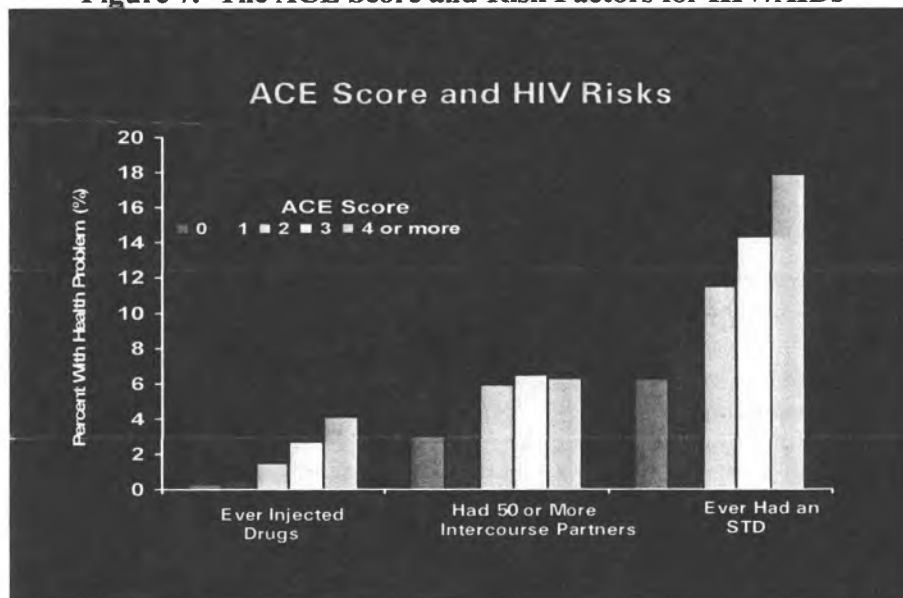
**Figure 6.- Relationship of the ACE Score to Alcohol Use and Abuse**



**The ACE Score and Risk Factors for HIV/AIDS**

The risk factors for transmission of the Human Immunodeficiency Virus (HIV), the causative agent of the AIDS epidemic are now well known. What appears to be less well known is that ACEs are a major hidden “engine” underlying these preventable risk factors for the transmission of HIV (Figure 6). Injected drug use, promiscuity (defined as having had 50 or more lifetime intercourse partners), and ever having a sexually transmitted disease (including AIDS), all increase dramatically as the ACE Score increases.<sup>11,16,29,35,38</sup>

**Figure 7.- The ACE Score and Risk Factors for HIV/AIDS**



somewhat more common in women. Even in this well educated population of HMO patients, less than one-third had an ACE Score of 0! Or from the perspective of a provider of health or social services in this population 1 or 2 out of every ten adults seen have an ACE Score of 5 or more!

**Table 4. Prevalence of the ACE Score by Gender**

ACE Score	Prevalence (%)		
	Women	Men	Total
0	31.3	34.2	32.7
1	24.2	27.3	25.6
2	14.8	16.4	15.5
3	10.4	9.3	9.9
4	6.8	4.8	5.9
>5	12.5	8.0	10.5

**The ACE Score Has a Graded Relationship to Numerous Health and Social Outcomes:  
An Indicator of the Effects of Cumulative Stress on (Neuro)Development**

The relationship of the ACE Score to a wide range of health, emotional, and social outcomes has been described.<sup>1-41</sup> It is noteworthy that the use of the ACE Score as a measure of the cumulative exposure to traumatic stress during childhood is consistent with more recent understanding, from the neurosciences<sup>1,45</sup> of the effects of traumatic stress on neurodevelopment. Neuroscientists have linked childhood maltreatment--using experimental animal models as well as case-control studies in humans--to long-term changes in brain structure and function, involving several inter-connected brain regions including the prefrontal cortex, hippocampus, amygdala, corpus callosum, and cerebellum.<sup>46-51</sup> Early stress is also associated with lasting alterations in stress-responsive neurobiological systems, including the hypothalamic-pituitary-adrenal axis and monoamine neurotransmitter systems; these lasting effects on the developing brain would be expected to affect numerous human functions into adulthood including (but not limited to) emotional regulation, somatic signal processing (body sensations), substance abuse, sexuality, memory, arousal, and aggression.<sup>52-57</sup>

Numerous publications have documented a graded or “dose-response” relationship between the number of categories of ACEs (ACE Score) and a wide variety of health and social problems of national importance.<sup>1-41</sup> I consider the “dose-response” findings quite literally; the ACE Score appears to capture cumulative exposure of the developing brain to the activated stress response, which is the pathway by which ACEs exert their neurobiological impact. This “dose response” relationship is evident in the figures that follow in the next section; as the ACE Score goes up, so does the risk of problems from adolescence to adulthood.

**Relationship of the ACE Score to Alcohol Use and Abuse**

One of the strongest relationships seen was between the ACE score and alcohol use and abuse (Figure 5).<sup>2,25</sup> Given recent research indicating the negative impact of alcohol use on neurodevelopment of adolescents, the relationship of ACEs to early initiation of alcohol use is particularly worrisome. The negative health and social consequences of alcohol abuse and alcoholism constitute a major public health problem—and ACEs have a particularly strong association with alcohol abuse. In addition, it is notable that the perpetuation of the cycle of alcohol abuse appears to be tightly interwoven with the number of ACEs, including marriage to an alcoholic.

### The Occurrence of One ACE Should Evoke a Search for Others

Table 1 shows the probability (%) of experiencing additional ACEs based upon the occurrence of each individual category of ACE.<sup>5</sup> In the case of persons who had grown up with household substance abuse, 81% reported at least one additional ACE and the majority had experienced 2 or more ACEs. In the entire study population, 81%-98% of respondents who had experienced one ACE reported at least one additional category of ACE (median: 87%).<sup>13</sup>

Table 1.-Prevalence of Each Category of Adverse Childhood Experience and Likelihood of Other ACEs<sup>13</sup>

ACE category	Additional ACEs (%)						
	0	≥ 1	≥ 2	≥ 3	≥ 4	≥ 5	≥ 6
<b>Abuse</b>							
Emotional	2	98	90	77	62	42	25
Physical	17	83	64	46	32	20	12
Sexual	22	78	58	42	29	19	12
<b>Neglect</b>							
Emotional	7	93	79	63	47	32	19
Physical	11	89	75	61	50	37	24
<b>Household dysfunction</b>							
Parental separation or divorce	18	82	61	43	30	19	12
Household substance abuse	19	81	60	41	29	18	11
Household mental illness	16	84	65	48	34	21	13
<b>Battered Mother</b>							
Crime	5	95	82	64	48	32	20
Crime	10	90	74	56	43	30	23
Median	13.5	86.5	69.5	52.0	38.5	25.0	16.0
Range	2-22	78-98	58-90	41-77	29-62	18-42	11-25

Thus, ACEs are highly interrelated; the occurrence of one should evoke a search for others. In addition, this interrelatedness made assessment of the effects of *single ACEs* on health and social well-being illogical.

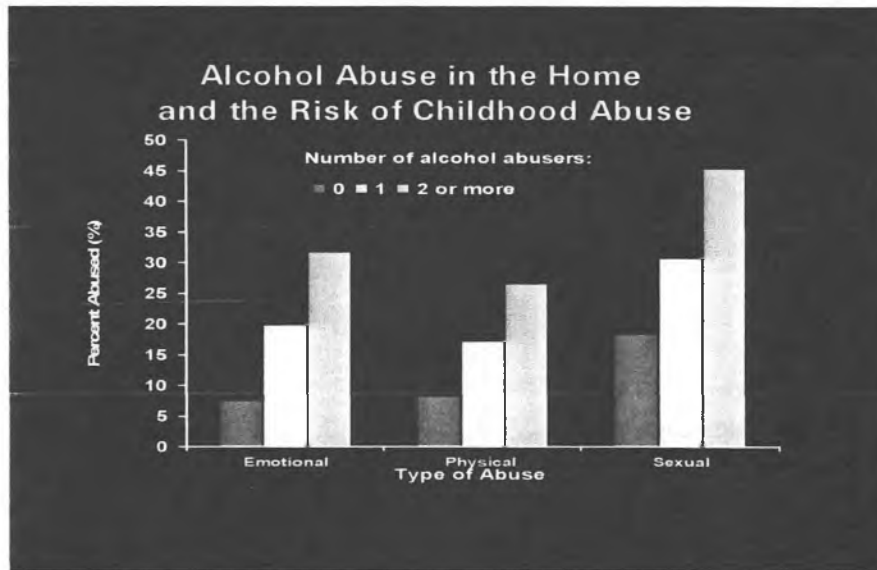
### The ACE Score

Because adverse childhood experiences are highly interrelated, we developed the ACE Score as a measure of the cumulative exposure to abuse, neglect, alcohol and other substance abuse, domestic violence and other forms of serious household dysfunction.<sup>1,13,36,38</sup> Exposure to any ACE category (Table 1, above) counted as one "point" on the Score; the number of *categories* of adverse experience were then summed. The ACE Score therefore ranged from 0 to 10. The ACE Score indicates, in summary form, the amount of exposure to the ten categories of adverse experience in childhood and adolescence. There was no further scoring within a category. Statistical analysis has confirmed that the observed number of respondents with high ACE scores was notably higher than the expected number under the assumption of independence of ACEs ( $p < .0001$ ).<sup>13</sup> The prevalence of the ACE Scores by gender is presented in Table 4.<sup>13</sup> Two-thirds of participants reported at least one category of ACE. One in ten people had an ACE Score of 5 or more; higher ACE Scores are

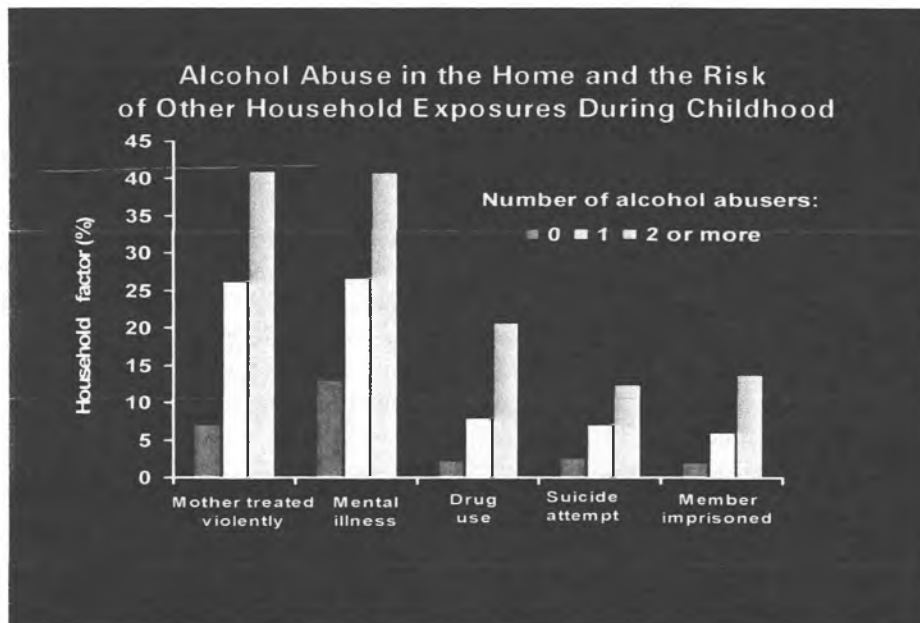
**ACEs are Highly Interrelated**

Probably as a result of the categorical approaches to the various ACEs, at the time that the ACE Study was designed relatively little was known about the co-occurrence of the 10 ACE categories chosen for study. Even less was known about the cumulative impact of multiple different exposures. Because initial analyses of the data showed that ACEs tended to be highly interrelated,<sup>13,36,38</sup> we described their co-occurrence in detail.<sup>13</sup> Figures 4 and 5 illustrate how growing up with alcohol abusing parents is strongly related to the risk of experiencing other categories of ACEs.<sup>13</sup>

**Figure 4.-Alcohol Abuse and the Risk of Childhood Abuse**



**Figure 5.-Alcohol Abuse in the Home and the Risk of Other ACEs**



The 10 ACEs studied are as follows:

- Childhood abuse
  - Emotional
  - Physical
  - Sexual
- Neglect
  - Emotional
  - Physical
- Growing up in a seriously dysfunctional household as evidenced by:
  - Witnessing domestic violence
  - Alcohol or other substance abuse in the home
  - Mentally ill or suicidal household members
  - Parental marital discord (as evidenced by separation or divorce)
  - Crime in the home (as evidenced by having a household member imprisoned)

**ACEs Are Common**

The first important conclusion to be drawn is that adverse childhood experiences are very common, even in this well-educated, predominantly middle-class study sample (Figure 3, below).<sup>1,13,36,38</sup> Moreover, ACE Study estimates of the prevalence of childhood exposures to physical and sexual abuse are similar to population-based surveys. A national telephone survey of adults conducted by Finkelhor et al.<sup>43</sup> used similar criteria for childhood sexual abuse and determined that 16% of men and 27% of women had been sexually abused; in the ACE Study cohort 16% of men and 25% of women in our sample had experienced contact childhood sexual abuse. In our study, 30% of the men had been physically abused as boys; this closely parallels the 31% prevalence recently found in a similarly structured population-based study of Canadian men<sup>44</sup> The similarity of the estimates from the ACE Study to those of population-based studies suggests that our findings would be applicable in other settings.

**Figure 3. – Prevalence of Adverse Childhood Experiences<sup>1,13</sup>**

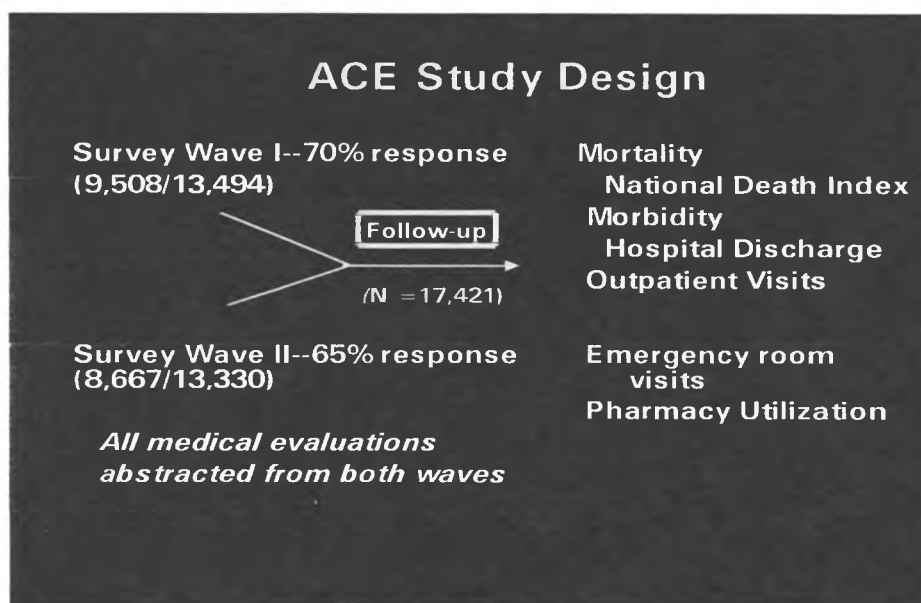
Adverse Childhood Experiences Are Common	
<u>Household dysfunction:</u>	
Substance abuse	27%
Parental sep/divorce	23%
Mental illness	17%
Battered mother	13%
Criminal behavior	6%
<u>Abuse:</u>	
Psychological	11%
Physical	28%
Sexual	21%
<u>Neglect:</u>	
Emotional	15%
Physical	10%

## Design of the ACE Study

The Adverse Childhood Experiences (ACE) Study is the largest of its kind ever conducted both in size and scope of information collected. It examines the health and social effects of adverse childhood experiences throughout the lifespan and is an ongoing, decade-long collaboration between the Division of Adult and Community Health at the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente's Department of Preventive Medicine in San Diego. The relationship of these experiences to a wide range of health and social problems throughout the lifespan has been, and continues to be, described by the ACE Study team.<sup>1,36,38</sup>

During two survey "waves" conducted during 1995 to 1997, 17,337 predominantly well educated, middle-class members of the Kaiser Permanente Medical Care Program in San Diego, California agreed to participate in the Study, as part of a comprehensive medical evaluation.<sup>38</sup> Prospective assessment of the relationships of ACEs to health care utilization, rates of pharmaceuticals prescribed, disease incidence, and causes of death is an ongoing focus of the Study (Figure 2).

Figure 2.—Design of the ACE Study



The ACE study population included 9,367 (54%) women and 7,970 (46%) men (total sample=17,337). Their mean age was 56 years. Seventy-five percent were white, 39% were college graduates, 36% had some college education, and 18% were high school graduates. Only 7% had not graduated from high school.<sup>1,13</sup>

The Study assessed 10 categories of stressful or traumatic childhood experiences.<sup>13</sup> The experiences chosen for study were based upon prior research that has shown them to have significant adverse health or social implications, and for which efforts in the public and private sector exist to reduce the frequency and consequences of their occurrence.

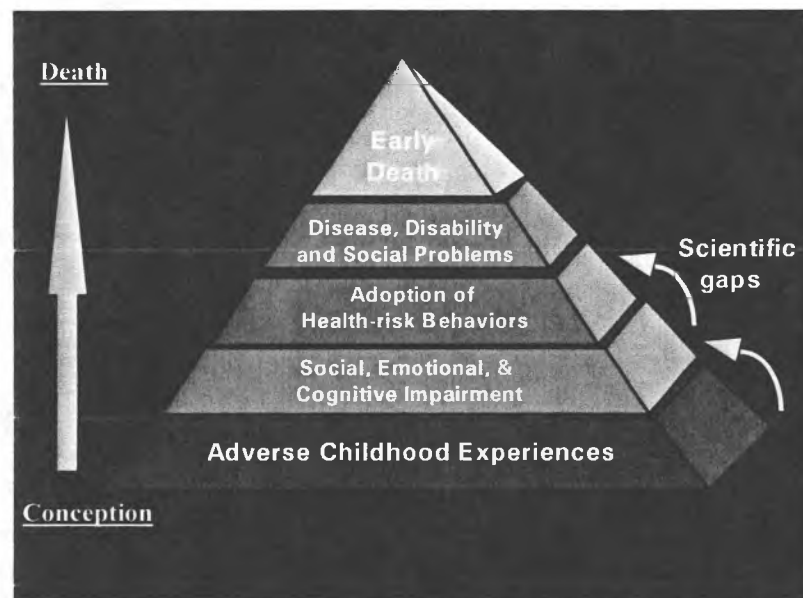
Prior research into the effects of childhood maltreatment and related experiences (including witnessing domestic violence) has tended to focus on only one or two categories of experience, such as physical or sexual abuse or domestic violence, and has generally focused on a limited range of outcomes. The ACE Study is unique not only because of its size, but because it was also designed to assess the relationships of a *broad range* of adverse childhood experiences (ACEs) to a *wide range* of health and social consequences.

## Introduction

This overview focuses on key findings from the ACE Study, published in peer-reviewed scientific journals, with an emphasis on how growing up with alcohol abuse and/or illicit drug use in the home becomes part of a spectrum of damaging childhood experiences. These childhood traumas lead to a wide array of negative health and social consequences.

The key concept behind the design of the ACE Study is that risk factors for health and social problems are not randomly distributed in the US population. We hypothesized that the experiences of childhood—specifically stressful or traumatic experiences that can negatively affect childhood development were fundamental underpinnings of the occurrence of these problems. We sought to fill the “scientific gaps” using a whole life model as depicted in Figure 1, below.<sup>36,38</sup>

**Figure 1-Conceptual Framework for the ACE Study.**



It is important to recognize that:

- Adverse childhood experiences (ACEs) are common.
- ACEs tend to occur in clusters, rather than single experiences.
- The cumulative impact of multiple exposures can be captured in an “ACE Score”.
- The ACE score likely captures the cumulative (neuro)developmental consequences of traumatic stress.
- The ACE Score has a strong, graded relationship to numerous health, social, and behavioral problems throughout a person's lifespan
- These ACE-related problems tend to be co-morbid or co-occurring

These points will be highlighted in the course of this review.

**Adverse Childhood Experiences  
As a National Health Issue**

**ACEs have a strong influence on:**

- adolescent health
- teen pregnancy
- smoking
- alcohol abuse
- illicit drug abuse
- sexual behavior
- mental health
- risk of revictimization
- stability of relationships
- performance in the workforce

**And...**

**ACEs increase the risk of:**

- Heart disease
- Chronic Lung disease
- Liver disease
- Suicide
- Injuries
- HIV and STDs
- and other risks for the leading causes of death

This vast array of problems that arise from ACEs calls for an integrated, rather than a separate or categorical perspective of the origins of health and social problems throughout the lifespan. This approach to growing up with ACEs, and to the consequences of exposure to them, may unify and improve our understanding of many seemingly unrelated health and social problems that tend to be identified and treated as categorically separate issues in Western society. Development of more integrated approaches will likely contribute to more meaningful diagnoses, improved treatment of affected persons, and better integration of research priorities, preventive and social services, and legal venues.<sup>1,3</sup>

*The ACE Study calls for an integrated approach to intervene early on children growing up being abused, neglected, witnessing domestic violence, or with substance abusing, mentally ill, or criminal household members. All of these childhood stressors are interrelated and usually co-occur in these homes. Prevention and treatment of one ACE frequently can mean that similar efforts are needed to treat multiple persons in affected families.*

## Executive Summary

The Adverse Childhood Experiences (ACE) Study is a decade-long and ongoing study designed to examine the childhood origins of many of our Nation's leading health and social problems. The Study represents collaboration between the Nation's leading prevention agency, the Centers for Disease Control and Prevention (CDC) and the Kaiser Health Plan's Department of Preventive Medicine in San Diego, CA.<sup>1-41</sup>

The key concept underlying the Study is that stressful or traumatic childhood experiences such as abuse, neglect, witnessing domestic violence, or growing up with alcohol or other substance abuse, mental illness, parental discord, or crime in the home (which we termed adverse childhood experiences—or ACEs) are a common pathway to social, emotional, and cognitive impairments that lead to increased risk of unhealthy behaviors, risk of violence or re-victimization, disease, disability and premature mortality (Figure A).<sup>1-4,36,37</sup> We now know from breakthroughs in neurobiology that ACEs disrupt neurodevelopment and can have lasting effects on brain structure and function—the biologic pathways that likely explain the strength of the findings from the ACE Study.<sup>1</sup>

**Figure A.-Conceptual Framework for the ACE Study**



We found that **ACEs are common**, even in a relatively well educated population of patients enrolled in one of the Nation's leading HMOs.<sup>1,13,18,23,36,37</sup> More than 1 in 4 grew up with substance abuse and two-thirds had at least one ACE! More than 1 in 10 had 5 or more ACEs! And we found that **ACEs are highly interrelated**.<sup>13</sup> In order to assess the relationship of the ACEs to health and social problems we developed the **ACE Score**,<sup>36,37</sup> which is a count of the number of ACEs designed to assess **their cumulative impact on childhood development and therefore, their impact on a variety of health and social priorities in our country.**

What we found, using the ACE Score, stunned us even more. As the ACE Score increases so does the risk of numerous health and social problems throughout the lifespan (See Figure below). These problems are a "Who's Who?" list of problems that encompass the priorities of many agencies, public and private, that are working to prevent and treat a vast array of problems.<sup>1-41</sup> A summary of the problems strongly associated with the ACE Score follows.

**The Health and Social Impact of Growing Up With  
Adverse Childhood Experiences**

**The Human and Economic Costs of the Status Quo**

Robert Anda, MD, MS

Co-Principal Investigator  
Adverse Childhood Experiences (ACE) Study

*The common stressful and traumatic exposures affecting the (neuro)development of our children are referred to herein as adverse childhood experiences (ACEs). Key among the constellation of these experiences is growing up in households affected by alcohol abuse; others include abuse (emotional, physical, sexual), neglect (emotional, physical), witnessing domestic violence, and growing up with substance abusing, mentally ill, parental discord, or crime in the home*

*The information presented in this handout is in the public domain (reference list)<sup>1-41</sup> and does not necessarily reflect the viewpoints of any organization(s) with which Dr. Anda may currently be, or has previously been affiliated.*

Page 4, Sec. 6:

Following "Sec."

Delete: "6"

Insert: "8"

Page 6, Sec. 7:

Following "Sec."

Delete: "7"

Insert: "9"

Page 6, Sec. 8:

Following "Sec."

Delete: "8"

Insert: "10"

the person does not have reasonable cause to suspect that a child has suffered harm as a result of the resumption.

**(j) Any person who witnesses child sexual abuse shall immediately report the harm to the nearest office of the department.**

Page 4, Sec 5:

Following “\*Sec 5.”

Insert: “Sec. 47.17.023 is repealed.”

Page 4, Sec. 6:

Following “\*Sec. 6.”

Insert a new bill section to read:

“\*Sec. 6. Sec. 47.17.290(14) is amended to read:

(13) "practitioner of the healing arts" includes chiropractors, mental health counselors, social workers, dental hygienists, dentists, health aides, nurses, nurse practitioners, certified nurse aides, occupational therapists, occupational therapy assistants, optometrists, osteopaths, naturopaths, physical therapists, physical therapy assistants, physicians, physician's assistants, **paid or volunteer emergency medical providers, paid or volunteer emergency medical technicians, paid or volunteer paramedics, paid or volunteer ambulance drivers,** psychiatrists, psychologists, psychological associates, audiologists and speech-language pathologists licensed under AS 08.11, hearing aid dealers licensed under AS 08.55, marital and family therapists licensed under AS 08.63, religious healing practitioners, acupuncturists, and surgeons;”

Page 4, after new Sec. 6:

Insert a new bill section to read:

“\* Sec. 7. Sec. 47.17.290 is amended by adding a new paragraph to read:

(17) “clergy” means a minister, priest, rabbi, iman or other similar functionary of a religious entity, or an individual reasonably believed so by the person consulting the individual; clergy also includes regular volunteers of the church or religious body and persons employed by a church or religious body to supervise, educate, coach, train, or counsel children.”

(B) whether the person who is believed to have caused the harm has responsibility for the child's welfare; or

(3) concludes that the report involves

(A) possible criminal conduct under AS 11.41.410 - 11.41.458; or

(B) abuse or neglect that results in the need for medical treatment of the child.

(f) If a law enforcement agency determines that a child has been abused or neglected and that (1) the harm was caused by a teacher or other person employed by the school or school district in which the child is enrolled as a student, (2) the harm occurred during an activity sponsored by the school or school district in which the child is enrolled as a student, or (3) the harm occurred on the premises of the school in which the child is enrolled as a student or on the premises of a school within the district in which the child is enrolled as a student, the law enforcement agency shall notify the chief administrative officer of the school or district in which the child is enrolled immediately after the agency determines that a child has been abused or neglected under the circumstances set out in this section, except that if the person about whom the report has been made is the chief administrative officer or a member of the chief administrative officer's immediate family, the law enforcement agency shall notify the commissioner of education and early development that the child has been abused or neglected under the circumstances set out in this section. The notification must set out the factual basis for the law enforcement agency's determination. If the notification involves a person in the teaching profession, as defined in AS 14.20.370, the law enforcement agency shall send a copy of the notification to the Professional Teaching Practices Commission.

(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

(7) paid employees **or volunteers** 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 a multidisciplinary child protection team created under AS 47.14.300;

**(9) veterinarians, veterinary assistants and technicians, state and municipal animal control officers;**

**(10) clergy;**

**(11) persons working in a public or private child welfare or social services agency who have regular contact with or control over children, including but not limited to, state, municipal and tribal child protection workers and social workers, licensed or unlicensed, and grantees, vendors, or contractors of any agency who receive grants from the Department of Health and Social Services for the purpose of providing services to child, parents and families; and**

**(12) persons providing instruction or coaching to a child.**

(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.

(e) The department shall immediately notify the nearest law enforcement agency if the department

(1) concludes that the harm was caused by a person who is not responsible for the child's welfare;

(2) is unable to determine

(A) who caused the harm to the child; or

# Proposed CJATF Alternative to Universal Reporting

## A M E N D M E N T

OFFERED IN THE \_\_\_\_\_ BY \_\_\_\_\_  
TO: B ( )

Page 2, line 3:

Following "read:"

Delete all material in section 4 and insert:

(a) The following persons who, in the performance of their **paid** occupational duties, or **as otherwise identified below in the performance of volunteer activities 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, **paid or volunteer teacher's aides or assistants, school counselors and guidance personnel**, and school administrative staff members of public and private schools;
- (3) peace officers, **paid or volunteer firefighters, juvenile probation officers, juvenile treatment or detention facility employees**, and officers of the Department of Corrections;
- (4) administrative officers of institutions;
- (5) child care providers, **court appointed public or private guardian ad litem and paid or volunteer special advocates**;
- (6) paid employees **or volunteers** of domestic violence and sexual assault programs, and crisis intervention and prevention programs as defined in AS 18.66.990;

1 investigators, experts, and others as necessary for the preparation of the defendant's case, and shall be  
2 subject to other terms and conditions that the court may provide.

3 (D) If a defendant is proceeding without counsel, materials covered by subsection  
4 (d)(3)(A) may be provided to the defendant. If materials are provided to an unrepresented defendant  
5 under this paragraph, the court shall order that the materials remain in the defendant's exclusive custody,  
6 be used only for purposes of conducting the case, and be subject to other terms, conditions, and  
7 restrictions that the court may provide. Upon a showing of good cause, the court may impose specific  
8 terms, conditions, or restrictions concerning inspection of the materials by other persons involved in the  
9 preparation of the case, such as staff, investigators, experts, witnesses, or others. The court shall also  
10 inform the defendant and such other persons involved in the preparation of the case that violation of an  
11 order issued under this paragraph is punishable as a contempt of court.

12 \* **Sec 7.** The uncodified law of the State of Alaska is amended by adding a new section to read:

13 DIRECT COURT RULE AMENDMENT. Rule 8 of the Alaska Child in Need of Aid Rules is  
14 amended to add a new paragraph to read:

15 (j) Disclosure of recordings and medical records

16 Video, audio recordings, medical records of a child, including photographs produced as  
17 part of a medical examination of a child may not be redisclosed by parties to any person except that the  
18 material may be disclosed to the party's attorney, the attorney's staff, investigators and others as  
19 necessary for the preparation of the party's case.

20 \* **Sec. 8.** This Act takes effect immediately.

1 (A) Materials furnished to an attorney pursuant to these rules shall be used only  
2 for the purpose of conducting the case. The following materials must remain in the custody of the  
3 defense attorney, the attorney's staff, investigators, experts, and others as necessary for the preparation  
4 of the defendant's case, and shall be subject to other terms and conditions that the court may provide.  
5 The materials listed in this paragraph shall not be provided to the defendant, but the information in the  
6 materials may be shared with the defendant to the extent necessary to prepare the defense of the case:

7 (i) a criminal history record of a victim or witness;

8 (ii) a medical, psychiatric, psychological, or counseling record of a victim  
9 or witness;

10 **(iii) an audio or video interview of a victim of a crime charged**  
11 **pursuant to AS 11.41.410-440.**

12 **(iv) photographs generated during a medical examination of a victim**  
13 **of a crime charged pursuant to AS 11.41.410-440.**

14 **(v)** [iii] an adoption record;

15 **(vi)** [iv] a record that is confidential under AS 47.12.300 or a similar law  
16 in another jurisdiction;

17 **(vii)** [v] a report of a presentence investigation of a victim or witness  
18 prepared pursuant to Criminal Rule 32.1 or a similar law in another jurisdiction;

19 **(viii)** [vi] a record of the Department of Corrections other than the  
20 defendant's own file and any other incident report relating to the crime with which the defendant is  
21 charged; and

22 **(ix)** [vii] any other record that the court orders be kept in the exclusive  
23 custody of the attorney.

24 (B) An attorney shall not disclose to a defendant the residence or business  
25 address or telephone number of a victim or witness, obtained from information provided under this rule,  
26 even if the defendant is acting as co-counsel. If the address and telephone numbers of all victims and  
27 witnesses have been obliterated, materials that had contained the address or telephone number of a  
28 victim or witness may be provided to a defendant proceeding without counsel only as allowed by AS  
29 12.61.120.

30 (C) Notwithstanding a defendant's status as co-counsel, materials covered by  
31 subsection (d)(3)(A) shall remain in the custody of the defendant's attorney, the attorney's staff,

1           (g) (h) This section does not require **paid employees or volunteers of domestic violence and**  
2 **sexual assault programs, and crisis intervention and prevention programs as defined in AS**  
3 **18.66.990** [A PERSON REQUIRED TO REPORT CHILD ABUSE OR NEGLECT UNDER (a)(6) OF  
4 THIS SECTION] to report mental injury to a child as a result of exposure to domestic violence so long  
5 as the person has reasonable cause to believe that the child is in safe and appropriate care and not  
6 presently in danger of mental injury as a result of exposure to domestic violence.

7           (h) (i) This section does not require **paid employees or volunteers of an organization that**  
8 **provides counseling or treatment to individuals seeking to control their use of drugs or alcohol** [A  
9 PERSON REQUIRED TO REPORT CHILD ABUSE OR NEGLECT UNDER (a)(7) OF THIS  
10 SECTION] to report the resumption of use of an intoxicant as described in AS 47.10.011(10) so long as  
11 the person does not have reasonable cause to suspect that a child has suffered harm as a result of the  
12 resumption.

13       \* **Sec. 5.** Sec. 47.17.064 is amended to read:

14           **Sec. 47.17.064. Photographs, imaging studies and diagnostic testing** [X-RAYS].

15           (a) The department or a practitioner of the healing arts may, without the permission of the  
16 parents, guardian, or custodian, take the following actions with regard to a child who the department or  
17 practitioner has reasonable cause to suspect has suffered physical harm as a result of child abuse or  
18 neglect:

19                   (1) take or have taken photographs of the areas of trauma visible on the child; and

20                   (2) if medically indicated, have a medical [OR RADIOLOGICAL] examination,  
21 **including imaging or other diagnostic testing**, of the child performed by a person who is licensed to  
22 administer the examination.

23           (b) The department or a practitioner of the healing arts shall notify the parents, guardian, or  
24 custodian of a child as soon as possible after taking action under (a) of this section with regard to the  
25 child.

26       \* **Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

27           **DIRECT COURT RULE AMENDMENT.** Rule 16(d)(3), Alaska Rules of Criminal Procedure, is  
28 amended to read:

29           (d) **Regulation of Discovery.**

30                   (3) *Materials to Remain in Custody of Attorney.*

1            **(d)** [(e) ] The department shall immediately notify the nearest law enforcement agency if the  
2 department

3                    (1) concludes that the harm was caused by a person who is not responsible for the child's  
4 welfare;

5                    (2) is unable to determine

6                            (A) who caused the harm to the child; or

7                            (B) whether the person who is believed to have caused the harm has  
8 responsibility for the child's welfare; or

9                    (3) concludes that the report involves

10                           (A) possible criminal conduct under AS 11.41.410 - 11.41.458; or

11                           (B) abuse or neglect that results in the need for medical treatment of the child.

12            **(e)** [(f) ] If a law enforcement agency determines that a child has been abused or neglected and  
13 that (1) the harm was caused by a teacher or other person employed by the school or school district in  
14 which the child is enrolled as a student, (2) the harm occurred during an activity sponsored by the school  
15 or school district in which the child is enrolled as a student, or (3) the harm occurred on the premises of  
16 the school in which the child is enrolled as a student or on the premises of a school within the district in  
17 which the child is enrolled as a student, the law enforcement agency shall notify the chief administrative  
18 officer of the school or district in which the child is enrolled immediately after the agency determines  
19 that a child has been abused or neglected under the circumstances set out in this section, except that if  
20 the person about whom the report has been made is the chief administrative officer or a member of the  
21 chief administrative officer's immediate family, the law enforcement agency shall notify the  
22 commissioner of education and early development that the child has been abused or neglected under the  
23 circumstances set out in this section. The notification must set out the factual basis for the law  
24 enforcement agency's determination. If the notification involves a person in the teaching profession, as  
25 defined in AS 14.20.370, the law enforcement agency shall send a copy of the notification to the  
26 Professional Teaching Practices Commission.

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

1 \* **Sec. 3.** AS 12.45.042 is amended to read:

2 **Sec. 12.45.042. Mental examination of victim.**

3 In a criminal prosecution under AS 11.41, the court may not order or compel the victim to  
4 undergo a psychiatric or psychological examination or to produce their mental health records unless

5 (1) the victim's psychiatric or psychological condition is an element of the offense  
6 charged; or

7 (2) the prosecution has given notice that it will present evidence at trial that the victim  
8 suffers from a continuing psychological or psychiatric condition that resulted from the offense charged.

9 \* **Sec. 4.** Sec. 47.17.020(a) is amended to read:

10 (a) Any person 18 years or older [THE FOLLOWING PERSONS] who [IN THE  
11 PERFORMANCE OF THEIR OCCUPATIONAL DUTIES, OR WITH RESPECT TO (8) OF THIS  
12 SUBSECTION, IN THE PERFORMANCE OF THEIR APPOINTED DUTIES, HAVE] has reasonable  
13 cause to suspect that a child has suffered harm as a result of child abuse or neglect shall immediately  
14 report the harm to the nearest office of the department[:

15 (1) REPEALED

16 (2) REPEALED

17 (3) REPEALED

18 (4) REPEALED

19 (5) REPEALED

20 (6) REPEALED

21 (7) REPEALED

22 (8) REPEALED].

23 (b) [REPEALED

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

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

# CJATF Proposed Legislation

1 **“An act relating to the crime of family violence; relating to persons required to report suspected**  
2 **child abuse; relating to the production and discovery of sensitive victim information; amending**  
3 **Rule 16 of the Alaska Rules of Criminal Procedure and Rule 8 of the Alaska Child in Need of Aid**  
4 **Rules; and providing for an effective date”**

5 \* **Section 1.** AS 11.41 is amended by adding a new section to read:

6 **Sec. 11.41.240 Family violence**

7 (a) A person commits the crime of family violence if that person commits an offense against a  
8 household member, as defined in AS 18.66.990, against another household member that is a crime under  
9 AS 11.41.100 - 11.41.220, 11.41.230(a)(1) or (2), or 11.41.410 - 11.41.432 or an attempt to commit an  
10 offense that is a crime under AS 11.41.100 - 11.41.220 or 11.41.410 - 11.41.432 with knowledge or  
11 reckless disregard that offense was committed in the visual or aural presence of a child or children under  
12 the age of 12 years.

13 (b) Family violence is a class A misdemeanor.

14 \* **Sec. 2.** AS 11.51 is amended by adding a new section to read:

15 **Sec. 11.51.112. Unlawful publication of protected materials.**

16 (a) Unless otherwise provided by law, court rule, or order of the court, a person may not publish  
17 or otherwise distribute

18 (1) an audio or video recording of a child interviewed pursuant to a law enforcement  
19 or child protection investigation or

20 (2) medical records, including photographs, produced as part of a medical  
21 examination

22 (A) pursuant to a child protection investigation or

23 (B) of a victim of an offense charged pursuant to AS 11.41.410-440.

24 (b) Violation of this section is a class A misdemeanor.

# *The Alaska Children's Justice Act Task Force*

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## **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.



## **Vision**

The Alaska Children's Justice Act Task Force will work to improve safety and healing for Alaskan children by evaluating and promoting:

- Early and effective interventions for abused children and their families;
- The integration of agencies and systems involved to reduce the risk of further trauma to children;
- The continuum of services that abused children may need to become strong, productive and stable adults.

## **History of the Task Force**

Founded in 2002, the Alaska CJATF is a state-wide multidisciplinary group that is federally mandated and funded. Section 107(d) of Child Abuse Prevention and Treatment Act requires the State Task Force to undertake a comprehensive review and evaluation of law, policy and the investigative, administrative and judicial handling of cases of child abuse and neglect and to make training and policy recommendations. Responsibilities include:

- the investigative, administrative, and judicial handling of cases of child abuse and neglect in a way that minimizes further trauma;
- experimental, model, and demonstration programs for testing innovative approaches and techniques;
- reform of State laws, ordinances, regulations, protocols and procedures;
- while ensuring fairness to all affected.

## **Membership**

The Task Force is comprised of state-wide representatives from law enforcement, medicine, child protection, law (both prosecution and defense), child advocacy centers, judiciary, behavioral health, court-appointed special advocates/guardians ad litem, schools, tribal organizations and parents.



Alaska Children's  
Justice Act Task Force

## **Funding**

Our limited annual federal funding (approximately \$85,000) pays for our part-time coordinator, our quarterly meetings, and our projects. We are very careful stewards of these funds.

## **Projects Have Included:**

- Amendment of pertinent criminal child abuse statutes
- Guidelines for the Multidisciplinary Response to Child Abuse in Alaska publication
- Reporting Child Abuse in Alaska training CD for mandated reporters
- Scholarships and sponsorships of training for professionals in the field
- Development of standardized child abuse medical exam forms
- Collaboration with Alaska Maternal Child Health Epidemiology Unit, DHSS, to disseminate data on child abuse
- Needs assessment of professionals in the field
- Annual presentation to legislature with recommendations for system improvement

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## **Contact the Task Force:**

[ciataskforcecoordinator@alaska.gov](mailto:ciataskforcecoordinator@alaska.gov)

**Publications  
available on  
our website or  
by contacting  
the Task Force  
Coordinator:**

- **Reporting Child Abuse in Alaska**  
interactive training CD for mandated reporters; additional training materials on website
- **Guidelines for the Multidisciplinary Response to Child Abuse in Alaska**

**Did you know?**

- Up to 34 Alaskan children EVERY DAY experience some type of maltreatment (sexual abuse, physical abuse, neglect)
- Up to 5 Alaskan children EVERY DAY are sexually abused
- 3 out of 4 victims of sex crimes reported to the Alaska State Troopers are less than 18 years old
- 1 out of 5 Alaskan child deaths are maltreatment related
- 3 out of 4 maltreatment related deaths are infants
- Research shows that children who experience or witness interpersonal violence are at greatly increased risk of adult health problems\* including heart disease, chronic lung disease, cancer, mental health problems as well as substance abuse, criminal behavior, and future victimization

(\*Adverse Childhood Experiences studies at [www.cdc.gov/ace](http://www.cdc.gov/ace))



Alaska Children's  
Justice Act Task Force

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*Improving the  
system response  
for Alaskan  
children*

*[http://hss.state.ak.us/ocs/  
ChildrensJustice/](http://hss.state.ak.us/ocs/ChildrensJustice/)*



## Alaska Children's Justice Act Task Force

Presentation to Alaska Legislature  
February 2013

[hss.state.ak.us/ocs/ChildrensJustice/default.htm](http://hss.state.ak.us/ocs/ChildrensJustice/default.htm)

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### OVERVIEW OF 2013 PRESENTATION

- Introduction to Alaska CJATF
- Child maltreatment in Alaska & why it matters to all of us
- Proposed legislative changes
- Questions?

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### Introduction to Alaska CJATF

- Membership
- Handouts
  - History, mission, projects
  - Membership list
  - Proposed legislation
  - Summary of ACE studies
- Thank you for SB 210

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## ALASKAN CHILDREN IN DANGER

UPDATE

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### Data Sources

- State of Alaska OCS 2012 statistics website
- Kids Count Data 2011-2012 – Alaska and national websites
- Prevent Child Abuse America website
- All information current as of 2/4/13

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### Maltreatment - All Types

- In 2012 >16,000 Alaskan children were reported victims of at least one incident of maltreatment
  - As many as **44 children a day**
    - 25 for neglect
    - 7 for mental injury (exposure to DV)
    - 5 for physical abuse
    - 2 for in home sexual abuse
      - **Does not include out of home sexual abuse!!**
      - Likely gross underestimation

State of Alaska OCS website

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**OVERALL**  
**171% OF NATIONAL AVERAGE**

(...but improved from prior years)  
*Kids Count Alaska 2011-2012*

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What does this mean for Alaskans?

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**Consequences**

- Physical
- Psychological
- Behavioral
- Societal
- Short-term
- Long-term
- Throughout the lifespan

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### Maltreatment-Related Child Deaths

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

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

Alaska Maltreatment Evaluation

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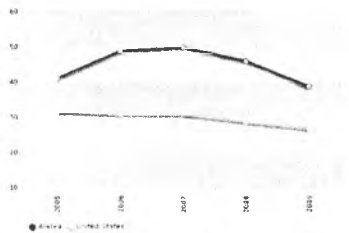
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### Child & teen death in Alaska



Child and teen death rate (Rate) – 2000 to 2009  
 HHS | CDC | Data Center, www.datacenter.cdc.gov  
 A project of the Alaska & Casey Foundation

Homicide 4th leading cause of death for Alaskan children

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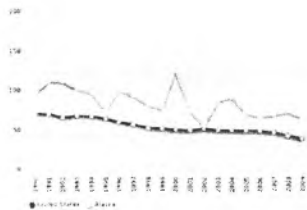
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### Violent death of teens in Alaska



Teen deaths by homicide, suicide, and suicide (Rate per 100,000) – 1990 to 2009  
 HHS | CDC | Data Center, www.datacenter.cdc.gov  
 A project of the Alaska & Casey Foundation

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### What does this cost?

- Direct & indirect costs
- Child protection system
- Criminal justice system
  - Including juvenile justice system
- Future earnings and productivity
- Medical & mental health care
  - Short and long term

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### Total Annual Cost of Child Abuse and Neglect in the US

- **\$220 million EVERY DAY**
- **\$80 billion each year**

ProQuest Child Abuse: America's Economic Impact Study 2012

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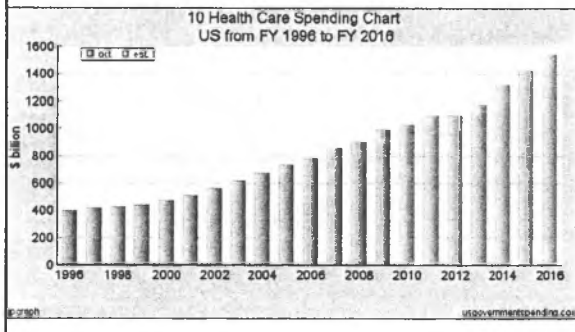
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### Health Care Costs



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**THE ADVERSE CHILDHOOD EXPERIENCES  
(ACE)  
STUDY**

***“Turning Gold Into Lead”***

- Collaborative study between researchers at CDC and Kaiser Permanente
- [www.cdc.gov/ace/](http://www.cdc.gov/ace/)

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**ACE Study Description**

- >17,000 participants
- Employed
- 54% female, 46% male
- 75% white
- Average age 57
- 75% at least some college

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**Adverse Childhood Experiences  
During 1st 18 years of Life**

- Abuse
  - Verbally abused
  - Sexually abused
  - Physically abused

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### Adverse Childhood Experiences

- Growing up with:
  - Alcohol or drug abusing adults
  - Violence or threats of violence against mother
  - A mentally ill parent
  - Divorced or separated

(2<sup>nd</sup> wave added neglect)

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### ACEs are common

<u>Abuse, by Category</u>	<u>%</u>
Emotional	11%
Physical	28%
Sexual (anyone)	21%

<u>Household Dysfunction, by Category</u>	<u>%</u>
Substance Abuse	27%
Mental Illness	19%
Mother Treated Violently	13%
Parental separation/divorce	23%
Incarcerated family member	5%

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### ACE Scores

<u>ACE Score</u>	<u>Prevalence</u>
0	36.1%
1	26 %
2	15.9%
3	9.5%
4 or more	12.5%

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Results

- ACE score correlated in strong and graded fashion with almost ALL chronic health problems seen in US today

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ACE Score vs. Smoking

ACE Score	Smoking	Odds Ratio*
≥5	Started by age 14	5.4
	Ever smoked	3.1
	Current smoking	2.1
	Heavy smoking	2.8

\*compared with those with ACE score = 0  
N=9215 p<0.001

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ACE Score vs. Alcoholism

ACE Score	Alcohol Abuse	Odds Ratio
0	2.9%	1.0
1	5.7%	2.0
2	10.3%	4.0
3	11.3%	4.9
≥4	16.0%	7.4

N=8,002 p<0.001

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### ACE Score vs. Ever Injected Drugs

ACE Score	Ever Injected Drugs	Odds Ratio
0	0.3%	1.0
1	0.5%	1.6
2	1.2%	3.0
3	1.4%	3.5
4	1.0%	2.4
>=5	4.3%	10.1

N=8,613 p<0.05

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### ACE Score vs. Depression

ACE Score	Prevalence of Depression*	Odds Ratio
0	14.0%	1.0
1	21.0%	1.5
2	31.5%	2.4
3	36.0%	2.6
≥4	50.7%	4.6

\*in past year N=7,945 p<0.001

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### ACE Score vs Ever Attempted Suicide

ACE Score	Prevalence	Odds Ratio
• 0	• 1.2	1
• 1	• 2.4	1.8
• 2	• 4.3	3.0
• 3	• 9.5	6.6
• >=4	• 18.3	12.2
• >=7	• 35.2	

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### ACE Score vs BMI $\geq$ 35

ACE Score	Prevalence	Odds Ratio
• 0	• 5.4	1
• 1	• 7.0	1.1
• 2	• 9.5	1.4
• 3	• 1.3	1.4
• $\geq$ 4	• 12	1.6

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### ACE Score vs Sedentary Lifestyle

ACE Score	Prevalence	Odds Ratio
• 0	• 18.4	1
• 1	• 22.8	1.2
• 2	• 22	1.2
• 3	• 26.6	1.4
• $\geq$ 4	• 26.6	1.4

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### ACE Score & Chronic Disease

<u>Disease</u>	<u>Odds Ratio for ACE <math>\geq</math>4</u>
• Any cancer	• 1.9
• Stroke	• 2.4
• Chronic lung disease*	• 3.9
• Diabetes	• 1.6
• Hepatitis (liver disease)	• 2.4
• Sleep disturbances	• 2.0

\*Association only modestly reduced by adjustment for cigarette smoking

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### ACE Score & Heart Disease

- For ACE  $\geq 4$ : Adjusted Odds Ratio 2.2
- For ACE  $\geq 7$ : Adjusted Odds Ratio 3.6
- Stronger relationship than traditional risk factors



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### More ACE Links

- Reproductive health
  - Teen & unintended pregnancy
  - Fetal death
- Mental health
  - Memory disturbances
  - Hallucinations
- Auto-immune diseases
- Skeletal fractures
- Further victimization & perpetration
- Work absenteeism

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### Sampling of other confirmatory research

- Child Abuse Negl 2008: CSA & CPA increased risk later depression, anxiety, conduct/antisocial personality disorder, substance abuse, suicide attempts
- Amer J Pub Health 2009: 30 year prospective study -- child physical & sexual abuse increases risk for STIs in adults
- Cancer 2009: significant & stable association between child physical abuse and cancer even adjusting for other risk factors

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### Adolescent suicide attempts

- Riggs et al; J Pediatrics 1990
- 600 high school students – anonymous survey
- Physical abuse history
  - 5 times more likely to attempt suicide
- Sexual abuse history
  - 3 times more likely to attempt suicide

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### Revictimization & substance use

- CAN 2008: lifetime re-victimization study -- childhood victimization risk for future physical & sexual abuse/assault, kidnapping, stalking, having family friend murdered or commit suicide
- J Psychoactive Drugs 2008: family substance abuse predictive of earlier, more severe meth dependence

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### Adult obesity

- Obesity 2009: 30 year prospective study – child physical abuse predicted significantly higher BMI in adulthood even controlling for other factors

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**Evidence from ACE Study Suggests:**

**Adverse Childhood Experiences are properly viewed as the most basic causes of health risk behaviors, illness, disability, premature death, and health care costs.**

CDC Adverse Childhood Experiences  
Study website  
www.cdc.gov/ace

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**Next questions:**

- Why?
  - Area of current research
  - Likely multifactorial:
    - Brain development
    - Effects on immune system
    - Genetics
    - Epigenetics
- What do we do with this information?
  - MORE BAD THINGS = MORE BAD THINGS

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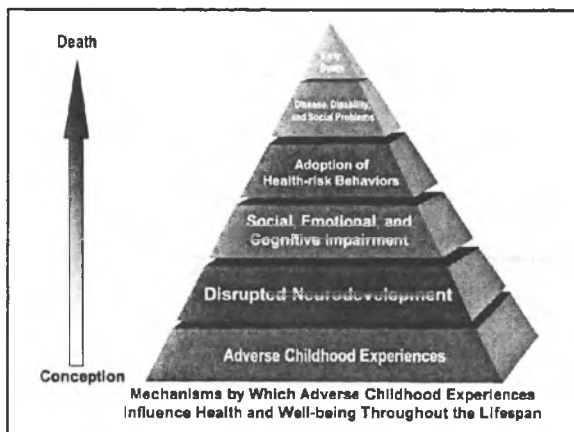
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Alaska Children's  
Justice Act Task Force

Recommendations

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Support for Child Advocacy Center  
Funding

- Federal funding to develop/support CACs 2001
- State began funding 2008

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Alaska CACs

- Now 10 CACs with 2 satellites
- Nearly 18,000 children seen since first CAC opened in 1996
- Funding has been flat despite:
  - significant increase in utilization in many CACs
  - increased cost of operations

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**Recommendation**

- Support increased funding for CACs
  - \$520,109 requested and submitted
  - \$400,000 currently in Governor’s Budget

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**Support for HB <sup>73</sup> 22/SB <sup>22</sup> 73**

- Many provisions will benefit children
  - Sex trafficking
  - Investigations of child abuse images
  - Sentencing provisions regarding 3 judge panels and child sexual exploitation images
  - Expanded admission of evidence of prior bad acts
  - Mandatory reporter statutory revision

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**SYSTEM IMPROVEMENT  
THROUGH  
LEGISLATIVE CHANGE  
FOR FURTHER PROTECTION OF  
OUR CHILDREN**

*How do we know what is making  
a difference?*

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**RECOMMENDATION #1**

**REVISE MANDATORY REPORTING  
STATUTE**

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**MANDATORY REPORTING:  
BACKGROUND**

- Over 50 years ago first mandatory reporting laws in USA
- By 1967 all states had mandatory reporting statutes in place
- Laws and public awareness campaigns dramatically increased reporting rates

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**Problems:**

- Research shows child abuse is still under-reported
- Confusion and questions about who must report in Alaska
- Current Alaska law only requires certain professionals to report
  - Misses many adults in regular contact with children

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- Alaska still has one of highest rates of child abuse in US
- We should lead the nation in laws that protect our children
  - Including mandatory reporting laws

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**Solution:**

- Make us ALL equally responsible for protecting Alaskan children
- Require ALL adults to report when they have reasonable cause to believe that a child is a victim of abuse

Sec 4 proposed CJATF legislation

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**Alternate Solution:**

- If not currently feasible:
- Clarify and add to current list of mandatory reporters to partially fill gaps

Proposed CJATF alternative to universal reporting

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**First responders**

- Firefighters
- Emergency medical personnel
- Paid or volunteer

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**Social Services Personnel**

- Juvenile Justice personnel
- Social workers
- Guardian ad litem
- Court appointed special advocates (CASAs)

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**Veterinarians and animal control officers**

- Strong research links between animal abuse and child abuse
- May be only contact with family
- Child witnessing cruelty to animals is predictor for future violence (by child)

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### Clergy

- Create consistency with statute for protection of vulnerable adults (Adult Protective Services AS 47.24.010)

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### Persons providing instruction and coaching to children

- Examples: athletic coach, music teacher, etc.
- Similar to HB 73/SB 22 Sec 37 & 38

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### Certain other volunteers

- That have training and/or come in frequent contact with children
  - DV advocates
  - Drug and alcohol treatment providers
  - Teacher assistants

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**RECOMMENDATION #2**

**UPDATE CURRENT STATUTE  
CONCERNING MEDICAL EVALUATIONS  
OF SUSPECTED CHILD ABUSE**

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**Problem:**

- Present law (AS 47.17.064) is not current with regard to diagnostic testing
- Limited to x-rays and photographs
- Multiple newer tests
  - CT, MRI, blood tests, etc.
  - More accurate
  - May be less invasive
  - Help differentiate between abuse and non-abuse
- Parent not always available

*Add CAT scans, MRIs, etc.  
Who pays for??*

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**Solution:**

- Modernize Statute 47.17.64 to allow necessary testing of abused children with current technologies
- Continue to require parent notification

Section 5 of proposed CJATF legislation

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**Recommendation #3**  
**ADD NEW SECTION TO CRIMINAL CODE  
REGARDING CHILDREN'S EXPOSURE TO  
DOMESTIC VIOLENCE (DV)**

*New law!*

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**Problem:**

- Research shows children exposed to DV have same outcomes as children directly experiencing abuse
- It is not a crime under state law to expose a child to DV

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**Solution:**

- Add and define a new section to Alaska Criminal Code making it unlawful to expose a child to DV
  - Patterned after Municipality of Anchorage Criminal Code

Section 1 of proposed  
CJATF legislation

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**Recommendation #4**

**ADD VICTIM PROTECTIONS TO CRIMINAL AND CHILD PROTECTION LAWS**

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**Problem:**

- Discovery process: criminal and child protection
- However: interviews of children and their physical and mental health evaluations often end up in the wrong hands
  - Further victimization
- Examples:
  - Forensic interview of abused child published on YouTube
  - Forensic medical exam photographs shared with others (including inmates)

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**Solution:**

- Make unauthorized publication of a victim's protected material a crime
- Modify rules of discovery in criminal and child protection cases regarding redistribution of protected materials
- Protect mental health records of a victim

Sections 2, 3, 6, 7 of proposed CJATF legislation

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### Summary of Recommendations

1. Support increased funding for CACs
2. Support HB 73/SB 22
3. Make all Alaskans responsible for child abuse reporting
4. Modernize Statute 47.17.64 (medical evaluation)
5. Make it unlawful to expose a child to DV
6. Protect children from further victimization in the discovery process

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We need champions for Alaskan children!



THANK YOU

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