ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit

P.O. Box 113300
Juneau, AK 99811-3300
(907) 465-3830
FAX (907) 465-2347
legaudit@legis.state.ak.us

SUMMARY OF: A Special Report on Training, Policies, and Practices Related to Reporting Suspected Statutory Rape, Department of Health and Social Services, Division of Public Health, April 28, 2008.

PURPOSE OF THE REPORT

In accordance with Title 24 of the Alaska Statutes and a special request by the Legislative Budget and Audit Committee, we have conducted an audit of training, policies, procedures and practices related to the mandatory reporting of the form of child sexual abuse commonly referred to as statutory rape.

More specifically, we were directed to evaluate these factors as they related to the provision of reproductive health services to adolescents. Our review was limited to health care professionals, specifically Public Health Nurses (PHNs) that fell into one of two groups: (1) those employed by the Department of Health and Social Services (DHSS), Division of Public Health, Section of Public Health Nursing (SOPHN); and (2) those employed by organizations receiving grant funding from DHSS.

REPORT CONCLUSIONS

A summary of the conclusions follows:

- SOPHN mandatory reporting policy addresses child sexual abuse and mandatory reporting statutes.
- One out of the four DHSS grantees lacks a written policy on child sexual abuse reporting.
- Revision to SOPHN policy lagged behind statutory amendments by more than one year.
- Most PHNs report receiving adequate training on child sexual abuse.
- Child sexual abuse training covers common risk factors of child sexual abuse.

FINDINGS AND RECOMMENDATIONS

1. The director of Public Health should ensure that SOPHN's mandatory reporting policy more timely reflect changes in state law.

In April 2006, the Legislature amended the child sexual abuse statute, effective immediately. SOPHN was not informed about the amended law in a timely manner. DHSS' revision and review of the new policy by its legal advisors took over one year, with the new policy being implemented in August 2007. We recommend DPH improve its mechanism for informing SOPHN of changes in statute and for ensuring more timely revisions to policy and procedures.

2. The SOPHN chief should amend mandatory reporting policy to better align written guidance with expected practice.

Ostensibly, SOPHN's standard practice is to ask a client who is 15 years old or younger and seeking reproductive health services the age of his or her partner(s). This practice is not reflected in SOPHN's formal mandatory reporting policy. A third of the PHNs responding to our survey reported they did not routinely ask about the age of the partner during the course of consultation or treatment. This standard practice would be better communicated and more likely to be consistently implemented if incorporated into the written policy and procedures or practice guidelines.

3. The SOPHN chief should further strengthen oversight of PHN child sexual abuse training.

The majority of PHNs report receiving adequate, frequent, and recent training on child sexual abuse recognition and reporting. However, 12 percent of the public health nurses reported having either received training less than once every five years or having never received training in this area. We encourage management to continue to monitor training and to identify areas and individuals needing additional training.

As part of their grant, the agreements between DHSS and the grantees include the assurance that the organizations comply with the State's child protection statute. SOPHN may wish to consider increasing their oversight by including as an additional grant assurance that the grantee PHNs attend training specifically on child sexual abuse recognition and reporting at least once every five years.

4. The commissioner should ensure DHSS complies with child abuse curriculum requirements.

State law, at AS 47.17.022, requires all state agencies and local school districts with employees covered by the State's mandatory reporting law must have a current copy of their training curriculum and materials on file with the Council of Domestic Violence and Sexual Assault. Currently the council does not have either a curriculum or materials for DHSS' child protection training.

We recommend DHSS seek the council's technical assistance in developing future trainings on child abuse in general and child sexual abuse in particular. We also recommend DHSS file its current child abuse training curriculum and materials with the council for both the council's review and for accessibility by state mandatory reporters and the general public.

ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Audit

P.O. Box 113300
Juneau, AK 99811-3300
(907) 465-3830
FAX (907) 465-2347
legaudit@legis.state.ak.us

April 28, 2008

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH
TRAINING, POLICIES AND PRACTICES RELATED TO
REPORTING SUSPECTED STATUTORY RAPE
April 28, 2008

Audit Control Number

06-30044-08

The purpose of this audit was to review and assess the training, policies, and practices related to reporting suspected instances of statutory rape. The report addresses these factors as they are carried out by public health nurses who are either employed by the state or by an organization funded by state grants who provide reproductive health care to adolescents.

The audit was conducted in accordance with generally accepted government audit standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope, and Methodology

Pat Davidson, CPA
Legislative Auditor

TABLE OF CONTENTS

OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Title 24 of the Alaska Statutes and a special request by the Legislative Budget and Audit Committee, we have conducted an audit of the training, policies, procedures, and practices related to the reporting of the form of child sexual abuse commonly referred to as statutory rape. More specifically, we were directed to evaluate these factors as they were related to the provision of reproductive health services to adolescents.[1] Our review was limited to health care professionals, specifically clinicians who fell into one of two groups: (1) those employed by the Department of Health and Social Services (DHSS), Division of Public Health, Section on Public Health Nursing (SOPHN), and (2) those employed by organizations receiving grant funding from DHSS.

Objectives

For the entities included in our audit scope (SOPHN professionals and DHSS grantees), the specific objectives of the audit were:

- To assess how clearly SOPHN and grantee policies and procedures set out and explain child sexual abuse and mandatory reporting laws.
- To evaluate the adequacy and frequency of training on the recognition and reporting of child sexual abuse provided to DHSS and grantee clinicians.

Scope

The scope of the audit includes the practices of public health nurses (PHNs) working for SOPHN and other clinicians funded through DHSS grants who provided reproductive health services. The grantee organizations reviewed included North Slope Borough Health and Social Services Agency Wellness Center; Maniilaq Association Public Health Nursing; Norton Sound Health Corporation; and, Kachemak Bay Family Planning Clinic.

Methodology

We reviewed the mandatory reporting policies and procedures established by SOPHN for use by state PHNs. We also obtained and reviewed similar guidance developed and followed by grantee organizations included in the scope of our review. By comparing the established guidance available to front-line health care providers, we could assess similarities and overall consistency with the requirements of state law.

[1] Reproductive health care includes services related to pregnancy, contraception, and sexually transmitted infections.

We reviewed agenda, summaries, handouts for seminars and trainings offered to DHSS nurses, and the training syllabus for the Public Health Nursing Academy. By doing so, we were able to better understand the nature and extent of the basic training provided to PHN professionals related to reporting suspected child abuse.

We attended training on mandatory reporting jointly presented by the Office of Children's Services (OCS) and the Alaska State Troopers. This was done to better understand the nature and extent of some of the ongoing training provided to PHN professionals related to reporting suspected child abuse.

We researched reports of harm (ROH) made to OCS involving adolescent girls who also received reproductive health services funded through the State's Medicaid program. The period we selected from covered the years 1999 through 2007. Review of ROHs provided confirmation that many sexually active adolescent girls are at high risk for abuse as evidenced by being involved with a report to OCS.

We surveyed 102 individuals who were involved in providing reproductive health care funded through DHSS. With the exception of two clinicians working for one of the department's grantee organizations, all these individuals were PHNs.[2] The survey was done through the internet and included questions about policies, training, practices, and experiences related to the recognition and reporting of child sexual abuse. There were 19 questions including yes/no, agree/disagree, multiple choice, and open-ended format. Analysis of the responses received provided a perspective as to the extent PHNs applied the training and guidance they received relating to reporting suspected sexual abuse.

Since statutory rape is covered under child sexual abuse statutes in Alaska, the survey questions referred to child sexual abuse in general. However, the introductory letter to the survey explained that the particular form of child sexual abuse being reviewed was the illegal sexual activity between an adolescent and a partner of an inappropriate age –such that, were it not for their ages, it would otherwise be considered consensual and legal.

Exhibit 1

Regions and Groups	Respondents
DHSS PHN	
Southeast region	20
Southwest region	12
South Central region	21
Interior region	20
Total DHSS PHN	73
Grantee PHN	8
Total	**81**

Exhibit 1 illustrates the composition of the survey participants. Eighty-one out of 102 clinicians responded to our survey for a participation rate of 79 percent. As shown, DHSS public health nurses work within SOPHN in one of four geographical regions. Three of the four grantee organizations responded to the survey; all respondents were PHNs.

[2] As used in this report, PHNs includes public health nurses, nurse managers, and program managers.

To better understand state law, recent amendments, and legislative history related to what is referred to as statutory rape, we reviewed the following documents:

- Alaska Statutes including AS 11.41.434 – 436, AS 47.17, AS 12.55.125, and AS 12.55.135.
- Session Law Chapter 14, SLA 06. This legislation modified the statutory definitions of what constituted illegal sexual contact for adolescents below the established age of consent.
- Relevant legislative committee minutes.

To better understand the organizational structure of the State's public health care system, the specific training to state PHNs, and general public policy related to statutory rape, we reviewed the following:

- DHSS budget documents and other relevant DHSS documents.
- SOPHN Training Policy.
- *State of Alaska Family Planning P&P Manual* and review tools.
- *"The Association Between Reproductive Health-Related Medical Claims and Criminal Activity or the Experience of Abuse among Medicaid-enrolled Adolescent Females."* This is a study conducted by the Division of Public Health within DHSS.
- Professional guidance including the American Nurses Association's *Code of Ethics for Nurses with Interpretive Statements* (2001) and *Nursing: Scope and Standards of Practice* (2004), the American Medical Association's *Principles of Medical Ethics* (2001), and the *Code of Ethics of the National Association of Social Workers* (1999) and *Standards for the Practice of Social Work with Adolescents* (2003).
- Other relevant studies and articles.

To better understand current practices, operational philosophy and guidance, and the implementation of the State's mandatory reporter law, we interviewed the following individuals:

- DPH director, deputy director, and staff.
- Department of Law attorneys for DHSS.
- SOPHN chief, deputy chief, regional managers, and sub-regional managers.
- Grantee executive director and program managers.
- Women's, Children's, and Family Health section chief and staff.
- Council on Domestic Violence and Sexual Assault executive director.

- DHSS grants administrator and research analysts.
- OCS management and staff.
- Board of Nursing executive administrator and Alaska Nursing Association executive director.
- Anchorage Police Department Special Victims Unit lieutenant.
- Alaska school district nurses.
- Municipality of Anchorage, Department of Health and Human Services, management.

ORGANIZATION AND FUNCTION

Department of Health and Human Services

The mission of the Department of Health and Human Services (DHSS) is to promote and protect the health and well-being of all Alaskans. To carry out these responsibilities, the department utilizes over 3,000 personnel and an operating budget of more than $1.9 billion. The Division of Public Health (DPH) is one of eight divisions within DHSS. Two sections within DPH, the Section of Public Health Nursing (SOPHN) and Women's, Children's, and Family Health (WCFH), are involved in the provision of health services to the public.

Section of Public Health Nursing

SOPHN provides public health nursing services statewide through 21 public health centers,[3] four regional offices, and two administrative offices. SOPHN reaches an additional 250 communities through itinerant nurse services. The section operates with a staff of over 100 public health nurses and a budget of more than $23 million. Health care is provided primarily to rural and low income or under-insured individuals and families. Four additional locations provide public health nursing services with the oversight of SOPHN.[4]

Department of Health and Social Services Grantees

During FY 06 and FY 07, DHSS administered state or federal funds to four grantee organizations providing reproductive health services. These grantees included:

1. North Slope Borough Health & Social Services Agency Wellness Center.
2. Maniilaq Association Public Health Nursing.
3. Norton Sound Health Corporation.
4. Kachemak Bay Family Planning Clinic.

Exhibit 2

FY 07 DHSS Grantee Funding

Grantee	Funding (thousands)
North Slope Borough	310.8
Maniilaq	514.1
Norton Sound	596.1
Kachemak Bay	85.1
Total	**1,506.1**

Exhibit 2 summarizes how more than $1.5 million was distributed between these organizations in FY 07.

[3] SOPHN public health centers are located in Bethel, Cordova, Craig, Delta Junction, Dillingham, Fairbanks, Fort Yukon, Galena, Haines, Homer, Juneau, Kenai, Ketchikan, Kodiak, Mat-Su, Petersburg, Seward, Sitka, Tok, Valdez, and Wrangell.

[4] The four SOPHN grantees include: Municipality of Anchorage, Norton Sound, Northwest Arctic/Maniilaq, and the North Slope Borough.

SOPHN provides state funding, oversight, and technical assistance to the first three agencies listed.[5] The fourth, the Kachemak Bay Family Planning Clinic, receives funding through the federal Title X Family Planning program,[6] which is administered by the State's WCFH section within DPH.

[5] While it is one of four grantees under SOPHN, the Municipality of Anchorage does not provide reproductive health care with funding received from the state.

[6] Title X Family Planning Grant funds services to low-income women and teens. In addition to Kachemak Bay Family Planning Clinic, the State receives assistance to provide such services through its second delegate, the state-operated Mat-Su Public Health Center.

BACKGROUND INFORMATION

Statutory rape is defined by the Federal Bureau of Investigation as "nonforcible sexual intercourse with a person who is younger than the statutory age of consent."[7] Even if both parties assert the intercourse is voluntary, under the law, a minor under a certain age is presumed not to be able to consent to sexual intercourse; consequently sex with a minor is considered intrinsically coercive. For the majority of states, including Alaska, the age of consent is 16 years old.

All states have laws against statutory rape, but the legal definition varies. In the majority of states, whether a minor can legally consent to sexual activity depends on the age of the minor, the age of the partner, or a combination of the two. Many states also have an age differential attached to avoid criminalizing peer group consensual intercourse. Age differentials typically range from two to five years. While it is commonly referred to as statutory rape, few states actually use the term in their statutes. Other terms include sexual assault, forcible rape,[8] and in Alaska, sexual abuse of a minor.

Child abuse laws involve mandatory reporting

Another statute common to all states is what is termed a mandatory reporting law. This term refers to a law which requires certain designated professionals to report any situation they may encounter in the course of their professional responsibilities that might reasonably suggest child abuse.

While all states have mandatory reporting laws, as is the case with statutory rape statutes, there is variability among the states. In approximately one-third of the states, mandatory reporting is limited to situations where the suspected abuser is responsible for the care of the child. In three states – Florida, Tennessee, and Wisconsin – mandatory reporters are specifically permitted in statute to exercise professional discretion when reporting suspected statutory rape.[9]

Exhibit 3

FBI Profile of Statutory Rape

- One in four rapes of juveniles was statutory rape (2000 data).
- Forty-five percent of offenders of female victims and 70 percent of offenders of male victims were 21 or older.
- Six years was the median age difference between female victims and male offenders; nine years between male victims and female offenders.
- Offenders were arrested in 42 percent of the cases; arrest was more likely the younger the victim and the older the offender.

[7] Troup-Leasure, Karyl, and Snyder, Howard N., "Statutory Rape Known to Law Enforcement," U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, *Juvenile Justice Bulletin*, August 2005.
[8] The Lewin Group, *Statutory Rape: A Guide to State Laws and Reporting Requirements,* December 15, 2004. p. 5.
[9] The Lewin Group, p. 13.

In August 2005, the U.S. Department of Justice published the results of a study on statutory rape. The study analyzed statutory rape reports from law enforcement agencies in 21 states for the period 1996 to 2000. The results are listed in Exhibit 3 on the previous page.[10]

Statutory rape elements are codified in Alaska child sexual abuse and protection statutes

Since statutory rape elements are codified in the Alaska criminal child abuse statutes, a lot of reliance is put on mandatory reporters. It is necessary for such reporters to consistently report situations of suspected child sexual abuse for investigation. Under the State's child protection law, at AS 47.17.020, individuals who, in the course of their professional duties, have contact with children are mandatory reporters of suspected child abuse and neglect. Included in the statutory list of mandatory reporters are doctors, nurses, and other medical providers.[11] Failure to comply with the child protection law and report child abuse that the mandatory reporter knew of or had reasonable cause to suspect is a class A misdemeanor.[12]

In addition to other forms of child sexual abuse, state laws, AS 11.41.434, and AS 11.41.436, address sexual acts that are also commonly referred to as statutory rape. Alaska Statute 11.41.434(a)(1) prohibits sexual penetration of a minor under the age of 13 by an offender 16 years of age or older, and classifies this offense as first degree sexual abuse of a minor. Alaska Statute 11.41.436(a)(1) prohibits sexual penetration of a minor 13, 14, or 15 years of age by an offender 17 years of age or older with at least a four year age difference, and classifies this offense as second degree sexual abuse of a minor. First degree sexual abuse of a minor is an unclassified felony. Second degree sexual abuse of a minor is a class B felony.[13]

The term reasonable cause to suspect, as it relates to statutory rape, is not specifically defined in state law. Individuals who are subject to the mandatory reporter law must rely on their judgment and make decisions to report in the context of state law and their profession's ethics or established standards of care and practice. Nurses in Alaska would most typically look to the American Nurses Association's *Code of Ethics for Nurses* and *Nursing: Scope and Standards of Practice* for professional guidance. Nurses we interviewed and our own review of these publications confirmed there was no specific guidance provided to nurses

[10] Troup-Leasure, Karyl, and Snyder, Howard N., "Statutory Rape Known to Law Enforcement," U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, *Juvenile Justice Bulletin*, August 2005.

[11] Mandatory reporters include the following designated professionals: teachers and school administrative staff; peace and corrections officers; institution administrative officers; child care providers; paid employees of domestic violence, sexual assault, crisis intervention and prevention programs; paid employees of drug or alcohol or drug counseling treatment organizations; and child fatality review team and multidisciplinary child protection team members.

[12] To underscore the importance of reporting child abuse and neglect, the 2005 Legislature elevated noncompliance from a class B to a class A misdemeanor effective April 28, 2006. This change increased the definite term of imprisonment from a maximum of 90 days, to a maximum of one year (see AS 12.55.135).

[13] In accordance with AS 12.55.125, first and second degree sexual abuse of a minor may be sentenced to a definite term of imprisonment of not more than 99 years and shall be sentenced to a definite term of at least fifteen years or five years, respectively, in the absence of mitigating factors. The term depends on a number of factors including the age of the minor and the number of the offender's prior convictions.

regarding under what particular circumstances they must report suspected sexual abuse. [14] Accordingly, professional guidance does not require nurses to report based solely on the presence of certain risk factors in a minor such as pregnancy, request for contraceptives, or a sexually transmitted infection (STI). Still, as discussed in Report Conclusions, the nurses we surveyed responded that they received training about various risk factors that would indicate who may be in a sexual abuse situation.

Health care providers and other mandatory reporters are reporting child sexual abuse

In 2006, there were an estimated 29,600 girls statewide between the ages of 10 and 15 years old.[15] Just over 10,300, or 35 percent, of these adolescents received health care services funded through Medicaid. Of the girls receiving services through Medicaid, 295 or 3 percent received services that could be classified as involving reproductive heath care. Of these 295 adolescent girls, the Office of Children's Services (OCS) received a sexual abuse report of harm (ROH) for 34 of them in either 2006 or 2007.

Exhibit 4

Medicaid-enrolled 10 to 15 Year Old Girls			
	Years 1999 - 2003	**Years 2004 - 2007**	**Total Years 1999 - 2007**
Girls who received pregnancy, STI or contraceptive services	1,249	991	2,240
Girls (Medicaid enrolled) with at least one report of harm (ROH)	642	399	1,041
Girls (Medicaid enrolled) with at least one ROH involving suspected sexual abuse	275	190	465
ROHs for Girls (Medicaid enrolled) involving suspected sexual abuse	446	268	714

Source: Department of Health and Social Services Medicaid, PROBER, and ORCA databases.

Exhibit 4 offers a nine year perspective on the number of Medicaid enrolled girls receiving reproductive health care and the number of times they have been reported to OCS. Specifically, between 1999 and 2007, 2,240 adolescent girls between the ages of 10 and 15 received reproductive health care services[16] paid for through the State's Medicaid program.[17] Of these adolescent girls, 1,041 or 45 percent had at least one referral, or ROH, to OCS (or its predecessor agency the Division of Family and Youth

[14] Similarly, we found this to be the case with the professional guidance followed by physicians and social workers, two other professions that also often have regular contact with adolescents in the course of their duties. Such guidance includes for physicians the American Medical Association's *Principles of Medical Ethics* (2001) and for social workers the *Code of Ethics of the National Association of Social Workers* (1999) and *Standards for the Practice of Social Work with Adolescents* (2003).

[15] We developed this estimate based on the number of 10 to 15 year old female applicants for the 2007 Alaska Permanent Fund Dividend – based on 2006 residency status.

[16] We have classified health care services related to pregnancy, contraception, and STIs as reproductive health care services. The treatment codes that fall into the various categories mirror, but slightly expand on the codes used in the report cited in footnote 19 – authored by Dr. Gessner.

[17] In performing our analysis, we were limited to Medicaid data. The experience of the adolescent girls enrolled in Medicaid may or may not be consistent with the general population.

Services) during this period. More specifically, 465 of these girls had at least one ROH involving suspected sexual abuse. A total of 714 ROH were received by OCS for the 465 girls.

For these 714 referrals for sexual abuse, the largest percentage (30 percent) of the reports of harm came from health care providers. Exhibit 5 provides additional detail on other reporter categories. Exhibit 5 also summarizes the percentages for each reporter group separately for the two different periods presented (1999 to 2003 and 2004 to 2007).[18] While all of these referrals may not necessarily have been for suspected or known statutory rape, they do indicate that front-line health care providers, as well as other mandatory reporters, are reporting suspected sexual abuse to OCS for investigation and follow-up.

Exhibit 5

Sexual Abuse Reports of Harm by Reporter

Reporter Category	Years 1999 - 2003	Years 2004 - 2007	Total Years 1999 - 2007
Health Care Provider	26%	36%	30%
Non-state Agency	21%	5%	15%
Court/Police	14%	11%	13%
School	11%	10%	11%
Parent/Relative	7%	6%	6%
Anonymous	7%	14%	9%
Community	6%	4%	5%
Child Protective Services	6%	14%	9%
Neighbor	1%	0%	1%
Self	1%	0%	1%
TOTAL	100%	100%	100%

Source: Department of Health and Social Services PROBER (1999 to 2003 data) and ORCA (2004 to 2007 data) databases.

In 2006, the Division of Public Health (DPH), within the Department of Health and Social Services (DHSS), published a study on the association between the provision of reproductive health services provided to teenage girls enrolled in the state Medicaid program and possible associated referrals to OCS.

The study concluded that among Medicaid-enrolled teenage girls there was a "strong association" between receiving reproductive health services and sexual or physical abuse.[19] As discussed in Report Conclusions, many public health nurses are knowledgeable about this connection and the need to consider this risk factor when evaluating a possible statutory rape situation.

PHNs are presented with dual, and for some conflicting, responsibilities

Health care providers are required ethically and legally to protect their clients' confidentiality. One exception to this responsibility is the reporting of known or suspected

[18] The difference between the percentages of health care providers for 1999 to 2003 versus 2004 to 2007 may be due in part to differences in how reporters were categorized between the two periods. For 1999 to 2003, some mental health reporters may have been categorized as non-state agency reporters.

[19] Gessner, Bradford D., "The Association Between Reproductive Health-Related Medical Claims and Criminal Activity or the Experience of Abuse among Medicaid-enrolled Adolescent Females," *State of Alaska Epidemiology Bulletin*, 10:1, January 3, 2006.

child abuse. Given these dual responsibilities, we included in our survey a question about the concerns that health care providers in general may have about reporting child sexual abuse and whether DHSS and grantee PHNs in particular believe there is a conflict between reporting and maintaining confidentiality.

The two primary concerns cited were that the client may not return for services, which could lead to increased unplanned pregnancies and sexually transmitted infections, and that client confidentiality would be breeched and trust lost. Exhibit 6 lists additional concerns health care providers may have about reporting.

Exhibit 6

Potential Concerns about Reporting

- Client may not return for services
- Breech of client confidentiality and trust
- Lack of follow-up (child protection system overloaded)
- Partner will abuse client
- Health care provider's fear for personal safety
- Backlash from parents or partner
- Possibility of being wrong

Approximately 25 percent of PHNs responding to this question report they believe there is a conflict between reporting child sexual abuse and maintaining client confidentiality. One nurse commented:

> *I believe health care providers sometimes walk a fine line of reporting suspected abuse, at times risking the client not coming to the clinic versus not reporting her or his suspicions and getting into legal trouble. All providers that I work with are very concerned about child sexual abuse and do not look on it lightly…*

The existence of this conflict is reflected further in SOPHN's practice of asking the age of the client's partner, but not pressing for the information. Fifty percent of PHNs believe that pressing the patient for such information discourages adolescents from seeking health care.

Conversely, 43 percent of the responding PHNs report that they do not believe there is a conflict between reporting child sexual abuse and maintaining client confidentiality. One nurse stated, *"If you need to report a case of child sexual abuse, then it needs to get reported (period)."*

(Intentionally left blank)

REPORT CONCLUSIONS

We were directed to review the statutory rape policies and procedures of state agencies and grantees providing reproductive health services. We were also directed to review the training provided to front-line health care providers on recognizing and reporting the form of child sexual abuse commonly referred to as statutory rape. The organizations reviewed are identified in the Background Section.

As discussed further in this section, we have developed the following conclusions:

- The Section of Public Health Nursing (SOPHN) mandatory reporting policy satisfactorily addresses child sexual abuse and mandatory reporting statutes.
- One of the four Department of Health and Social Services (DHSS) grantees lacks a written policy on child sexual abuse reporting.
- SOPHN policy revision lagged behind statutory amendments by more than one year.
- Most public health nurses (PHNs) report receiving adequate training on child sexual abuse.
- Child sexual abuse training covers common risk factors of child sexual abuse.

Each of these conclusions is discussed further as follows:

SOPHN mandatory reporting policy addresses child sexual abuse and mandatory reporting statutes

SOPHN's current written policy and procedures, implemented August 2007, addresses both Alaska's criminal child sexual abuse statute and civil mandatory reporting statute. The policy is consistent with the statutes and includes a matrix (a step-by-step guide) to assist DHSS public health nurses in applying the law when they encounter a possible mandatory reporting situation. All but one DHSS survey respondent believe that the policy and procedures provide clear guidance on when and how to report a sexually abusive situation.

One potential shortfall of SOPHN's written policy and procedures is that they do not fully specify SOPHN's formal practices for identifying child sexual abuse. While it is not in the written policy, according to the section chief, when a child under the age of 15 presents for reproductive health services, it is SOPHN's practice to inquire about the partner's age. However, when we asked DHSS nurses whether they routinely ask the partner's age, a third of the nurses who responded to the survey replied they did not routinely ask this question during treatment.

One of the four DHSS grantees lacks a written policy on child sexual abuse reporting

Three of the four organizations providing reproductive health services through grant funds have written policies that address application of Alaska statutes on child sexual abuse reporting. Two organizations' policies cover both Alaska's child sexual abuse statute and mandatory reporting statute. The other policy discusses mandatory reporting requirements, but does not identify the ages and age differentials which define an abusive situation that may violate the child sexual abuse laws. While the nurse manager for the fourth organization was cognizant of the statutes, her agency does not have a specific written child sexual abuse reporting policy. SOPHN reports they have provided all grantees a copy of the section's mandatory reporting policy and procedures.

As grantees of the state and employers of mandatory reporters, it is essential that the organizations ensure their clinicians have clear and comprehensive written policies and procedures to follow. Of the three organizations with written policies, Kachemak Bay Family Planning Clinic has the most comprehensive policy, addressing both statutes and providing guidance that is tailored to the organization. This policy was developed with the technical assistance of DHSS.

SOPHN policy changes lagged behind statutory changes by more than one year

The current child sexual abuse statute became effective in April 2006. The statute increased the age span between the offender and the victim from three years or more to four years or more for a situation to constitute statutory rape. SOPHN did not amend its policy and procedures until August 2007; over a year later. SOPHN was aware of the amendment in law much earlier in the year; however, according to many of the nurse managers, the PHNs were instructed to continue following the old policy until it was revised and the new one released. As a result of this difference between policy and law, some PHNs were following the amended law and others were following the former law.

Most PHNs report receiving adequate training on child sexual abuse reporting

We surveyed DHSS and grantee clinicians about the frequency and adequacy of the training they receive on child sexual abuse recognition and reporting. We also asked how often their supervisors discuss with them their responsibilities under the mandatory reporting statute.

According to DHSS regional nurse managers, sub-regional nurse managers, and grantee PHN managers, training on child sexual abuse is provided through a variety of means. Methods include regular staff meetings, regional meetings, in-house trainings, seminars, and online courses. New DHSS nurses participate in the Public Health Nurse Academy which includes training on Alaska's child sexual abuse and mandatory reporting statutes. Information also is disseminated through emails, handouts, and informal discussions with supervisors.

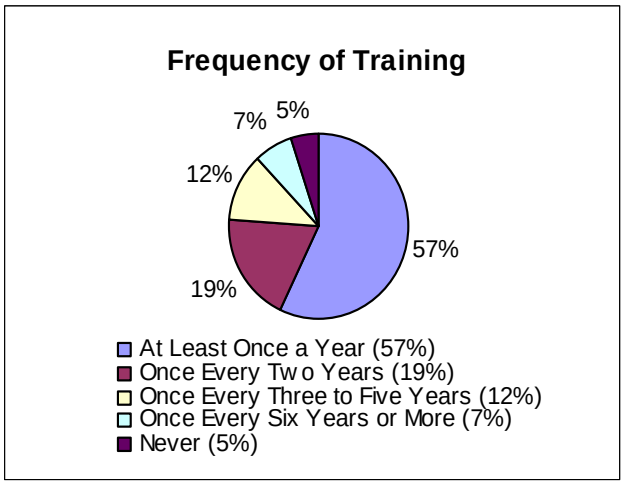
Of the respondents, 98 percent of the PHNs reported that they have received information on Alaska's child sexual abuse statutes within the last year. Eighty-four percent of the PHNs responded that their supervisors discuss with them (or if they are supervisors they discuss with their staff), either formally or informally, their mandatory reporting responsibilities at least once a year.

As illustrated in Exhibit 7, 57 percent of the PHNs responded that they receive training at least once a year. Approximately 85 percent of the PHNs responding to the survey have received training on child sexual abuse recognition and reporting within the last two years. Over 80 percent of the PHNs report that the training they've received has adequately prepared them to be able to recognize and report child sexual abuse.

In recent years, some of the formal training relevant to child sexual abuse offered to DHSS nurses or grantee organizations has included curricula entitled:

1. *"Risk Reduction/Preventing Sexual Coercion."*
2. *"Unequal Partners."*
3. *"Statutory Rape Laws in Alaska and Reporting Requirements."*
4. *"How to Talk To Your Clients about Statutory Rape and Mandatory Reporting."*
5. *"Teens: Mandatory Reporting and You."*

Exhibit 7



While not all PHNs attend every course or seminar offered, according to the nurse managers we spoke with, the PHNs who do attend share the information they obtained during staff meetings.

Child sexual abuse training covers common risk factors of child sexual abuse

Alaska's mandatory reporting statute requires PHNs who know or reasonably suspect abuse to report it to OCS. Based on their experiences, the PHNs surveyed identified several risk factors that would provide a reasonable basis for suspicion of child sexual abuse. Exhibit 8 lists the top 10 risk factors cited by survey respondents. Although these risk factors are not specifically spelled out in either the SOPHN or grantee policies, the PHNs

Exhibit 8

Common Risk Factors

- Unstable living situation
- Substance or alcohol abuse
- Promiscuity
- Runaway or homelessness
- Positive for sexually transmitted infections
- School problems or drop-out
- Pregnancy, repeated testing, or birth control request
- Physical injury; other signs of abuse
- Depression or suicide attempts
- Early onset of sexual activity

who responded to this question report that many of these factors are covered in training.

Several PHNs surveyed state that they have reported a child sexual abuse situation solely on suspicion. Some have reported situations based on the presence of two or three risk factors; others have reported based on the presence of only one risk factor. Most commonly, the basis of suspicion cited was the client's age coupled with a sexually transmitted infection, request for pregnancy test, or request for birth control. Other suspicious situations reported by PHNs included self-mutilating behavior coupled with multiple sexual partners, substance abuse, or acting out.

While it is helpful to know that there are common risk factors, several PHNs report that identifying a possibly sexually abusive situation still depends on developing rapport with the client, assessing multiple factors, and exercising professional judgment. As one nurse pointed out, reporting is not as simple as filling out a check list. Others similarly expressed concern that naming specific risk factors in statute or policy would be too restrictive and potentially lead to less reporting of suspected cases.

FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

The director of the Division of Public Health (DPH) should ensure that the Section of Public Health Nursing's (SOPHN) mandatory reporting policy more timely reflect changes in state law.

In April 2006, the Legislature amended the child sexual abuse statute, effective immediately. The former law prohibited sexual intercourse between a child 15 or younger and an individual 16 or older with at least a three year age difference; the 2006 increased the age difference to four years.

SOPHN was not informed about the amended law in a timely manner. When the section chief and nurse managers were eventually updated, they informed their staff, but continued to follow the existing policy pending revision and subsequent review of the new policy by the Department of Health and Social Services' (DHSS) legal advisors. This process took over one year, with the new policy being implemented in August 2007. Through discussions with regional and sub-regional nurse managers, we learned that during the review process some continued to use the former policy as instructed by central management and some were following the new law.

A one year lag in policy revision is unreasonable and warrants a review of the process. We recommend DPH improve its mechanism for informing SOPHN of changes in statute and for ensuring more timely revisions to policy and procedures.

Recommendation No. 2

The SOPHN chief should amend mandatory reporting policy to better align written guidance with expected practice.

As discussed in Report Conclusions, ostensibly SOPHN's standard practice is to ask a client who is 15 years old or younger and seeking reproductive health services the age of his or her partner. This practice is not reflected in SOPHN's formal mandatory reporting policy, but is part of training and orientation for state PHNs.

A third of the public health nurses (PHNs) responding to our survey reported they did not routinely ask the underage patient about the age of the partner(s) with whom they are having sexual intercourse. While it is not statutorily required, the standard practice may be more closely followed if incorporated into the written policy and procedures or practice guidelines.

Recommendation No. 3

The SOPHN chief should further strengthen oversight of PHN child sexual abuse training.

The majority of PHNs report receiving adequate, frequent, and recent training on child sexual abuse recognition and reporting. However, as illustrated on page 13 in Exhibit 6, 12 percent of the PHNs responding to our survey reported having either received training less than once every five years or having never received training in this area. These nine PHNs include eight DHSS nurses and one grantee nurse.

Under AS 47.17.022, all state employees who are mandatory reporters must receive appropriate training in child abuse at least once every five years. This is a reasonable guideline for child sexual abuse training for both state and grantee clinicians to follow as well.

According to some members of management, it is the PHNs' responsibility to ensure they receive the required training and that they stay informed of their statutory requirements. While we agree the PHNs have a duty to manage their training, it should not be their responsibility alone. As administrators of the program, management also has the responsibility to ensure their staff is adequately trained and informed. It is our understanding that beginning last year management began maintaining a database compiling staff training. We encourage them to continue in this regard and to use the database to better identify areas and individuals needing additional training.

As part of their grant, the agreements between DHSS and the grantee agencies include the assurance that the agencies comply with the State's child protection statute. To be able to properly report child sexual abuse, the grantee clinicians have to be informed and adequately trained. Currently, SOPHN provides some oversight of training by offering grantees the option to attend. SOPHN may wish to consider increasing their oversight by including as an additional grant assurance that the grantee clinicians attend training specifically on child sexual abuse recognition and reporting at least once every five years.

Recommendation No. 4

The commissioner should ensure DHSS complies with child abuse curriculum requirements.

State law, at AS 47.17.022, requires all state agencies and local school districts with employees covered by the State's mandatory reporting law have a current copy of their training curriculum and materials on file with the Council of Domestic Violence and Sexual Assault. Currently, the council does not have either a curriculum or materials for DHSS' child protection training.

The purpose of the council is to:

> *…provide for planning and coordination of services to victims of domestic violence and sexual assault and to perpetrators of domestic violence and sexual assault and to provide for crisis intervention and prevention programs.*[20]

We recommend DHSS seek the council's technical assistance in developing future trainings on child abuse in general and child sexual abuse in particular. To be in compliance with statutory requirements, we also recommend DHSS file its current child abuse training curriculum and materials with the council for both the council's review and for accessibility by state mandatory reporters and the general public.

[20] AS 18.66.010.

(Intentionally left blank)

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

SARAH PALIN, GOVERNOR

P.O. BOX 110601
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030
FAX: (907) 465-3068

June 4, 2008

Pat Davidson
Legislative Auditor
Legislative Budget and Audit Committee
PO Box 113300
Juneau, AK 99811-3300

Dear Ms. Davidson:

Thank you for the opportunity to respond to the preliminary audit entitled, *"A Special Report on Training, Policies, and Practices Related to Reporting Suspected Statutory Rape, Department of Health and Social Services, Division of Public Health, April 28, 2008."* The Department of Health and Social Services (DHSS), the Division of Public Health (DPH) and the Section of Public Health Nursing (SOPHN) agree in principle with your findings and recommendations. We do wish to offer comments regarding the four recommendations in the report.

I want to point out that, given the importance of the subject of mandatory reporting; we are generally pleased with the tone of the report. I point specifically to three of the report's five conclusions: that SOPHN mandatory reporting policy satisfactorily addresses child sexual abuse and mandatory reporting statutes, that most of our nurses receive adequate training on the subject, and that the training covers the common risk factors of child sexual abuse. The two other conclusions are more negative – that one of our four Nursing grantees lacks a written policy on the subject, and that SOPHN policy lagged behind statutory changes – yet can be easily addressed. The bottom line is that your report affirms that SOPHN does not demonstrate institutional carelessness or disregard for the law. Instead, it offers constructive criticism we can use to make improvements.

Here are more specifics on the report's two negative conclusions:

- On Page 14, you state that one of four DHSS grantees lacks a written policy of child sexual abuse reporting. It should be noted again that all four of those grantees (North Slope Borough, Maniilaq, Norton Sound and the Municipality of Anchorage) did receive written copies of the SOPHN Mandatory Reporting Policies and Procedures (P&P) and were encouraged to adopt them; in addition grantee managers were included in state SOPHN management discussions on educating staff on the recognition and reporting of abuse, and on the P&P. Nevertheless, in our next grant cycle, we will add a special condition to the award asking that SOPHN is copied by each grantee with a written copy of its policy on child sexual abuse reporting.

- Also on Page 14, regarding "SOPHN policy changes lagged behind statutory changes by more than one year," as noted in our December 2007 response to the management letter on this subject, the new statute is actually *less restrictive* than the previous statute, so

while our PHNs followed the old P&P they were meeting the requirements of the new statute. It is important to note that if this were not the case – if the new reporting requirements were more stringent – then the urgency of implementing a new P&P would have increased exponentially. Finally, as the management letter mentioned, the new law was undergoing review by DHSS legal advisors, which slowed adoption of the revised P&P. Nevertheless, we agree that SOPHN needs to update policies affected by statutory changes in a consistent and timelier manner.

Your cover letter dated May 14, 2008, asks for specific responses to the report's four recommendations. Here they are, in order:

- *No. 1 – The Director of DPH should ensure that the SOPHN's mandatory reporting policy more timely reflects changes in state law.* We agree, and will ensure that relevant law changes are better communicated to all of the DPH Sections, and that Section chiefs are aware that any affected policies must be updated in a timely manner.

- *No. 2 – The SOPHN chief should amend mandatory reporting policy to better align written guidance with expected practice.* We agree, with one important caveat: standard practice must also include the ability for nurses to use their professional judgment. Currently, questioning a young client regarding the age of his or her sexual partner whenever there is any suspicion of sexual coercion is included in PHN training, is part of guidance provided by PHN managers to nurses, is expected of our nurses and is indeed the norm. However, our Nursing management team recognizes the need for the nurse/health professional to be able to exercise professional judgment in individual client interactions. Our nurses have extensive education and experience in working with clients in personal and often stressful health and social situations of all kinds, both in their professional education and in regularly held in-house trainings. We strongly believe that they must be allowed to decide how best to protect the health and well-being of the client in both the immediate and the longer term – occasionally that may mean taking the time to develop additional trust and rapport before approaching a client about a particular issue. This is very important because young clients always need a trusting relationship with a health professional who can advocate for their safety and well-being. As your report states on Page 11 (along with a box labeled Exhibit 6), the chief concerns are that "the client may not return for services, which could lead to increased unplanned pregnancies and sexually transmitted infections, and that client confidentiality would be breached and trust lost." The exercise of professional judgment is particularly important for those working with teens because of normal intellectual and emotional growth and development stages, and because of additional distrust of authority figures that is particularly common of abuse victims. As your report further states, some states acknowledge the critical importance of professional judgment in their mandatory reporting laws for sexual coercion.

- *No. 3 – The SOPHN chief should further strengthen oversight of PHN sexual abuse training.* We agree, and will use already existing opportunities to provide consistent and timely training. We would like to note that the statistics in your report state that 88 percent of 102 nurses interviewed said they did receive timely training on this very important subject, and that only 5 percent said they were never trained. We do track this matter diligently – it is now part of the staff orientation manual – and believe it is possible that at least some of those respondents were newly hired nurses and simply not yet trained. Of course it is always our goal to provide the best possible training to all staff, and we will continue to strive to accomplish that.

- *No. 4 – The commissioner should ensure that DHSS complies with child abuse curriculum requirements.* We agree. DHSS directors in divisions whose missions include child abuse prevention will be assigned the responsibility of contacting the Council on Domestic Violence and Sexual Assault about this matter.

Thank you again for the chance to comment on this matter.

Sincerely,

William H. Hogan
Acting Commissioner

cc: Jay Butler, M.D., Chief Medical Officer
Beverly K. Wooley, Director, Division of Public Health
Rhonda Richtsmeier, Chief, Section of Public Health Nursing, Division of Public Health