MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1462

2001 HOUSE HUMAN SERVICES

HB 1462

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1462

House Human Services Committee

☐ Conference Committee

Hearing Date January 30, 2001

Tape Number	Side A	Side B	Meter #
Tape 1		X	150 to 4970
Tape 3	X		475 to 550
Committee Clerk Signature	Connie Easton		

Minutes:

Chairman Price, Vice Chairman Devlin, Rep. Dosch, Rep. Galvin, Rep. Klein, Rep. Pollert, Rep. Porter, Rep. Tieman, Rep. Weiler, Rep. Weisz, Rep. Cleary, Rep. Metcalf, Rep. Niemeier, Rep. Sandvig

Chairman Price: Open hearing on HB 1462.

Rep. Nancy Johnson: Presented Bill. Rather than protecting abused victims, this mandatory reporting has, at times, caused victims not to seek medical help. I urge a DO PASS and make victims lives less difficult.

Rep. Svedjan: Cosponsor of Bill. I am here today to express my support of HB 1462. There are definitely problems with reporting of domestic violence. HB 1462 defines first steps for reporting this crime. Mental health professionals would no longer be mandated as reporters of violence, they would need to report life threatening injuries only. When professionals report a crime, they will have referrals so the victim is safe.

Rep. Porter: What is the infraction for those who do not follow through with the reporting process?

Rep. Svedjan: The fine is fairly small.

Rep. Porter: I noticed that it specifically states Sheriff and States Attorney - is this an oversight? This does not include local law enforcement.

Rep. Svedjan: This is something that will need to be pursued. If that was an oversight, it was an inadvertent oversight.

Connie Hildebrand: Legislative Chairman of the North Dakota Chapter of the National Association of Social Workers. (See support of HB 1462 in written testimony.) Current law is not working, therefore, we are in favor of the passage of HB 1462.

Gayla Dengson: Manger of Social Work Department, Altru Health Systems. (See written testimony.) Health care settings should be safe havens, not places where women have to consider the consequences. I ask for a DO PASS on HB 1462.

Mr. Wetzel: Presented letter of support from Dr. Gordon Leingang.

Arnold Thomas: President, North Dakota Health Care Association. This bill would allow us to sit down and positively work to develop ways to deal with domestic violence. What you're hearing is that the professionals want some help.

Bonnie Polachek: Spoke on behalf of the North Dakota Council on Abused Women's Services in support of HB 1462. After 25 years, it's time to look at this bill again. This bill clarifies our existing law and provides an important safety net for victims by encouraging referrals to advocacy and treatment program.

Diane Zainhofsky: Executive Director of Abused Adult Resource Center. (See written testimony.) I can't stress enough the importance of passing HB 1462 and keeping victims trust in the few people she can reach out to for help.

David Peske: North Dakota Medical Association. (Neutral) Physicians are having to struggle in confidentiality issues. We certainly support the improvements to the law, we just aren't sure about the wordage of this bill. We will certainly work with the supporters of this bill.

Bonnie Larson Staiger: Lobbyist, Executive Director of the N.D. Psychological Association. (See written testimony.) I am neutral because there are some ambiguities that need to be addressed and we are willing to work with the initiators of the bill to correct this.

John Olson: Representing North Dakota Attorney's Association. I am asking the committee to hear prosecutors point of view before passing this bill. Maybe there is a better way. We want to make the law better, make it work. We are here to help.

Chairman Price: Close hearing on HB 1462..

COMMITTEE WORK:

CHAIRMAN PRICE: On HB 1464, my local State's Attorney was in briefly at this hearing and said we need to check at the federal law concerning the privacy issues on this in addition to some of the things that Mr. Olson questioned as far as some of the language. I am going to ask a subcommittee to take a look at this bill. If no objections from these people it will be Rep. Porter, Rep. Klein, and Rep. Cleary.

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1462 A

House Human Services Committee

☐ Conference Committee

Hearing Date February 12, 2001

Tape Number	Side A	Side B	Meter #
Tape 2	X		415 to 1420
Committee Clerk Signature	Connie Easton		

Minutes:

COMMITTEE WORK:

CHAIRMAN PRICE: Let's go to HB 1464.

REP. PORTER: (Thanked Rep. Cleary and Rep. Klein for serving on the subcommittee with me. Explained amendments.) I would move the amendments.

REP. CLEARY: Second.

CHAIRMAN PRICE: Discussion on the amendments?

REP. WEILER: My notes I jotted down during testimony is that one of the persons stated that this bill is going down a dangerous path, and it forces a doctor or a health care professional to report domestic violence to authorities. Do these amendments take care of that? Are they not forcing the doctor or health care professional to do that?

REP. PORTER: They are in essence continuing an existing practice of requiring that the crime be reported, but what they are also doing is allowing the practitioner to opt out of reporting if

they feel that it is in the best interest of the injured person considering their safety. If the victim and the assailant are both standing in the emergency room, and the physician knows that by calling the police that the victim could possibly be assaulted again right there in the emergency room or right after discharge.

REP. NIEMEIER: I'm wondering about the 18 years of age and older? Why is that wording in there.

REP. PORTER: Currently in North Dakota law anyone under 18 cannot refuse the services, and cannot refuse the physician or practitioners wishes in regards to what is in their best interest. They are not allowed to make that decision.

CHAIRMAN PRICE: All those in favor of the amendments signify by saying Aye (14 Yes, 0 No). We have an amended bill.

REP. CLEARY: Do Pass as amended.

REP. METCALF: Second

CHAIRMAN PRICE: Any further discussion? Clerk will take the roll on a **DO PASS as amended.**

14 YES 0 NO 0 ABSENT CARRIED BY REP. PORTER

PROPOSED AMENDMENTS TO HB 1462

Page 1, line 7, after "physician" insert "physicians assistant" overstrike "other medical" overstrike "health professional" and insert immediately thereafter "any individual licensed under chapter 43-12.1"

Page 1, line 8 remove "provides" and overstrike "care or" overstrike "professional services" and insert immediately thereafter "diagnosis or treatment"

Page 1, line 9, overstrike "inflicted" and insert immediately thereafter ":
a. Inflicted"

Page 1, line 10, after "pistol" insert "shall as soon as practicable report the wound injury, or trauma to a law enforcement agency in the county in which the care was rendered"

Page 1, line 11, after "or" insert
"b. Which the individual"
and remove the overstrike over "has reasonable cause to suspect was inflicted in violation of any"

Page 1, line 12, remove the overstrike over "criminal law of this state" and remove "suffering serious bodily injury as defined in section"

Page 1, line 13, remove "12.1-01-04"

Page 1, line 14, overstrike "the sheriff or state's attorney of" and insert immediately thereafter "a law enforcement agency in" and after the period insert
"2."

Page 1, line 15, after "report" insert "under subsection one" and overstrike ", if known," and remove "the"

Page 1, line 16, remove "individual's" and overstrike "whereabouts"

Page 1, after the period, insert "Unless the injured person is being treated for injuries inflicted by means of a knife, gun, or pistol or for serious bodily injury as defined by chapter 12.1-01-04, a physician, physicians assistant, or an individual licensed under chapter 43-12.1 is not required to report under this subsection if the injured person is eighteen years of age or older, is a victim of domestic violence as defined in chapter 14-07.1-01 and the physician, physicians assistant, or any individual licensed under chapter 43-12.1 determines that not reporting the injury is in the best interests of the injured person after considering the person's safety and autonomy."

Page 1, line 18, overstrike "2" and insert immediately thereafter "3" after the second comma insert "or a report of physical injury resulting from a sexual offense as defined in chapter 12.1-20,"

Page 1, line 19, replace "sheriff or states attorney" with "law enforcement agency"

Page 1, line 20, replace "a referral to" with "with information regarding"

Page 1, line 21, after "program" insert "by the physician physicians assistant, or any individual licensed under chapter 43-12.1 unless it is known that such information has previously been provided to the injured individual"

Page 1, line 22, replace "3" with "4"

Page 2, line 3, replace "4" with "5"

Page 2, line 5, replace "5" with "6" and after "making" insert "or not making"

Renumber accordingly

YR
2/13/01
1 of 2

10708.0102
Title.0200

Adopted by the Human Services Committee
February 12, 2001

HOUSE AMENDMENTS TO HB 1462 HOUSE HS 2-13-01

Page 1, line 7, after "physician" insert ", physician assistant,", overstrike "other medical", overstrike "health professional", and after the overstruck comma insert "any individual licensed under chapter 43-12.1"

Page 1, line 8, remove "provides", overstrike "care or", and overstrike "professional services" and insert immediately thereafter "diagnosis or treatment"

Page 1, line 9, overstrike "inflicted" and insert immediately thereafter ":

a. Inflicted"

Page 1, line 10, overstrike the third comma and insert immediately thereafter "shall as soon as practicable report the wound, injury, or trauma to a law enforcement agency in the county in which the care was rendered,"

Page 1, line 11, after "~~he~~" insert:

"b. Which the individual" and remove the overstrike over "~~has reasonable cause to suspect was inflicted in violation of any~~"

Page 1, line 12, remove the overstrike over "~~criminal law of this state~~" and remove "suffering serious bodily injury as defined in section"

Page 1, line 13, remove "12.1-01-04"

Page 1, line 14, overstrike "the sheriff or state's attorney of" and insert immediately thereafter "a law enforcement agency in" and after the period insert:

"2."

Page 1, line 15, after "report" insert "under subsection 1", remove "individual", overstrike ", if known,", and remove "the"

Page 1, line 16, remove "individual's" and overstrike "whereabouts," and insert immediately thereafter "individual"

Page 1, line 17, after the period insert "Unless the injured person is being treated for injuries inflicted by means of a knife, gun, or pistol or for serious bodily injury as defined by section 12.1-01-04, a physician, physician assistant, or an individual licensed under chapter 43-12.1 is not required to report under this subsection if the injured person is eighteen years of age or older, the injured person is a victim of domestic violence as defined in section 14-07.1-01, and the physician, physician assistant, or any individual licensed under chapter 43-12.1 determines that not reporting the injury is in the best interests of the injured person after considering the person's safety and autonomy."

Page 1, line 18, overstrike "2." and insert immediately thereafter "3." and after the second underscored comma insert "or a report of physical injury resulting from a sexual offense as defined in chapter 12.1-20"

Page 1, line 19, replace "sheriff or state's attorney" with "law enforcement agency"

Page 1, line 20, replace "a referral to" with "with information regarding"

Page 1, line 21, after "program" insert "by the physician, physician assistant, or any individual licensed under chapter 43-12.1, unless it is known that the information has previously been provided to the injured individual"

Page 1, line 22, replace "3" with "4"

HOUSE AMENDMENTS TO HB 1462 HOUSE HS 2-13-01

Page 2, line 3, replace "4" with "5"

Page 2, line 5, replace "5" with "6" and after "making" insert "or not making"

Page 2, line 6, replace "the" with "or not making a"

Renumber accordingly

Date: 2-12-01
Roll Call Vote #: 1

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1462

House Human Services Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Moved Amendments

Motion Made By Rep. Porter Seconded By Rep Cleary

Representatives	Yes	No	Representatives	Yes	No
Rep. Clara Sue Price, Chairman	✓		Rep. Audrey Cleary		
Rep. William Devlin, V, Chairman	✓		Rep. Ralph Metcalf		
Rep. Mark Dosch	✓		Rep. Carol Niemeier		
Rep. Pat Galvin	✓		Rep. Sally Sandvig		
Rep. Frank Klein	✓				
Rep. Chet Pollert	✓				
Rep. Todd Porter	✓				
Rep. Wayne Tieman					
Rep. Dave Weiler					
Rep. Robin Weisz					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-12-01
Roll Call Vote #: 2

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1462

House Human Services Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken DO PASS as Amended

Motion Made By Rep. Cleary Seconded By Rep Metcalf

Representatives	Yes	No	Representatives	Yes	No
Rep. Clara Sue Price, Chairman	✓		Rep. Audrey Cleary	✓	
Rep. William Devlin, V, Chairman	✓		Rep. Ralph Metcalf	✓	
Rep. Mark Dosch	✓		Rep. Carol Niemeier	✓	
Rep. Pat Galvin	✓		Rep. Sally Sandvig	✓	
Rep. Frank Klein	✓				
Rep. Chet Pollert	✓				
Rep. Todd Porter	✓				
Rep. Wayne Tieman	✓				
Rep. Dave Weiler	✓				
Rep. Robin Weisz	✓				

Total (Yes) 14 No _____

Absent _____

Floor Assignment Rep. Porter

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1462: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1462 was placed on the Sixth order on the calendar.

Page 1, line 7, after "physician" insert ", physician assistant,", overstrike "other medical", overstrike "health professional", and after the overstruck comma insert "any individual licensed under chapter 43-12.1"

Page 1, line 8, remove "provides", overstrike "care or", and overstrike "professional services" and insert immediately thereafter "diagnosis or treatment"

Page 1, line 9, overstrike "inflicted" and insert immediately thereafter ":

a. Inflicted"

Page 1, line 10, overstrike the third comma and insert immediately thereafter "shall as soon as practicable report the wound, injury, or trauma to a law enforcement agency in the county in which the care was rendered;"

Page 1, line 11, after "~~he~~" insert:

"b. Which the individual" and remove the overstrike over "~~has reasonable cause to suspect was inflicted in violation of any~~"

Page 1, line 12, remove the overstrike over "~~criminal law of this state~~" and remove "suffering serious bodily injury as defined in section"

Page 1, line 13, remove "12.1-01-04"

Page 1, line 14, overstrike "the sheriff or state's attorney of" and insert immediately thereafter "a law enforcement agency in" and after the period insert:

"2."

Page 1, line 15, after "report" insert "under subsection 1", remove "individual", overstrike ", if known,", and remove "the"

Page 1, line 16, remove "individual's" and overstrike "whereabouts," and insert immediately thereafter "individual"

Page 1, line 17, after the period insert "Unless the injured person is being treated for injuries inflicted by means of a knife, gun, or pistol or for serious bodily injury as defined by section 12.1-01-04, a physician, physician assistant, or an individual licensed under chapter 43-12.1 is not required to report under this subsection if the injured person is eighteen years of age or older, the injured person is a victim of domestic violence as defined in section 14-07.1-01, and the physician, physician assistant, or any individual licensed under chapter 43-12.1 determines that not reporting the injury is in the best interests of the injured person after considering the person's safety and autonomy."

Page 1, line 18, overstrike "2." and insert immediately thereafter "3." and after the second underscored comma insert "or a report of physical injury resulting from a sexual offense as defined in chapter 12.1-20"

Page 1, line 19, replace "sheriff or state's attorney" with "law enforcement agency"

Page 1, line 20, replace "a referral to" with "with information regarding"

Page 1, line 21, after "program" insert "by the physician, physician assistant, or any individual licensed under chapter 43-12.1, unless it is known that the information has previously been provided to the injured individual"

Page 1, line 22, replace "3" with "4"

Page 2, line 3, replace "4" with "5"

Page 2, line 5, replace "5" with "6" and after "making" insert "or not making"

Page 2, line 6, replace "the" with "or not making a"

Renumber accordingly

2001 SENATE HUMAN SERVICES

HB 1462

2001 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1462

Senate Human Services Committee

❑ Conference Committee

Hearing Date March 3, 2001

Tape Number		Side A	Side B	Meter #
	1		X	8
	1	X		33
March 19, 2001	1	X		29
March 20, 2001	1	X		
March 20, 2001	2		X	25.5
March 26, 2001	1	X		
Committee Clerk Signature		Carol Kolodychuk		

Minutes:

The hearing was opened on HB 1462.

REPRESENTATIVE NANCY JOHNSON, Sponsor of the bill introduced the bill. Mandatory reporting is now in law. This bill would allow discretion for bruise or black eye if the victim does not want to press charges. The bill requires injured person to be given referrals to domestic violence, sexual assaults, or other victim assistance program Urge DO PASS. SENATOR POLOVITZ: What's the difference between person and individual? MS. JOHNSON: I don't know.

REPRESENTATIVE PORTER, cosponsor or bill, explained the bill. It was almost hoghoused. We didn't feel that it was necessary to have all the people report, only the people that were diagnosing the individual needed to report. We cleaned that part up a little bit. We had all the medical, advocacy, and legal divisions present. Reports still need to be made to law enforcement

in regard to the serious injuries by knife, gun or pistol as described in code, but if its under the crime described under simple assault and the victim is 18 years and older there are some options put in between the victim and diagnosing persons. There was conflict between the law enforcement and social services. This bill is in definite conflict. There was not a compromise. SENATOR MATHERN: Individual or person, what is the difference? REP. PORTER: I don't know, except the verbiage by Legislative Council.

BONNIE PALECEK, ND Council on Abused Women's Services, supports bill. (Written testimony). SENATOR MATHERN: Why are we limiting, shouldn't the victim have the full choice? MS. PALECEK: It would be placing an additional burden to make these referrals. One of the changes from providing referral to providing information because it was perceived that providing referral was very specific and that might involved and that would involve some liability for law enforcement if they neglected to do that. Broader information would be very acceptable. SENATOR LEE: read the definitions of individual means a human being; person means an individual, organization , government, political subdivision, or government agency.

CONNIE HILDEBRAND, ND Chapter of National Assoc. Of Social Workers, supports this bill. (Written testimony) because current ND is not working. Presented written testimony from GAYLA DRENGSON, Social Work Dept at Altru Health System.

DIANE BAUMBACH, medical social worker at Altru Health System, supports bill in written testimony. SENATOR MATHERN: My concerns are the women beaten in ways you wouldn't see walking down the street. What happens to a beaten woman on breasts and abdomen; would that be reportable? MS. BAUMBACH: If she is willing to show us bruises and not willing to file charges, it will be under lawful discretion to visit the individual or not. SENATOR MATHERN: If this passes would bruises manifested as black and blue marks in a covered area

of the body be considered serious bodily injury or would they not. MS. BAUMBACH: I'm not sure; the discretion of the physician comes into play.

BRUCE LEVI, ND Medical Assoc., supports bill as amended on the House side. Attention has turned to how providers and care givers can intervene. Medical discretion is necessary. Risks and consequences to mandatory reporting. There is a retaliation issue. Confidentiality - conformed consent - discretion - also immunity. Better recognition of role of physicians. SENATOR MATHERN: What is serious bodily injury? MR. LEVI: The definition is bodily injury that creates a substantial risk of death, or which causes serious permanent disfigurement, unconsciousness, extreme pain, permanent loss or impairment of the function of any body member or organ or a bone fracture.

ROGER WETZEL supports bill and shared written testimony from DR. GORDON LEINGANG.

DIANE ZAINHOFSKY, Executive Director of the Abused Adult Resource Center, supports bill as amended. (Written testimony)

BONNIE LARSON-STAIGER, ND Psychological Assoc., supports bill. Has concern of self inflicted injuries be reported. (Written testimony) SENATOR KILZER: If we take out self-inflicted won't it create a loophole for people who do not want to report? MS. STAIGER: Absolutely. The current law has loophole and this bill is a work in progress. It will also produce loopholes. The issue of domestic violence reporting and treatment is simply a work in progress. We have to do the best we can in any stage and we have to cooperate to protect the people who are battered.

JOHN OLSON, ND States Attorney and Peace Officers Assoc., testified in opposition. The end result of getting people getting help. We have no problem with Section 1, a and b. Section 2, first sentence is OK. Duty to report serious assault. This bill would be a leap backward in trying

to investigate domestic violence. Line 18 - 20 on page 2 makes no sense if physician doesn't have to report. HB1363 enhances penalty for perpetrators. This bill will create mass confusion.

SENATOR LEE: What is the recommendation for security of individuals? MR. OLSON: Many programs are in place - councilors, awareness - intervention is most important.

DOUG MATSON, Ward County States Attorney, opposes bill. Physicians can talk to the victim and from his or her testimony we learn who is the problem and from whom we must protect her from. We are fearful of losing the ability to go forward for prosecution. We need a way to get evidence in otherwise it is unworkable.

WADE ENGET, Mountrail County States Attorney, opposes bill. When is the victim ready to leave? The intervention step at the earliest possible date is what we need. Delete section 2, bottom of page 1 and page 2. There is no need for those lines.

No more testimony. The hearing was closed on HB 1462.

March 19, 2001, Tape 2, Side A, Meter 29.

Discussion resumed on HB 1462.

BONNIE POLECHEK reviewed the purpose and bill on intervention of criminal justice department. It affords discretion's. It is the best interest of the victim. There will be the referral to social worker that is important. JOHN OLSON was called to the meeting tomorrow morning at 9:00. The committee was adjourned until tomorrow.

March 20, 2001, Tape 1, Side A.

Discussion resumed on HB 1462.

JOHN OLSON was asked to give us some information. He stated that there was a total difference between law enforcement and abuse center people. Doctors will report only if victim wants to report. Early intervention is considered to be the best. This is confusing to Doctors:

simple assault vs aggravated assault. Which side of line they're on. Reporting all cases the judicial has information to start legal action against offenders. The abuse people want referral and the law enforcement will not initiate anything unless a report is filed. If a first offense is not filed the offender will be able to abuse in more instances than otherwise. Discussion BRUCE LEVI indicated the bill is a good compromise for Doctors. They are looking for a better environment for reporting.

The committee continued in the afternoon: Tape 2, Side A, Meter 25.5.

SENATOR MATHERN moved DO PASS. SENATOR KILZER seconded the motion.

Discussion. Roll call vote carried 6-0-0. SENATOR LEE will carry the bill.

March 20, 2001, Tape 2, Side A, Meter 25.5.

Discussion resumed on HB 1462.

SENATOR MATHERN moved DO PASS. SENATOR KILZER seconded the motion.

Discussion. Roll call vote carried 6-0-0. SENATOR LEE will carry the bill.

March 26, 2001, Tape 1, Side A

HB 1462 was brought back to the committee. It was discussed that several contacts had been made to various committee members from law enforcement officials concerning the bill.

SENATOR ERBELE moved to reconsider the bill. SENATOR FISCHER seconded the motion.

Roll call vote failed 3-3.

Date: 3/20/01

Roll Call Vote #: 1

2001 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1462

Senate HUMAN SERVICES Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass

Motion Made By Sen Mathern Seconded By Sen Kilzer

Senators	Yes	No	Senators	Yes	No
Senator Lee, Chairperson	✓		Senator Polovitz	✓	
Senator Kilzer, Vice-Chairperson	✓		Senator Mathern	✓	
Senator Erbele	✓				
Senator Fischer	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Sen Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1462, as engrossed: Human Services Committee (Sen. Lee, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1462 was placed on the Fourteenth order on the calendar.

Date: 3/26/01

Roll Call Vote #: 1

2001 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1462

Senate HUMAN SERVICES Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Reconsider 1462

Motion Made By Sen Erbele Seconded By Fischer

Senators	Yes	No	Senators	Yes	No
Senator Lee, Chairperson	✓		Senator Polovitz		✓
Senator Kilzer, Vice-Chairperson		✓	Senator Mathern		✓
Senator Erbele	✓				
Senator Fischer	✓				

Total (Yes) 3 No 3

Absent 0

Floor Assignment Sen Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
March 26, 2001 3:05 p.m.

Module No: SR-52-6778
Carrier: Lee
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

HB 1462, as engrossed: Human Services Committee (Sen. Lee, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1462 was placed on the Fourteenth order on the calendar.

2001 HOUSE HUMAN SERVICES

CONFERENCE COMMITTEE

HB 1462

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1462 CC

House Human Services

☐ Conference Committee

Hearing Date 4/04/01

Tape Number	Side A	Side B	Meter #
1	X		0-3440
Committee Clerk Signature	Connie Easton		

Minutes:

CHAIRMAN PORTER called the conference committee to order with all members present. Which consisted of REP. F. KLEIN , REP. CLEARY, SEN. LEE, SEN. T. FISCHER and SEN. T. MATHERN.

CHAIRMAN PORTER greets the committee members. Let's start out by asking the Senate to explain their amendments to HB 1462. SEN. LEE states that on the floor the amendments ended up being switched so that the amendment that related to mandatory recording were deleted so that the current statute remains in place during mandatory reporting, by a medical professional, but the rest of the amendments passed, which dealt with defining who reports and so forth. So that would be really the only area that we had a difference with the House. So whether or not the mandatory reporting remained as it is or would the discretionary for medical professionals as it was sent to us by you. CHAIRMAN PORTER asks if there is anything to add to that.

SEN. MATHERN states that he would add the advocates who are dealing with victims of domestic violence made a strong case in the Human Service Committee, to leave the bill as the House and the Senate did to us. Just so you know that the Human Service Committee struggled with a number of amended issues. But in the final analysis we supported what the House had done. Then it was changed on the Senate floor. So that is our struggle at this point.

CHAIRMAN PORTER asks if SEN. T. FISCHER has anything to add. SEN. T. FISCHER states that one of the problems that they had was that there was so much information that had come in late, in making decisions on whether or not to be mandatory or not. At the end of it I really felt as though that the old law was doing the mandatory requirements. I would be in favor of.

CHAIRMAN PORTER comments to the committee, to them his spin on things, he thinks that when they initially put that language in about the physicians being able to not report that came up during a subcommittee hearing, and it didn't come up at all during the main hearing of the bill. We put it on, then after there was disagreement after that point. The law enforcement community was in disagreement to that. I think that it really is for, what it boils down to that the advocacy groups felt that it would increase referrals, by making it optional. Law enforcement community feels that it won't increase referrals. It would only decrease referrals. It will then increase reporting. I think that the substantiate changes were taken out for the states attorney, and putting in the law enforcement, so that it doesn't have to wait until Monday morning if the act of domestic violence happens on a Friday night. Then it can immediately be reported to the law enforcement. I guess I am tending to side with the law enforcement community that the mandatory reporting aspects are not broken. What the problem seems to me is that they aren't working because there isn't enough education out there amongst the law enforcement and among the physicians. A lot of physicians have visited with. There was one right in our subcommittee

that didn't even realize that it was mandatory requirement. The emergency room physician that I spoke with feels that they have policies in place dealing with domestic violence, and that it's either way that the bill comes out. It isn't going to effect what their local policy is, in their local facilities, and what they deal with. REP. CLEARY states that she has sat on that same subcommittee, and she likes what they did to the bill. Because she thinks that it does in fact give the physicians some discretion. I think that these women will get help, if we make it mandatory that they have to report to the police all of the time. If they aren't going to admit that they have been beaten up by their boyfriends or their husband or what ever the case may be. They are just going to say that they fell down or something, because they're going to be afraid if they go to the law enforcement. That's what the advocacy side is saying. CHAIRMAN PORTER replies that he understands her concerns. I think that is what some of the advocates are saying. I think that we have heard from other advocates that like the law the way it is. One of the concerns that I have is that you have to remember that these are victims that are injured enough to the point that they are seeking medical treatment. Someone that is not injured to that point, someone who receives a slap on the face, typically is not going to the emergency room or to the physician for that act of violence. That is totally separate, I think what we are talking about is an act of violence that someone has considered big enough that they have sought out medical treatment for that act of violence, whether it be a laceration or a bruise big enough to think that it is a fracture that requires x-rays. It's not that we aren't catching every act of violence, what we are capturing are those acts of violence that are big enough that the person has sought out medical treatment. I think that those do require mandatory reporting. REP. F. KLEIN adds that many physicians are unaware of this. We had a doctor from Dickinson that didn't know about this law.

SEN. T. MATHERN comments about two concerns that he has. Someone noted that some of the victim advocates had suggested the House version. I heard from no one, there were no victim advocates or a victim that contacted him, wanting to see mandatory reporting. The only ones who contacted me were the ones who wanted the House version to eliminate that aspect of mandatory reporting. So if there is victim advocates out there who don't want the House version, no one ever contacted me. It was, in fact they were opposed to the Senate amendments. The other thing that I would add is the physicians education. I believe that you are right, REP. F. KLEIN and CHAIRMAN PORTER, about the need for education. But I think that this can be done either way. In fact the way the bill is passed now, and is before us in conference committee, it even has more pressure on the physicians. Because once we have eliminated all of the other persons who thought that they may be in this mandatory reporting group. We have eliminated the social workers, therapists and all these people who thought that the old law put them in. We focused on the medical profession. That is dramatic, and if they aren't following things now, and now there is greater focus. I am really concerned about those victims, those women that are abused, not getting the services that they need. So that is the point that I am concerned about.

REP. CLEARY comments that CHAIRMAN PORTER said a broken arm was reason enough to go to the emergency room. But then they would say that they fell down the stairs, or some other way explain it away if they were worried that its going to be reported. I like what we came up with. CHAIRMAN PORTER replies that in his limited experience those individuals that are that frightened will not tell the complete story regardless of the mandatory reporting law. Just from what I have witnessed. In that situation those victims typically are not willing to share the truth as to what happened regardless of their thought of the mandatory reporting law.

SEN. T. FISCHER comments, number one, why would we want it on the back of the doctor to decide whether or not to report the crime, because a crime has been committed? The other thing what kind of crime do we allow people to make choices whether or not to report? If either one of us sees a hit and run, do we stop and say , well maybe the next time he drives buy here he will do a little better, or we can work it out with him, or maybe he will seek counseling. What other crime that has been committed, do we give people discretion whether or not to report it? SEN. T. MATHERN states that most crimes have the discretion whether or not to report it. To me that is the case that I presume you mean as part of the accident. These people are afraid. I have worked with many women through the years, that have a mandatory reporter as a social worker, I understand what you are saying there. But I think the rational that I supported in terms in the House version of the bill, was that it would permit these people and encourage these people to spend some time with a physician or a medical practitioner, while they are afraid, so that they can start sharing the story of what is going on in their house, without having the fear on top of that someone from law enforcement is going to go right over and tell the person that is abusing them, that they have been in and sharing their fear. I think that is the rational of the bill is to give this woman or this person an opportunity to discuss their situation in a confidential environment, without feeling like they are going to come home to another abuse to the fact that they went in and made the report. So it's to address the fear. I think that you are right about the fear, it is to give a comfortable place to talk about their fear. CHAIRMAN PORTER comments that when he looks at it in that light, it still goes down to any crime committed, it still requires that the person has felt that they have been injured to the point where a physicians intervention is necessary. I think that the cases that you are talking about are more than simple assaults, a slap, those types of situations. I think that you are talking about a person who has loss of mobility of an extremity

and they needed x-rays. I think that you are talking about people that have open lacerations and wounds that need them sutured. Even though it includes those types of crimes, as low as simple assault, I think that we have to keep in mind that what we are talking about is a crime that has been committed that has inflicted an injury to the point where the victim now feels that they need physician intervention, or medical intervention. Because we have expanded to include nurse practitioners and physicians assistants. They are feeling that they need a skull x-ray, or a nose x-ray, or they need a cheek x-rayed. They are then going in. In order to have something accomplished in the first place you have to have a willing victim that admits to a crime being committed. I don't think this law changes that. I think this law says that once the person admits that crime has been committed on them, it is the duty of the physician to report that crime to law enforcement. SEN. LEE comments that a couple of things have occurred to her, that is the discretion that we are talking about is being moved. Currently the discretion is with the law enforcement, about what to do, when to report it. The House bill that came to the Senate, would change that impression to the physician as far as whether or not to report it. The frustration for me is the people directly involved didn't talk to us. Not only did advocates for the victims, we had lobbyists that represented law enforcement and physicians, and that's the role of the lobbyists is, but it was really interesting to me that I didn't get any direct conversation with the police officers or a medical professional until I called. So when I did call they said well you gotta deal with it the way it is. They surveyed their doctors and nurses to find out how they felt about it. There wasn't any really strong feeling one way or the other. They preferred the way the law is now. The hospitals and the doctors, but they could live with it fine if we passed it the other way. The reason was they probably wouldn't change the way they are doing things, because they have training and protocol in place at Merit Care, for this is suppose to be done, so that there is some

consistency. My concern is with the place, like the physicians that REP. F. KLEIN mentioned, whose practicing and doesn't even know that he is suppose to be reporting. So regardless how it comes out of this committee, I just think that we need to provide a strong charge to the law enforcement groups of every source, and to the medical community, to educate your members and make sure that they are following through on what they need to know. So whoever is to report, reports, and whoever has discretion then is making a really conscious effort to know whether or not counseling is the right thing to suggest, anger management counseling comes to mind that is one thing that was discussed. Is prosecution the right thing to do? How do we address what's really happening? One of the advocates that I was visiting with, her frustrations is that this stuff is reported but then nothing happens afterward. So it seems to me that it lies with the professionals in law enforcement and in the medical field, who are going to have to report and enforce in some fashion. Because we all want to do what is the best for the victim, either helping that person get out of that situation, or making sure if that person is staying that there is some kind of changes that have come about with that partner. So trying not to beat up on anybody, because there are a lot of nice people in these fields, but I do think that there has to be a really strong effort on the part of the professional organization to make sure that all of their members in the smallest communities, that may not see this real often, still know what their responsibilities are. You may have even seen in the newspaper this week, an article about pediatricians recognizing their roles in seeing victims of domestic abuse. Because mothers will bring their children in for medical treatment, for they will not seek treatment for themselves. So we need to also seek some effort made to educate the pediatricians to be attuned, otherwise they probably wouldn't do that. To be attuned to the situation might be for the mothers bringing in children that might be suffering from some kind of domestic abuse because that is another portal

to treatment actually. An opportunity for discovering that there is some kind of domestic abuse taking place. So I think that a lot of it is just everybody doing better in what they are suppose to be doing. The discretion is what we are talking about, where that may lie. CHAIRMAN PORTER asks if there is any other discussion. SEN. T. MATHERN replies that he has another concern that there is some evidence that some law enforcement and states attorneys do not necessarily follow through on all of these cases. In terms of making sure there is intervention or prosecution, so there is discretion already being expressed. I am not saying that the right decision or the wrong decision is being made, but there is discretion. I saw how the house passed the bill, essentially moving up that discretion, closer to the person who is abused. There is still discretion in the system, and to me it was moving closer to the victim. In terms whether or not this was the time that the incident triggered intervention or law enforcement or activity on the part of the states attorney. So that's why I supported the way you sent over the bill. It's a tough deal either way, it's not easy. I thought if I had to make a choice, I'll make it in favor getting it as close as possible to the time that it happened, and as close as possible to the victim that is involved. That's why I support the House bill. I think the Senate amendments make sure that discretion is really happened by the law enforcement community, states attorneys that I think are another step away. REP. CLEARY states that they have a copy of a letter from DR. LEINGANG, that was an emergency doctor at St. Alexius Hospital, he states that he supports the current literature. REP. CLEARY goes on to read the letter. She has a concern that it has been mandatory to report all of these things and the doctors haven't been doing it, because they are not aware of it. Thinking that they will find that to be very difficult. The medical association has said that they will see that they were properly informed, and educated in this respect. I just think the fact that we are giving them a little discretion is a very important part of both. CHAIRMAN PORTER comments that he

understands the statements made by the medical association, but if we had mandatory reporting up to this point, and physicians are not aware that it is in place, up to this point, then by relaxing the law and making it optional to record, with a statement that will look at further educating physicians. I wonder why there wasn't any educating process done to the existing law. To the extent that all physicians knew and followed the law. Rather than trying to relax the law and then educate.

REP. CLEARY states that she doesn't have an answer to that, but I am sure that there are lots of other things that fall through the cracks . SEN T. FISCHER comments that the other thing that they have to consider is how many physicians are out there that may not want to get involved for one reason or another. Giving discretion your giving them an out. The discretion that you eluded to, as far as states attorney and police, because they have to evaluate whether the case has enough merit to prosecute, I don't think that any case that they see, I mean they would like to prosecute everyone of them, but if there is not enough evidence they take it to court, its probably going to cause more of a problem. I don't think that it is the fact that the law enforcement isn't doing their job, it's just that they are doing their job to the best of their ability. However the evidence chain has been broken or there just isn't enough evidence. CHAIRMAN PORTER replies that two of the areas that come up in the discussion that I guess were changed for the better, was the fact that we changed from states attorney to law enforcement, so that the recording process starts sooner. The other part on page two is the fact that we have expanded the definition included sexual offenses and made sure law enforcement agencies is now also responsible to get information to that victim of advocacy groups available to that individual. I think that we are making the law enforcement community a friend of the victim. If there is enough information of course they fill reports, and if there is enough information and there is a case, when the states attorney review it

in two weeks, charges maybe filed, but I think the important thing to remember is what we are telling law enforcement and what we are telling the medical community is that we want that person referred to an advocacy group, right now! We don't want to wait until the office opens on Monday morning, we want it to happen on Friday night. That's the part or changes that were made, I think it strengthens this bill. We are not saying that the police department on a simple assault has to go and arrest a person. If that individual is not willing to participate in pressing charges. What we are saying is when that crime is reported, that not only should they get the information from the physician, but they should get the information from the law enforcement that says we understand what you are going through, I understand if you are not willing to make a statement right now, if you don't want to report this as a crime. We do understand that. What we are saying is, here is a card, call them or better yet let me call them for you, and get you some help. To prevent this from happening again. To help you get into a safe environment, so that you don't get hurt again. Then if the person is not willing to press charges, even though there is sufficient evidence that a crime was committeed, the law enforcement can do that without the help from the victim. But in most cases in these simpler crimes there is not enough evidence to pursue the case. What we are telling law enforcement is that we want them to be an advocate of the victim also, and get them the referral for the help. I think that, to me, is the heart and the soul of this piece of legislation. SEN. T. MATHERN comments as indicated by SEN. LEE in the beginning, I think that the Human Service committee saw some positive things in this bill. So that would be one of them. Certainly we have no problem with that, very supportive of that. It really is this other issue, you are right, there are some good things in the bill. Certainly we wouldn't want to kill the bill, since some of those positive features. SEN. T. MATHERN motions that the SENATE RECEDE FROM THE SENATE AMENDMENTS, seconded by

REP. CLEARY. The clerk calls the roll. CHAIRMAN PORTER: NO, REP. F. KLEIN: NO, REP. CLEARY: YES, SEN. LEE: NO, SEN. T. FISCHER: NO, SEN. T. MATHERN: YES. The motion fails: 2-4. SEN. LEE states that they had the question brought up at her previous conference committee, about whether or not it was important that a Senator or a Representative make a particular motion, depending on who the amendments are being addressed. I had never heard that it's fit. CHAIRMAN PORTER states that it is anybody's call to make a motion at any point in time. SEN. T. MATHERN asks if they are open to doing any more work on the bill. One of the things that they got involved in the Senate was that they were concerned that it preserved the bill, that they heard that this bill went back to the House amended considerably, there would be some problems passing it. I am just wondering are there some other things that you want to do on this bill, or do you want to act on it just the way you have on it. Do you want to take any more time on it, or do you want to move out on it today? CHAIRMAN PORTER replies that he would like to get it done today, but if there is an idea or a concept that you want to brush off in the conference committee I think that we would be more than willing to hear it. I think that I am leaning the House should accede to the Senate amendments, and then it should go back to the House in the version the Senate passed. To me right now in this piece of legislation , the important things are covered in the other sections. When you look at the concerns of the victim, it is covered in the other sections, the reporting sections. Making law enforcement now an advocate or part of the referral system. I think that SEN. LEE hit it right on the head, when we are in a situation where the education has not been done, so what makes you think that it will be done by weakening an existing mandatory reporting? When there hasn't been anything done to strengthen mandatory reporting? I guess I am inclined to think that until the education factor is done, that there is no reason to back down from mandatory reporting at this point in time.

SEN. T. MATHERN asks if CHAIRMAN PORTER feels that they can pass this in the House, with that amendment? CHAIRMAN PORTER replies, yes. SEN. T. FISCHER motions for the HOUSE TO ACCEDE TO THE SENATE AMENDMENTS, seconded by SEN. LEE.

REP. CLEARY states that she thinks that they are making the doctor not to be an advocate for the victim. I don't think that he will want to find out. SEN. LEE comments that she would really hate to think that highly principal, well intended, caring people that are medical professions, that are in North Dakota, would not report if they saw a need for that. I think that we are going to have people that will evade the law, no matter which way the law is stated. Whether the discretion is in one place or the other, someone is going to say they ran into a door. I just see this train moving, and I have no black and white about this. I think that there is so much of it that is gray. We all want what is right for the victim. I think that there are some great improvements that have come about in other parts of the law. I wish there was something that was cut and dried about this discretion verses mandates on who would report. But what I like at this point is to see what we may be able to accomplish in the next two years. With better education of medical professionals and law enforcement personnel, and if we find in the next interim that we are not accomplishing in the forward motion in this, then I think that we need to revisit again. Because I know that every one at this table is going to care about this. But it seems to me that we need to provide the best possible support that we can for medical professionals and law enforcement people, to know what their roles and their responsibilities are. Also what they can do to help the victim. Let's see what we can accomplish with that, and if that doesn't cut the mustard then we'll be talking about this in two years again. The mandate then may change. REP. CLEARY asks what if the person at the doctor is taken care of, begs him not to tell law enforcement, what if he is really in he middle then? Because by law he has to, but here is a person who is deathly afraid

she is going to be killled, she probably will be going back to the situation, and so I just think that it is a very difficult thing, not giving discretion. CHAIRMAN PORTER comments on the statement of the victim, being in a crisis situation, I think that is exactly the situation where the referral process is put into place, where restraining orders are put into place, where shelter and safe havens are put into place, and I think that if, again I go back to you have to keep in mind that this was someone who was injured to the point where they sought out medical treatment for their injuries, and I just think that they are in that grave of danger, that it shouldn't be optional. They should be placed in a safe house and they should be removed from the assailant. A crime has been committed to the point where the person needs medical attention and now there are further threats on the persons life. I mean that is a felony. The person that is making the threats should be locked up and the victim should be placed in safe harbor. SEN. LEE replies that the discretion at that point would lie with the law enforcement personnel, who has to in the most sensitive manner possible. Work with advocates for the victims to make sure that she has services available, and that they are not in some kind of brutal fashion, creating a problem for her with the way they might intervene, with the batterer. I think that there is more than one way for law enforcement to address these issues. They will have some discretion about how they handle the situation. It will require some special training on their part. I am assuming that many have that. CHAIRMAN PORTER replies that there is training, when you look at this entire situation, there is training that needs to be. The law enforcement community needs to step up to the plate. The physicians and assistants need to step up to the plate. There is a real educational part that is missing, that before I am willing to change that end of the law, I think there needs to be some people stepping up to the plate in their professions. Also doing some education. CHAIRMAN PORTER asks if there is any other discussion, hearing none the clerk takes the roll.

CHAIRMAN PORTER: YES, REP. F. KLEIN: YES, REP. CLEARY: NO, SEN. LEE: YES, SEN T. FISCHER: YES, SEN. T. MATHERN: NO. The motion carries 4-2. The CARRIER of the bill is REP. PORTER. CHAIRMAN PORTER then closes the hearing.

CONFERENCE COMMITTEE HB 1462: 4-2

CARRIER: REP. PORTER

Date: 4-4-01
Roll Call Vote # 1

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1462

House _____ Committee

☐ Subcommittee on _____
or
☒ Conference Committee

Legislative Council Amendment Number _____

Action Taken Senate Recede from Senate Amendments

Motion Made By Senator Mathern Seconded By Rep Cleary

Representatives	Yes	No	SENATORS	Yes	No
Chairman Porter		✓	Chairman Lee		✓
Rep. F. Klein		✓	Senator T. Fischer		✓
Rep. Cleary	✓		Senator T. Mathern	✓	

Total (Yes) _____ No _____

Absent _____

Floor Assignment Motion failed

If the vote is on an amendment, briefly indicate intent:

Date: 4-4-01
Roll Call Vote # 2

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1462

House _____ Committee

☐ Subcommittee on _____
or
☒ Conference Committee

Legislative Council Amendment Number _____

Action Taken House Accede to Senate Amendments

Motion Made By Senator Fischer Seconded By Senator Lee

Representatives	Yes	No	SENATORS	Yes	No
Chairman Porter	✓		Chairman Lee	✓	
Rep. F. Klein	✓		Senator T. Fischer	✓	
Rep. Cleary		✓	Senator T. Mathern		✓

Total (Yes) 4 No 2

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

2001 TESTIMONY

HB 1462

NASW
National Association of Social Workers
NORTH DAKOTA CHAPTER
P.O. Box 1775
Bismarck, ND 58502-1775
Telephone 701-223-4461
Fax Number 701-223-4824
E-Mail naswnd@aol.com
Web Site www.state.nd.us/naswnd

January 30, 2001

Chairman Price, Vice Chairman Devlin, and Members of the House Human Services Committee:

My name is Connie M. Hildebrand. I am the Legislative Chair of the North Dakota Chapter of the National Association of Social Workers. We favor passage of HB 1462 for the following reasons:

1. Current North Dakota law is not working because it does not recognize the separate role which each profession must play in the physical identification, referral, and treatment of domestic violence survivors, and the prosecution of its perpetrators.
2. Current North Dakota law is not working because reporting is required, while services go unacknowledged.

The questions posed under current North Dakota law are these:

How can a caring physician report if there are no support services present for the survivor of violence?
How can a social worker offer services if he/she is the source of the report?
How can a domestic violence advocate, advocate if the survivor is not referred? ..... and ....
How can the states attorney prosecute if there is little or no cooperation from the survivor?

We need act as a team if we are to impact the issue of family violence in our state, for domestic violence is an issue of power & control. We must not make our resolution of this problem a matter of power & control aswell.

Physicians need diagnose, treat, and report the physical result of family violence. Nurses must provide nursing care. Social workers and advocates must address the survivor's complex family dynamics and societal conditions, thereby mobilizing action for the states prosecution of the perpetrators of violence.

We need act as a team. We need act together, for our law is not working.

We ask for a Do Pass on HB 1462.

I wish to introduce Gayla Drengson, one of NASW's *front line* social workers from Altru Health System of Grand Forks, North Dakota.

Respectfully submitted,

Connie M. Hildebrand

Connie M. Hildebrand, LICSW
Chair, Legislative Committee, NASW-ND

HB 1462

NASW
National Association of Social Workers
NORTH DAKOTA CHAPTER
P.O. Box 1775
Bismarck, ND 58502-1775
Telephone 701-223-4161
Fax Number 701-224-9824
E-Mail nasw@aptnet.com
Web Site www.aptnet.com/~nasw

January 30, 2001

Chairman Price, Vice Chairman Devlin, and Members of the House Human Services Committee:

My name is Gayla Drengson and I manage the Social Work Department at Altru Health System in Grand Forks, North Dakota. I have fifteen years of social work experience, thirteen in a hospital setting. Our health system has social workers present in our emergency room from 2:30 to 11:00 pm seven days a week and a social worker on call at all other times. I am here to tell you that our law is not working .... and this is why.

A twenty-two year old woman comes into the ER. Her wrist is severely sprained. During the exam she is evasive regarding how the injury occurred. The patient is very distraught and crying. The ER staff contacts the social worker and asks her to assess this young woman. In confidence she shares with me, the social worker, that her live-in boyfriend is responsible for her injury. She is alienated from all of her family and friends (which is often typical in abusive relationships) because of this relationship. The only relationship that she has is with this boyfriend. She explains that she will go back to their apartment tonight and he will be fine for awhile. She also asks that I contact him and ask him to come to the ER and pick her up.

How can health care systems drive this woman or others like her away from seeking the care required for their injuries? This is often the only opportunity for professionals to share resource information and assist in developing safe plans for survivors who will return to these relationships...until they are strong enough to leave. It is critical to protect social work-client confidentiality so services can be accessed and patients continue to feel their health care providers are working with them and not opposing them.

It was during a routine update of our adult abuse policy two years ago that I discovered our current practice at that time was not consistent with North Dakota Century Code. Indeed, I was surprised and disappointed when I discovered that the North Dakota law was written in 1977 and has not been reviewed or updated since that time. Our law does not demonstrate awareness of current research in the area of domestic and family violence and the dynamics surrounding abusive relationships. I asked our hospital attorney to review this subject and find out if anything more current was available on the issue of domestic violence in state law. He advised that although this law has never been challenged, it still is the only one on the books that addresses domestic violence.

I started asking questions. As President of the Minn-Dak Society of Social Work Leaders in Health Care (an ancillary to the American Hospital Association) I took this issue to our next meeting. Again, I was surprised by the inconsistent manner in which this law was interpreted. Some hospitals did not report any domestic violence incidents because they assumed they were covered in another law; some only reported all serious or life threatening occurrences or injuries caused by a weapon.

e brought copies of our policies and discovered they were as different as the number of individuals at the meeting. The one thing we did agree on however was the fact that we needed to become a part of reviewing and revising this outdated law. We wanted to work as a community with other stakeholders to have our state benefit from new research results and assist our domestic violence survivors gain strength from the system and not feel additionally threatened by mandated reporting in a hospital or clinic setting.

Domestic violence policy should be guided by several considerations. First, the safety of the survivor should be of paramount importance. It is imperative to ensure that our interventions "do no harm" to survivors of domestic violence and their children.

Second, legislation should not create barriers to access medical care. Healthcare settings should be safe havens, not places where women have to consider carefully the consequences of talking about their experiences. Because of the variety of reactions that women have to domestic abuse, policies guiding the healthcare response to this problem should be flexible enough to allow physicians and other providers to provide for the needs of the individual patients.

Third, policymakers should consider the impact of legislation on the patients' autonomy and confidentiality. Infringing on confidentiality and autonomy often leads to impaired patient-provider communication and thus precludes abused women patients from receiving the referrals and support from which they would benefit. In light of the already existing barriers to the identification and treatment of abused patients, it is important to avoid placing further constraints on the patient-provider relationship.

I would recommend North Dakota legislators look at the Coordinated Community Response Audit that Grand Forks Community Violence Intervention Center has completed. Nine agencies are coordinating their efforts in responding to and intervening in domestic violence situations. This audit assisted all agencies to understand each other's perspectives and meet their individual agency responsibilities, while together working for the best outcome for the survivors of domestic violence as well as our society as a whole.

I ask for a Do Pass on HB 1462.

Respectfully submitted,

Gayla Drengson

Gayla Drengson
Manager Social Work/Case Management Department
Altru Health System
Grand Forks, North Dakota

NASW
National Association of Social Workers
NORTH DAKOTA CHAPTER
PO Box 1775
Bismarck, ND 58502-1775
Telephone 701-223-4161
Fax Number 701-224-9824
E-Mail naswnd@aptind.com
Web Site www.aptind.com/naswnd

MANDATORY REPORTING OF DOMESTIC VIOLENCE BY HEALTH CARE PROVIDERS: A POLICY PAPER

Prepared by Ariella Hyman, J.D
For the Family Violence Prevention Fund
November 3, 1997

CONCLUSION:

Mandatory reporting falls short of accomplishing the purported goals of enhancing patient safety and care, improving health care providers' response to domestic violence, holding perpetrators accountable, and increasing data collection and documentation. It also raises serious ethical concerns. The crisis of domestic violence requires a careful, well-conceived, effective response. Until further study demonstrates otherwise, there is ample reason to believe that mandatory reporting of *all injuries* due to domestic violence represents a threat to the health and safety of survivors of domestic violence. Health care providers and institutions need to strive to minimize harms to the patient under current laws. Advocates for survivors, health care providers, and others engaged in public policy should work together to consider legislative efforts to minimize risks to survivors posed by mandatory reporting laws. Education (plus teamwork) must be the focus of any attempt to combat domestic violence and must be the centerpiece of our efforts.

BISMARCK
Abused Adult Resource Center
222-8310
BOTTINEAU
Family Crisis Center
228-0928
[redacted]KE
S[redacted]rnatives for
Abused Families
1-888-662-7378
DICKINSON
Domestic Violence and
Rape Crisis Center
225-4506
ELLENDALE
Kedish House
349-4729
FARGO
Rape and Abuse Crisis Center
800-344-7273
FORT BERTHOLD RESERVATION
Coalition Against
Domestic Violence
627-4171
FORT YATES
Tender Heart Against
Domestic Violence
854-3402
GRAFTON
Tri-County Crisis
Intervention Center
352-4242
GRAND FORKS
Community Violence
[redacted]on Center
[redacted]S
JAMESTOWN
S.A.F.E. Shelter
888-353-7233
McLEAN COUNTY
McLean Family
Resource Center
800-651-8643
MERCER COUNTY
Women's Action and
Resource Center
873-2274
MINOT
Domestic Violence Crisis
Center
852-2258
RANSOM COUNTY
Abuse Resource Network
683-5061
STANLEY
Domestic Violence Program,
NW, ND
628-3233
VALLEY CITY
Abused Persons Outreach
Center
845-[redacted]
[redacted]
T[redacted]ers Crisis Center
642-2115
WILLISTON
Family Crisis Shelter
572-0757

1/30/1462

Rep. Clara Sue Price
Chair, House Human Services
HB1462
January 30, 2001

Chair Price and Members of the Committee:

My name is Bonnie Palecek and I am speaking on behalf of the ND Council on Abused Women's Services in support of HB1462.

We believe that HB1462 represents a major step forward for both victims of violence and helping professionals. It clarifies our existing law, and provides an important safety net for victims by encouraging referrals to advocacy and treatment programs.

Why are these changes needed, and why now?

Over the last decade, domestic violence advocates and other helping professionals, including mental health and medical personnel, have made great strides in creating awareness about intimate partner violence.

Screening processes have been instituted, protocols adopted, and trainings initiated.

A logical result of all of this work is that people have begun to ask questions. One of the most frequently asked questions is "what is North Dakota's law regarding the reporting of domestic violence injuries, and who has to report?"

The answer is before you. North Dakota does indeed have a mandatory reporting law for adults suffering injuries incurred "as the result of the violation of any of the criminal laws of the state of North Dakota." That is pretty comprehensive.

The reporter must report if there is "reasonable cause to suspect" this type of injury, which is also very broad.

Furthermore, the law requires all "medical or mental health professionals" to report, which is also very far reaching. Medical professionals are not defined, but could include not only physicians but dentists, nurses, EMT's, occupational therapists, and physical therapists; "mental health professionals" are not defined either, but in two other sections of the Century Code they are defined to include psychologists, social workers, addiction counselors, licensed professional counselors, psychiatrists and others.

Why would we as advocates not support such a broad-based mandatory reporting statute for adults? Why wouldn't we want the most comprehensive reporting statute possible in order to promote offender accountability and victim safety?

There are several answers to those questions. First, we believe that for any law to be implemented fairly, it must be clear. Currently, 43-17-41 is anything but clear. We are not even sure who the mandated reporter is. This raises significant training and liability issues. For example,

domestic violence advocates who may also be social workers or RN's or licensed counselors are probably also mandated to report, which raises critical ethical and advocacy issues for us. If a woman with a fading black eye comes to a shelter, should the first step be to make a law enforcement report? What if she sees a private counselor or a hospital social worker?

If every police report resulted in immediate arrest and significant jail time, one could perhaps argue that mandated reporting fosters offender accountability, but this is rarely the case. Very often, the offending partner is the one who takes the victim home from the ER, a report to law enforcement notwithstanding. At minimum, the offender arrives home within an hour or so, sometimes even before the victim gets there.

Second, we feel the current law leaves no room at all for professional discretion. If there is "a violation of any criminal law in this state," and an injury of any kind results, a report must be made.

This too is problematic. Although we absolutely believe that all domestic violence is serious, we do not believe a law enforcement response is appropriate or effective in all cases. Mandatory intervention may in fact increase the danger to the victim. Our laws governing reports of child abuse and the abuse of vulnerable adults reflect this philosophy. In these cases, a police report is coupled with a supportive network of services.

Therefore, we are asking that when a law enforcement intervention is required, as in a serious bodily injury or weapons injury, a referral must be made to some professional helping agency in order to mitigate the danger. Virtually every domestic violence and victim assistance program, as well as nearly every hospital social work department, is already geared up to respond in these cases.

Finally, we view HB1462 as a compromise bill and a first step in clarifying challenging professional responsibilities within a difficult and intimate context. We have learned a lot about domestic violence over the last 20 years. Part of what we have learned is that a criminal justice response alone is rarely enough.

And so in HB1462 we have shifted the responsibility of helping professionals from making reports to law enforcement to providing advocacy and treatment services. We have preserved the responsibility of medical professionals to report life-threatening injuries while allowing discretion in other cases, taking into consideration the patient's safety and autonomy.

This bill is clearly a first step. More clarification may be necessary in two years. But we feel it is imperative to involve the legislature in this evolving dialogue, particularly because we have a law on the books which is either not being used or impeding people from doing their jobs.

Thank you for your consideration.

ABUSED
ADULT
RESOURCE
CENTER

Representative Clara Sue Price
Chair, House Human Service Committee
January 30, 2001
RE: HB1462

Chairperson Price and Members of the Committee:

My name is Diane Zainhofsky. I am the Executive Director of the Abused Adult Resource Center in Bismarck. I am here this morning to speak in favor of House Bill 1462.

As House Bill 1462 reads, today as a licensed social worker in North Dakota and an advocate for battered women it is possible that under the current law on mandated medical reporting I am in violation of the law, each and every time I am in contact with a battered woman with injuries that I do not report to law enforcement. Fortunately because the law is so vague it has never been implemented.

Battered women want the violence to stop, but not all want the relationship to end. Ideally, they would like the relationship without the violence. A lot of women who have been assaulted do not want to think of themselves as battered, nor do they want to think of their husbands or boyfriends as batterers, but they do know that their partner has caused them to live in fear and has tried to take control of their lives.

As difficult as it is when women contact a domestic violence program they believe we will keep their name and records confidential. There are exceptions including "Duty to Warn" which requires reporting anyone who may be a danger to him/herself or others. Without a doubt we tell each victim that we are mandated reporters should this occur. But, we also tell them that all other information given is confidential.

House Bill 1462 makes this quite confusing and if we tell victims we are going to report all injuries, and she's been told, "you can not leave this relationship and you may not tell anyone about the violence because he is entitled to her obedience," her fear for her safety will surely stop her from reaching out for help and she will report nothing.

Could she be killed? In the past 20 years I have worked with seven families where a murder occurred. One-third of all female homicide victims are killed by their husband or an intimate partner. If you are a battered woman, you are in danger of being killed. Most homicides occur after women have left or when the assailants find out they are leaving.

I can't stress enough the importance of passing HB1462 and keeping victims trust in the few people she can reach out to for help. This is a very serious piece of legislation. Thank you.

PO BOX 167 · BISMARCK, ND 58502-0167
OFFICE: 701-222-8370 · FAX: 701-222-3272
24 HR. CRISIS: 1-800-472-2911

North Dakota Psychological Association

Bonnie Staiger
Executive Director

Testimony on HB 1462
House Human Services Committee
30 January 2001

Chairwoman Price and Members of the Committee

My name is Bonnie Larson Staiger, (Lobbyist #215) Executive Director of the North Dakota Psychological Association. I am here to testify in a neutral position on this bill.

I say neutral because there are some ambiguities that we feel need to be addressed and we are willing to work with the initiators of the bill to correct these.

HB1462 seems to deliberately excluded as mental health professionals, so on the surface it doesn't (any longer) affect psychologists directly. But over time, the term "medical professional" has become increasingly ambiguous. The Mental Health Assn, AMI, the American Psychological Assoc. and others are trying to remove arbitrary distinctions between "medical" and "mental" health practice---preferring all aspects to be conceptualized as health practice. Also, there's a subgroup of practitioners identifying themselves as "medical psychologists." Would they be included as targets here?

If psychologists are included as targets for this bill, my main concern is with the language of "suffering from ANY wound, injury, or other physical trauma...OR suffering serious bodily injury..."

1) By that language, even superficial self-inflicted knife cuts could be construed as mandatory reportable events, and I think the wisdom of that needs input from those psychologists who regularly treat individuals with this behavior.
2) How acute must the injury be, to trigger the mandatory reporting? The law only vaguely states that the individual must be "suffering" from the wound, injury, or trauma of 25 years ago? While common sense might say that of course this law isn't intended to obligate psychologists to notify authorities of such a thing, I can imagine a disgruntled former client (especially one with borderline personality disorder) who has continued to engage in self-injurious behavior (SIB), to bring complaint and/or suit against the former therapist for failing to notify authorities of abuse (or even past SIB) she or he told the former therapist about at some time during the treatment, and by failing to do so, didn't save the client from their subsequent (self-) injuries. This law, if it pertains to psychologists, does broaden liability risks in uncomfortable ways.
3) 3) If the injury is supposed to be limited to physical injury, how could a psychologist be qualified or expected to assess its degree of seriousness? Many

psychologists have had their share of clients who self mutilate, and some of them have at times needed an ER visit as a result of self-injury. Bringing law enforcement into the picture might make that population less willing to get medical attention. Among teens there is an epidemic of superficial self injury. If those cuts come to the attention of a health care provider the names and etc. will also be sent to law enforcement.

I believe most psychologists have been unaware of this law or have tended to ignore it. Now that it's come up for amendment and re-enactment we would like to take this opportunity to address some of these ambiguities so that we have a statute that will not need fixing in two years or as the profession evolves.

###

The North Dakota Psychological Association (NDPA), is the scientific and professional organization representing over 300 licensed psychologists, researchers, educators, clinicians, consultants and students in the state. The American Psychological Association is world's largest association of psychologists. APA includes more than 155,000 members. Through its divisions in 50 subfields of psychology and affiliations with 58 state, territorial and Canadian provincial associations, APA works to advance psychology as a science, as a profession and as a means of promoting human welfare.

Dr. Ben Roller
Dr. Dave Gayton
Dr. Kevin Mickelson
Dr. Charles Allen
Dr. Gordy Leingang

Emergency & Trauma Center

St. Alexius Medical Center

January 29, 2001

Dr. Gordon D. Leingang, DO, FACEP
President, N. D. Chapter, American College of Emergency Physicians
Member, National Coalition of Physicians Against Family Violence

Distinguished Legislative Assembly,

As an Emergency Trauma Physician and former Police Officer, I have been intimately involved in the care of domestic violence victims my entire adult life. As such, I have watched with keen interest House Bill number 1462 introduced by Representatives Johnson, Porter, and Svedjan and Senators Lee and Mathern. The proposed changes are astute and certainly needed. May I offer some thoughts from my perspective in interacting with these unfortunate victims on a daily basis.

First, let me make it clear that the advocacy programs for domestic violence victims in North Dakota are second to none. Unfortunately, all too often, these victims are not appropriately referred to these programs. Though I hate to admit it, Physicians are the worst offenders. Once abuse is recognized, a number of interventions are possible, but even if a victim is not ready to leave the abusive relationship or take other action, our recognition and validation of the victim's situation is important. Silence, disregard, or disinterest convey tacit approval or acceptance of domestic violence. In contrast, recognition, acknowledgment, and concern confirm the seriousness of the problem and the need to solve it. Your bill eloquently confirms this need.

So what's the problem? The current literature suggests that Law Enforcement Officers (as well as Physicians) are *not* diligent in referring these victims to the services that they so badly need. Therefore, paragraph 2 is certainly a step in the right direction. Although, the paragraph should include physicians.

Regarding the changes proposed in paragraph 1; several States have looked at the question of mandatory reporting of intimate partner violence, the most notable of which is California. House Bill 1462, paragraph 1 seeks to eliminate the requirement that we report essentially *all* domestic violence.

Again, what's the problem? First, mandatory reporting laws appear to deter some victims from seeking help. Second, there is good evidence to suggest that, in the face of reporting domestic violence, the most tempestuous and dangerous of the violence may escalate, putting the victim at much higher risk of injury or death. Finally, mandatory reporting violates both the confidentiality and autonomy of the victim. But, certainly, *"individuals suffering from wounds or injury inflicted by his own act or another by means of a knife, gun, or pistol suffering serious bodily injury as defined in section 12.1-01-04"* needs to be reported.

I appreciate your thoughtful consideration of my comments and welcome any questions or concerns that you may have. While I cannot be at the formal hearing of this bill, do not hesitate to contact me personally if I may be of further help.

Very respectfully yours,

Gordon Leingang, DO, FACEP

HOUSE BILL NO. 1462

A BILL for an Act to amend and reenact section 43-17-41 of the North Dakota Century Code,
relating to the duty to report injuries.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 43-17-41 of the North Dakota Century Code is amended and reenacted as follows:

43-17-41. Duty of physicians and others to report injury - Penalty.

1. Any physician, physicians assistant or any individual licensed under chapter 43-12.1 ~~other licensed medical or mental health professional~~, who ~~has under his~~ ~~charge~~ or ~~care or~~ performs any ~~professional services~~ diagnosis or treatment for any ~~person~~ individual suffering from any wound, injury, or other physical trauma:

a. Inflicted by ~~his~~ the individual's own act or by the act of another by means of a knife, gun, or pistol shall as soon as practicable report the wound, injury, or trauma to a law enforcement agency in the county in which the care was rendered, or

b. Which ~~he~~ the individual has reasonable cause to suspect was inflicted in violation of any criminal law of this state, shall as soon as practicable report the ~~same~~ wound, injury, or trauma to ~~the sheriff or state's attorney of~~ a law enforcement agency in the county in which ~~such~~ the care was rendered.

2. The report under subsection one must state the name of the injured ~~person~~ individual, ~~if known, his whereabouts,~~ and the character and extent of ~~his~~ the individual's injuries. Unless the injured person is being treated for injuries inflicted by means of a knife, gun, or pistol or for serious bodily injury as defined by chapter 12.1-01-04, a physician, physicians assistant, or any individual licensed under chapter 43-12.1 is not required to report under this subsection if the injured person is eighteen

years of age or older, is a victim of domestic violence as defined in chapter 14-07.1-01 and the physician, physicians assistant, or any individual licensed under chapter 43-12.1 determines that not reporting the injury is in the best interests of the injured person after considering the person's safety and autonomy.

2 3. When a report of domestic violence, as defined in section 14-07.1-01, or a report of physical injury resulting from a sexual offense as defined in chapter 12.1-20, is made to a law enforcement agency as required by this section, the injured individual must be provided with information regarding a domestic violence sexual assault organization as defined in section 14-07.1-01 or other victims' assistance program by the physician, physicians assistant, or any individual licensed under chapter 43-12.1 unless it is known that such information has been previously produced to the injured individual.

4. The reports mandated by this section must be made as soon as practicable and may be either oral or in writing. Oral reports must be followed by written reports within forty-eight hours if so requested by the sheriff or state's attorney to whom the oral report is originally made.

~~3.~~ 5. Any ~~person~~ individual required to report as provided by this section who willfully fails to do so is guilty of an infraction.

~~4.~~ 6. Any ~~person~~ individual making or not making a report in good faith pursuant to this section is immune from liability for making ~~said~~ the report.

Senator Judy Lee, Chair
Senate Human Services
HB1462
March 5, 2001

Senator Lee and Members of the Senate Human Services Committee:

My name is Gayla Drengson and I manage the Social Work Department at Altru Health System in Grand Forks, North Dakota. I have fifteen years of social work experience, thirteen in a hospital setting. Our health system has social workers present in our emergency room from 2:30 to 11:00 pm seven days a week and a social worker on call at all other times. I am here to tell you that our law is not working .... and this is why.

A twenty-two year old woman comes into the ER. Her wrist is severely sprained. During the exam she is evasive regarding how the injury occurred. The patient is very distraught and crying. The ER staff contacts the social worker and asks her to assess this young woman. In confidence she shares with me, the social worker, that her live-in boyfriend is responsible for her injury. She is alienated from all of her family and friends (which is often typical in abusive relationships) because of this relationship. The only relationship that she has is with this boyfriend. She explains that she will go back to their apartment tonight and he will be fine for awhile. She also asks that I contact him and ask him to come to the ER and pick her up.

How can health care systems drive this woman or others like her away from seeking the care required for their injuries? This is often the only opportunity for professionals to share resource information and assist in developing safe plans for survivors who will return to these relationships...until they are strong enough to leave. It is critical to protect social work-client confidentiality so services can be accessed and patients continue to feel their health care providers are working with them and not opposing them.

It was during a routine update of our adult abuse policy two years ago that I discovered our current practice at that time was not consistent with North Dakota Century Code. Indeed, I was surprised and disappointed when I discovered that the North Dakota law was written in 1977 and has not been reviewed or updated since that time. Our law does not demonstrate awareness of current research in the area of domestic and family violence and the dynamics surrounding abusive relationships. I asked our hospital attorney to review this subject and find out if anything more current was available on the issue of domestic violence in state law. He advised that although this law has never been challenged, it still is the only one on the books that addresses domestic violence.

I started asking questions. As President of the Minn-Dak Society of Social Work Leaders in Health Care (an ancillary to the American Hospital Association) I took this issue to our next meeting. Again, I was surprised by the inconsistent manner in which this law was interpreted. Some hospitals did not report any domestic violence incidents because they assumed they were covered in another law; some only reported all serious or life threatening occurrences or injuries caused by a weapon.

We brought copies of our policies and discovered they were as different as the number of individuals at the meeting. The one thing we did agree on however was the fact that we needed to become a part of reviewing and revising this outdated law. We wanted to work as a community with other stakeholders to have our state benefit from new research results and assist our domestic violence survivors gain strength from the system and not feel additionally threatened by mandated reporting in a hospital or clinic setting.

Domestic violence policy should be guided by several considerations. First, the safety of the survivor should be of paramount importance. It is imperative to ensure that our interventions "do no harm" to survivors of domestic violence and their children.

Second, legislation should not create barriers to access medical care. Healthcare settings should be safe havens, not places where women have to consider carefully the consequences of talking about their experiences. Because of the variety of reactions that women have to domestic abuse, policies guiding the healthcare response to this problem should be flexible enough to allow physicians and other providers to provide for the needs of the individual patients.

Third, policymakers should consider the impact of legislation on the patients' autonomy and confidentiality. Infringing on confidentiality and autonomy often leads to impaired patient-provider communication and thus precludes abused women patients from receiving the referrals and support from which they would benefit. In light of the already existing barriers to the identification and treatment of abused patients, it is important to avoid placing further constraints on the patient-provider relationship.

I would recommend North Dakota legislators look at the Coordinated Community Response Audit that Grand Forks Community Violence Intervention Center has completed. Nine agencies are coordinating their efforts in responding to and intervening in domestic violence situations. This audit assisted all agencies to understand each other's perspectives and meet their individual agency responsibilities, while together working for the best outcome for the survivors of domestic violence as well as our society as a whole.

I ask for a Do Pass on HB 1462.

Respectfully submitted,

Gayla Drengson
Manager Social Work/Case Management Department
Altru Health System
Grand Forks, North Dakota

North Dakota
Psychological
Association

Bonnie Staiger
Executive Director

05 March 2001

Senate Human Services Committee
HB 1462

Madame Chairman and Members of the Committee

My name is Bonnie Larson Staiger, (#215) Executive Director of the ND Psychological Association.

We worked successfully with the sponsors of this bill on the house side to resolve some problems with this bill. Our only remaining concern is that **self-inflicted** injuries continue to be reportable to law enforcement by those professionals. If this is intended to be a "domestic violence reporting law," and also apparently a "sexual assault reporting law," why do self-inflicted injuries continue to be a part of this? It criminalizes self-injurious behavior (SIB), and may only serve to create resistance to obtaining medical treatment for the same.

The North Dakota Psychological Association (NDPA), is the scientific and professional organization representing approximately 200 licensed psychologists, researchers, educators, clinicians, consultants and students in the state. The American Psychological Association is world's largest association of psychologists. APA includes more than 155,000 members. Through its divisions in 50 subfields of psychology and affiliations with 58 state, territorial and Canadian provincial associations, APA works to advance psychology as a science, as a profession and as a means of promoting human welfare.

1249 S. Highland Acres Rd., • Bismarck, ND 58503-0410 • 701-223-9045

BISMARCK
Abused Adult Resource Center
222-8370
BOTTINEAU
Family Crisis Center
[redacted]2028
[redacted]S LAKE
Safe Alternatives for
Abused Families
1-888-662-7378
DICKINSON
Domestic Violence and
Rape Crisis Center
225-4506
ELLENDALE
Kodiak House
349-4729
FARGO
Rape and Abuse Crisis Center
800-344-7273
FORT BERTHOLD RESERVATION
Coalition Against
Domestic Violence
627-4171
FORT YATES
Tender Heart Against
Domestic Violence
854-3861 Ext. 228
GRAFTON
Tri-County Crisis
Intervention Center
854-3861 Ext. 228
GRAND FORKS
[redacted]munity Violence
[redacted]vention Center
746-0405
JAMESTOWN
S.A.F.E. Shelter
888-353-7233
McLEAN COUNTY
McLean Family
Resource Center
800-651-8643
MERCER COUNTY
Women's Action and
Resource Center
873-2274
MINOT
Domestic Violence Crisis
Center
852-2258
RANSOM COUNTY
Abuse Resource Network
683-5061
STANLEY
Domestic Violence Program,
NW, ND
628-3233
VALLEY CITY
Abused Persons Outreach
Center
[redacted]0078
[redacted]PETON
Three Rivers Crisis Center
642-2115
WILLISTON
Family Crisis Shelter
572-0757

HB1462

Senator Judy Lee
Chair, Senate Human Services
HB1462
March 5, 2001

Chair Lee and Members of the Committee:

My name is Bonnie Palecek and I am speaking on behalf of the ND Council on Abused Women's Services in support of HB1462.

We believe that HB1462, as amended, represents a major step forward for both victims of violence and helping professionals. It clarifies our existing law, and provides an important safety net for victims by encouraging referrals to advocacy and treatment programs.

Why are these changes needed, and why now?

Over the last decade, domestic violence advocates and other helping professionals, including mental health and medical personnel, have made great strides in creating awareness about intimate partner violence.

Screening processes have been instituted, protocols adopted, and trainings initiated.

A logical result of all of this work is that people have begun to ask questions. One of the most frequently asked questions is "what is North Dakota's law regarding the reporting of domestic violence injuries, and who has to report?"

The answer is before you. North Dakota does indeed have a mandatory reporting law for adults suffering injuries incurred "as the result of the violation of any of the criminal laws of the state of North Dakota." That is pretty comprehensive.

The reporter must report if there is "reasonable cause to suspect" this type of injury, which is also very broad.

Furthermore, the law requires all "medical or mental health professionals" to report, which is also very far reaching. Medical professionals are not defined, but could include not only physicians but dentists, nurses, EMT's, occupational therapists, and physical therapists; "mental health professionals" are not defined either, but in two other sections of the Century Code they are defined to include psychologists, social workers, addiction counselors, licensed professional counselors, psychiatrists and others.

Why would we as advocates not support such a broad-based mandatory reporting statute for adults? Why wouldn't we want the most comprehensive reporting statute possible in order to promote offender accountability and victim safety?

There are several answers to those questions. First, we believe that for any law to be implemented fairly, it must be clear. Currently, 43-17-41 is anything but clear. We are not even sure who the mandated reporter is. This raises significant training and liability issues. For example, domestic violence advocates who may also be social workers or RN's or

licensed counselors are probably also mandated to report, which raises critical ethical and advocacy issues for us. If a woman with a fading black eye comes to a shelter, should the first step be to make a law enforcement report? What if she sees a private counselor or a hospital social worker?

If every police report resulted in immediate arrest and significant jail time, one could perhaps argue that mandated reporting fosters offender accountability, but this is rarely the case. Very often, the offending partner is the one who takes the victim home from the ER, a report to law enforcement notwithstanding. At minimum, the offender arrives home within an hour or so, sometimes even before the victim gets there.

Second, we feel the current law leaves no room at all for professional discretion. If there is "a violation of any criminal law in this state," and an injury of any kind results, a report must be made.

This too is problematic. Although we absolutely believe that all domestic violence is serious, we do not believe a law enforcement response is appropriate or effective in all cases. Mandatory intervention may in fact increase the danger to the victim. Our laws governing reports of child abuse and the abuse of vulnerable adults reflect this philosophy. In these cases, a police report is coupled with a supportive network of services.

Therefore, we are asking that when a law enforcement intervention is required, as in a serious bodily injury or weapons injury, a referral must be made to some professional helping agency in order to mitigate the danger. Virtually every domestic violence and victim assistance program, as well as nearly every hospital social work department, is already geared up to respond in these cases.

A House Human Services subcommittee worked very hard on the original bill, and developed several amendments which not only represent some important compromises, but also clarify and strengthen the bill. We strongly support those changes. They include:

1) a clarification of "medical professional" which identifies physicians, physicians' assistants, and those licensed sender 43-12.1 as mandated reporters. Further clarification identifies their role as providing "diagnosis or treatment."
2) a clarification of the law enforcement agency to which the report is made.
3) a clarification of the context in which discretion may be exercised (i.e. safety and autonomy concerns)
4) a clarification of the process of providing information on services to victims; a shift from "referral" language to "providing information."
5) an enhanced immunity clause for good faith reporting.

HB1462 shifts the responsibility of helping professionals from making reports to law enforcement to providing treatment and advocacy services which in some cases may or may not involve law enforcement. It preserves the responsibility of medical professionals to report life-threatening injuries while allowing discretion in other cases, taking into consideration the patient's safety and autonomy.

This bill is clearly a first step. More clarification may be necessary in two years. But we feel it is imperative to involve the legislature in this evolving dialogue, particularly because we have a law on the books which is either not being used or impeding people from doing their jobs.

Thank you for your consideration.

TALKING POINTS

MANDATORY REPORTING OF INJURIES
HB1462

- The current law on mandated reporting of injuries is simply not being implemented, and probably can't be effectively implemented as it now stands.

- North Dakota's law requiring all mental health and medical professionals to report injuries incurred as the result of the "violation of any criminal laws of the state of North Dakota" is vague and over broad.

    - There is no definition of "Mental Health Professional." Mandated reporters could include psychologists, addiction counselors, private therapists, social workers, and others. It is unclear which groups are mandated reporters, and most are totally unaware of their responsibilities under the statute.

- Mental Health professionals could face ethical conflicts between confidentiality and the client/counselor relationship and reporting mandates.

    - Domestic violence advocates who are licensed social workers or licensed professional counselors are especially concerned about this conflict.

- Mandated reporting, if fully implemented under our current statute, would have a chilling effect on victims seeking treatment.

    - "Duty to Warn" requirements already mandate mental health professionals to report anyone who may be a danger to him/herself or others.

- Medical professionals also sometimes need to exercise discretion in reporting non life-threatening injuries of adults, including considerations of victim safety and autonomy.

- Under HB1462, medical professionals will still need to report weapons wounds and serious bodily injury (substantial risk of death, serious permanent disfigurement, unconsciousness, extreme pain, permanent loss or impairment of function of any bodily member or organ, or bone fractures)

- A difference exists between reporting injuries to children and other vulnerable people, and reporting injuries incurred by an adult victim.

- Whenever a report to law enforcement is made, an accompanying referral for mental health and advocacy services should be made to help assure victim safety. This helps build a comprehensive community response to domestic violence.

- House amendments to HB1462 have strengthened the bill by:

    -further clarifying who mandated reporters are

    -encouraging medical professionals as well as law enforcement to provide information on victim services.

    -providing good faith immunity

Senator Judy Lee, Chair
Senate Human Services
HB 1462
March 5, 2001

Chairman Lee and Members of the Senate Human Services Committee:

My name is Diane Baumbach and I am a medical social worker at Altru Health System in Grand Forks, North Dakota. I work in the outpatient departments of the emergency room and clinic. I have five years of social work experience, four of them in these departments of Altru. I am one of three social workers in the Emergency Outpatient Department from 2:30 to 11:00 pm seven days a week. I have witnessed first hand the impact of the reporting law pertaining to domestic violence and the inadequate safety it provides to these victims and their family members.

A twenty-year-old female is brought to the ER by her neighbor. At first she tells the triage nurse that she slipped and put her hand through the glass door while coming down the stairs in her apartment, but the extent of the lacerations just do not coincide with the story she is telling. As I am visiting with her she beings to cry and tells me, "I need to talk to someone but I'm so scared." I then tried to reassure her she was safe here and I would do everything I could to help her. She tells me the horrific story of the abuse that occurred that day, inflicted by her husband. She then relays the extensive history of abuse she has been enduring at the hands of her husband for the past 1 ½ years. They recently moved to the area to be near his family. She had no one to turn to because she could not tell her husband's family about the abuse. She said that she has a 3-month-old daughter that was with her husband's parents for the day. Her family lives in a southern state and she has very little contact with them. She said she had to wait until her husband left for work that day, before she told her neighbor that she needed to see a doctor, which was four hours after the abuse. She had no vehicle and no friends, something that she repeats often throughout the visit with me. She explains that because she has no one else she has to return home to her husband. I talked about the alternatives to that, but I also knew that she was not ready to leave this relationship. She was very concerned about what her husband would do when he saw the stitches in her hand and arm. She was not willing to speak with anyone from our local community violence center at that time. She then was discharged with her neighbor to return home. I believe she is working on a plan to leave when it will be safer for her and her child, and I needed to respect that. She now has developed a trust relationship with helping professionals who she knows will be there for her.

Her voice was familiar to me after I started visiting with her. I recognized it as the same person who had called the ER a couple of times prior, asking for information on a safe shelter. She did acknowledge that she was that same person who had made those calls prior to seeing me that day. I stressed the importance of making a plan during the phone conversations, as I did several times with her when she was in the ER that night. I also shared information on the cycle of violence and she identified where she was at in that

cycle. I knew I could not send any material information home with her for fear that her husband would see it and the potential of danger that could create for her and her child

The importance of social work-patient confidentiality was a vital component as a context in which she could share the devastation she was living on a daily basis. Her need to trust someone enough to share that information was as important as the medical attention she received for her injuries. Opportunities like this are essential for victims of domestic violence. They need to know that we are there to help them and not double victimize them by automatically reporting them to the authorities without having a plan in place to protect them because they are not at the point, in the cycle of violence, to leave.

North Dakota Century Code 43-17-41 was written in 1977 and has never been revised. Current research in the area of domestic violence does not support the components of this law. We have learned a lot about victim safety since 1977. In addition to attending to medical needs, our number one concern should be for the victim and his/her safety. Providing a safe and secure environment to seek the medical attention that is necessary is vital in this process. It is also vital to keep them safe as much as possible when they are discharged after treatment. Providing them the needed information to understand the violence and how that cycle of violence can be broken when they are ready for that, is essential in this process.

The patient's confidentiality and autonomy play an important role as well. Their autonomy has already been imposed upon by the abuser. Powerlessness has become routine thinking to them. Relationships are controlled by the abuser as well as the isolation they feel. To be able to provide a sense of security for them to share this devastating information, is what we need to do. Sometimes, the only contact they have with others is when they seek medical attention for their injuries. There are many survivors of domestic violence but survival can only occur when there are ways to reach them. Otherwise, statistics speak for those that are not survivors.

House Bill 1462 represents a compromise between mandatory reporting of all injuries inflicted on domestic violence victims and reporting only those injuries caused by weapons or those assaults causing serious bodily injuries. It leaves some professional medical discretion. It allows medical professionals to weigh safety, confidentiality, and autonomy as factors in making the decision to report. It helps build a broader, collaborative base for intervention.

I ask for a Do Pass on House Bill 1462.

Respectfully submitted,

Diane K. Baumbach, LSW
Medical Social Worker
Altru Health System
Grand Forks, North Dakota

ABUSED ADULT RESOURCE CENTER

Senator Judy Lee
Chair, Senate Human Service Committee
March 5, 2001
RE: HB1462

My name is Diane Zainhofsky. I am the Executive Director of the Abused Adult Resource Center in Bismarck. I am here this morning to speak in favor of House Bill 1462, as amended.

Today as a licensed social worker in North Dakota and an advocate for battered women, it is possible that under the current law on mandated medical reporting I am in violation of the law, each and every time I am in contact with a battered woman with injuries that I do not report to law enforcement. Fortunately because the law is so vague it has never been implemented.

Battered women want the violence to stop, but not all want the relationship to end. Ideally, they would like the relationship without the violence. A lot of women who have been assaulted do not want to think of themselves as battered, nor do they want to think of their husbands or boyfriends as batterers. They do know that their partner has caused them to live in fear and has tried to take control of their lives.

As difficult as it is when women contact a domestic violence program they believe we will keep their name and records confidential. There are exceptions, including "Duty to Warn" which requires reporting anyone who may be a danger to him/herself or others. Without a doubt we tell each victim that we are mandated reporters should this occur. But, we also tell them that all other information given is confidential.

Current law makes these situations very confusing and difficult because if we tell victims we are going to report **all** injuries, and she's been told, "you can not leave this relationship and you may not tell anyone about the violence because I am entitled to your obedience," her fear for her safety will surely stop her from reaching out for help and she will report nothing.

Could she be killed? In the past 20 years I have worked with **seven** families where a murder occurred. One-third of all female homicide victims nationwide are killed by their husband or an intimate partner. If you are a battered woman, you are in danger of being killed. Most homicides occur after women have left or when the assailants find out they are leaving. We must be very careful about how we intervene in order to protect the safety of the victims who seek help from us. Law enforcement plays a key role, but it can't be the sole intervenor. One of the things we have learned over the last 20 years is that we need a comprehensive intervention strategy. HB1462, as amended, would provide a major step toward reinforcing such a system.

I can't stress enough the importance of passing HB1462. It will help keep victims' trust in the few people they can reach out to for help. This is a very serious piece of legislation. Thank yo

PO BOX 167 • BISMARCK, ND 58502-0167
OFFICE: 701-222-8370 • FAX: 701-222-3272
24 HR. CRISIS: 1-800-472-2911

St. Alexius Medical Center
PrimeCare

March 5, 2001

Dr. Gordon D. Leingang, DO, FACEP
President, N.D. Chapter, American College of Emergency Physicians
Member, National Coalition of Physicians Against Family Violence
Re: HB 1462

Distinguished Legislative Assembly,

As an Emergency Trauma Physician and former police officer, I have been intimately involved in the care of domestic violence victims my entire adult life. As such, I have watched with keep interest HB 1462, introduced by Representatives Johnson, Porter, and Svedjan, and Senators Lee and Mathern. The proposed changes are astute and certainly needed. May I offer some thoughts from my perspective in interacting with these unfortunate victims on a daily basis.

First, let me make it clear that the advocacy programs for domestic violence victims in North Dakota are second to none. Unfortunately, all too often these victims are not appropriately referred to these programs. Though I hate to admit it, physicians are the worst offenders. Once abuse is recognized, a number of interventions are possible, but even if a victim is not ready to leave the abusive relationship or take other action, our recognition and validation of the victim's situation is important. Silence, disregard or disinterest convey tacit approval or acceptance of domestic violence. In contrast, recognition, acknowledgment and concern confirm the seriousness of the problem and the need to solve it. Your bill eloquently confirms this need.

So what's the problem? The current literature suggests that law enforcement officers, as well as physicians, are not diligent in referring these victims to the services that they so badly need. Therefore, paragraph 3 is certainly a step in the right direction. The proposed amendment does include physicians and physician assistants.

Regarding the changes proposed in paragraph 1: several states have looked at the question of mandatory reporting of intimate partner violence, the most notable of which is California. HB 1462, paragraph 1, seeks to eliminate the requirement that we report essentially *every* incident of domestic violence.

Again, what's the problem? First, mandatory reporting laws appear to deter some victims from seeking help. Second, there is good evidence to suggest that, in the face of reporting domestic violence, the most tempestuous and dangerous of the violence may escalate, putting the victim at much higher risk of injury or death. Finally, mandatory reporting violates both the confidentiality and autonomy of the victim. But, certainly, individuals suffering from wounds or injury inflicted by his own act or another by means of a *knife, gun, or pistol, or suffering serious bodily injury*, as defined in section 12.1-01-04, needs to be reported.

I appreciate your thoughtful consideration of my comments and welcome any questions or concerns that you may have. While I cannot be at the formal hearing on this bill, do not hesitate to contact me personally (St. Alexius Emergency Room, 530-7001) if I can be of further help.

Very respectfully yours,

Gordon Leingang, DO, FACEP

NASW

March 5, 2001

Chairman Lee, Vice Chairman Kilzer, and Members of the Senate Human Services Committee

My name is Connie M. Hildebrand. I am Legislative Chair of the North Dakota Chapter of the National Association of Social Workers. We favor passage of HB 1462 for the following reasons:

1. Current North Dakota law is not working because it does not recognize the separate role which each profession must play in the physical identification, referral, and treatment of domestic violence survivors, and the prosecution of its perpetrators.
2. Current North Dakota law is not working because reporting is required, while services go unacknowledged.

The questions posed under current North Dakota law are these:

How can a caring physician report if there are no support services present for the survivor of violence?
How can a social worker offer services if he/she is the source of the report?
How can a domestic violence advocate, advocate if the survivor is not referred? and
How can the states attorney prosecute if there is little or no cooperation from the survivor?

We need act as a team if we are to impact the issue of family violence in our state, for domestic violence is an issue of power & control. We must not make our resolution of this problem a matter of power & control as well.

Physicians need diagnose, treat, and report the physical result of family violence. Nurses must provide nursing care. Social workers and advocates must address the survivor's complex family dynamics and societal conditions, thereby mobilizing action for the states prosecution of the perpetrators of violence.

We need act as a team. We need act together. We need "Do Pass" on HB 1462.

I wish to submit for the record written testimony from Gayla Drengson, NASW member and manager of the Social Work Department at Altru Health System in Grand Forks. In addition I would like to introduce you to one of her *front line* emergency room social workers, who drove here today in the very early morning hours to provide for you, her testimony.

Respectfully submitted,

Connie M. Hildebrand

Connie M. Hildebrand, LICSW
Chair, Legislative Committee, NASW-ND

MeritCare

March 22, 2001

From: Roger Gilbertson, MD,
President and CEO, MeritCare
North Dakota Registered Lobbyist Badge Number 207

Susan Bosak
Public Policy and Government Relations, MeritCare
North Dakota Registered Lobbyist Badge Number 208

To: Honorable Senator Judy Lee, Chairperson
Members of the Senate Human Services Committee
Fifty-Seventh Legislative Assembly
State of North Dakota

Re: **HB 1462 – Domestic Violence**

Dear Honorable Senator Lee and Members of the Senate Human Services Committee:

The purpose of this letter is to provide prospective from a healthcare provider standpoint regarding current implications of NDCC Section 43-17-41 and potential implications of HB 1462 . We respectfully request this document be filed with the House Human Services Committee proceedings.

MeritCare Health System is committed to the health of individuals and communities we serve by providing excellence in healthcare. As a health system, MeritCare represents 335 physicians, 49 physician assistants and 63 advanced practice registered nurses (nurse practitioners, certified registered nurse anesthetists, and clinical nurse specialists) in 68 specialty fields of medicine. Over 18,000 people are admitted annually to MeritCare Hospital.

The following statements reflect our experience and anticipated impact in the area of reporting of domestic violence:

MeritCare has experience with NDCC Section 43-17-41 with respect to mandated reporting of injuries that result from criminal activity. We did review the issue with the Emergency Room management at MeritCare Hospital. Generally, MeritCare has not had any problems with the current statute, but it does need to be amended with respect to which agency receives the report. The statute should simply require the report to be made with the appropriate law enforcement agency, rather than the County Sheriff or County Attorney. In Fargo, the report has to be made to the Fargo Police Department.

We understand that the amendments that are being proposed are aimed at giving the medical personnel more discretion with respect to injuries that result from domestic violence situations. Again, MeritCare has not had difficulty in applying the current statute. Local law enforcement agencies are very good at approaching the victim about the options available to them. The patient is also given information regarding other local agencies that could provide support and counseling that might be beneficial. In sum, we have not experienced any particular difficulties with the current statute.

We have been monitoring the amendments and believe that the amendments adopted by the Human Services Committee on February 12, 2001, address concerns MeritCare had with earlier versions of the proposed amendments to NDCC 43-17-41, particularly with respect to mandating injuries resulting from sexual assaults even if they arise out of situations that would fall within the definition of domestic violence. MeritCare can certainly work with the proposed statute, but as indicated we have not had any issues with the current statute with the exception of who gets the report.

One issue that will be created by the proposed amendment is the issue of requiring the medical personnel to interpret state statute as to when something falls within the definition of "domestic violence" and "serious bodily injury". The current statute gives wide latitude for reporting of injuries which then leaves the interpretation of the state statutes to the State's Attorney and other law enforcement agencies. In general the broad scope of the current statute has been beneficial and has not posed difficulties for MeritCare.

Please feel free to contact Susan Bosak, Public Policy and Government Relations, at (701)234-6332 or susanbosak@meritcare.com for further discussion of this or any health-related issues.

Chief Rasmussen has passed along your message reference this bill. I have a few thoughts about it.

1. Is there a Federal mandate that requires a mandatory reporting law under the Violence Against Women Act or other Federal Legislation? This may be a program funding issue for the state or local agencies.

2. Back in the dark ages when reporting domestic or sexual abuse was at the discretion of the medical staff, I think many medical personnel were concerned with:

a. They did not want to report because they would end up in court.

b. They did not want to be involved in something private, between man and wife.

c. Their job is to treat people, not play police officer.

d. Peer pressure against being involved in non-medical matter.

e. Second guessing of what would happen if they are wrong.

Surely there was an under reporting of abuse cases.

3. Allowing for discretion in reporting I feel would place unnecessary pressure on the medical staff. If the medical staff can find protection under the protection of a statutory umbrella I would think that would be to their advantage and provide them security. Why would the medical community wish to put themselves in the position of being the "bad guy" of making the decision as to what is reported and what is not.

4. What is to be gained by changing the present system? More importantly, how many domestic or sexual abuse cases will go unreported and the victim unprotected. I see this as a loss for the victims as the circle of violence is not interrupted without the control exerted by the court.

5. Advocacy groups, like Rape and Abuse, have a role in domestic violence prevention. Their role is counseling and assisting the victim in putting their life back together. Law Enforcements role is intervention and investigation to protect the victim. The States Attorney is there to represent the victim at trial. The Court is there to punish the offender and attempt to control the behavior through consequence. Each group needs to be involved and do their part in breaking the circle.

Infant child care harder to get (1) to 8 babies
parents need to be with kids

AT-HOME INFANT CHILD CARE PROGRAM
(Minnesota Rules Chapter 3400.0235)

Subpart 1. Purpose and applicability. This part governs the administration of the at-home infant child care program. Beginning July 1, 1998, a family in which a parent provides care for the family's infant child may receive a subsidy in lieu of child care assistance if the family is eligible for, or is receiving assistance under, the basic sliding fee program governed by parts 3400.0010 to 3400.0230.

Subp. 2. Administration of at-home infant child care program. The commissioner shall establish a funding pool of up to seven percent of the annual appropriation for the basic sliding fee program to provide assistance under the at-home infant child care program. Within the limits of available funding, the commissioner shall make payments to counties for expenditures under the at-home infant child care program. Participation in the statewide pool shall be determined based on the order in which requests are received from counties. Following the birth of an infant, counties shall submit family requests for participation in the at-home infant child care program on forms provided by the commissioner. The commissioner shall respond within seven days to county inquiries about the availability of funds. The commissioner shall monitor the use of the pool and if the available funding is obligated, the commissioner shall create a waiting list of at-home infant child care referrals from the counties. As funds become available to the pool, the commissioner shall notify counties in which eligible families on the waiting list reside.

At the end of the state fiscal year, any unspent funds must be used for child care assistance under the basic sliding fee program.

Subp. 3. General eligibility requirements. Items A to E govern eligibility for the program.

A. Eligible families must meet the requirements of Minnesota Statutes, section 119B.061, subdivision 2. For purposes of this subpart, "other cash assistance" under Minnesota Statutes, section 119B.061, subdivision 2, means other public cash assistance and includes the work first program under Minnesota Statutes, chapter 256K. "Other child care assistance" under Minnesota Statutes, section 119B.061, subdivision 2, means MFIP child care assistance, transition year child care assistance, subsidized adoption payments designated to cover child care costs associated with participating in job search, employment, or education, and the postsecondary child care grant program administered by the Minnesota Higher Education Services Office under Minnesota Statutes, section 136A.125.

B. A family is eligible to receive assistance under the at-home infant child care program if one parent provides full-time care for the infant. The eligible parent must meet the requirements of Minnesota Statutes, section 119B.061, subdivision 3. The requirements of caring for the infant full-time may be met by one or both parents. Eligible parents include parents, stepparents, guardians and their spouses. Nonfamily members may provide regular care for the child but are limited to a maximum of ten hours of care per week.

applicant's county of residence. There is no additional subsidy for infants with special needs. The maximum subsidy for full-time care shall be converted to a monthly amount. From that monthly amount, the county must subtract the family's monthly copayment required by part 3400.0100 to determine the final at-home infant child care monthly subsidy for the family.

C. Family income shall be determined or redetermined at the time a family applies for the at-home infant child care program. Family income shall be annualized from the beginning of the month in which the family would first participate in the at-home infant child care program. Family income includes:

(1) subsidy payments received as part of the at-home infant child care program. According to Minnesota Statutes, section 119B.061, subdivision 4, paragraph (b), counties shall use the copayment amount the family was paying or would have paid under the basic sliding fee program to estimate the subsidy payment;

(2) income from vacation leave;

(3) sick or temporary disability benefit payments; and

(4) other income the family may receive while participating in the at-home infant child care program, as determined under part 3400.0170 and Minnesota Statutes, section 119B.011, subdivision 16.

Excluded income is defined in part 3400.0170, subpart 6, and Minnesota Statutes, section 119B.011, subdivision 16. The calculation of the family copayment fee is described in part 3400.0100, subpart 4.

D. For purposes of counting the number of months that a family has participated in the at-home infant child care program, any portion of a month in which a family receives a subsidy under the at-home infant child care program is considered a full month of participation in the at-home infant child care program.

For purposes of calculating the at-home infant child care program copayment and subsidy in the first month, the county shall use the method described in part 3400.0100, subpart 4, item E. In addition, the county shall prorate the subsidy received in the first and last month of participation according to subitems (1) to (4).

(1) If the family participates in the at-home infant child care program during the month in which the infant is born, the subsidy must be prorated to cover the number of calendar days from the date of birth until the end of the month.

(2) If the family participates in the at-home infant child care program during the month of the infant's first birthday, the subsidy must be prorated to cover the number of calendar days from the beginning of the month to the date of the infant's first birthday.

Subp. 7. Data collection. The commissioner shall develop and implement an evaluation plan for the at-home infant child care program. Counties must participate in data collection for the evaluation and must adjust their data collection to reflect changes in the evaluation plan.

STAT AUTH: MS § 119B.02; 119B.061

HIST: 23 SR 1625; L 1999 c 205 art 5 s 21

AT-HOME INFANT CHILD CARE PROGRAM
(Minnesota Statutes § 119B.061)

Subdivision 1. Establishment. A family in which a parent provides care for the family's infant child may receive a subsidy in lieu of assistance if the family is eligible for, or is receiving assistance under the basic sliding fee program. An eligible family must meet the eligibility factors under section 119B.09, the income criteria under section 119B.12, and the requirements of this section. Subject to federal match and maintenance of effort requirements for the child care and development fund, the commissioner shall establish a pool of up to seven percent of the annual appropriation for the basic sliding fee program to provide assistance under the at-home infant child care program. At the end of a fiscal year, the commissioner may carry forward any unspent funds under this section to the next fiscal year within the same biennium for assistance under the basic sliding fee program.

Subd. 2. Eligible families. A family with an infant under the age of one year is eligible for assistance if:

(1) the family is not receiving MFIP, other cash assistance, or other child care assistance;

(2) the family has not previously received all of the one-year exemption from the work requirement for infant care under the MFIP program;

(3) the family has not previously received a life-long total of 12 months of assistance under this section; and

(4) the family is participating in the basic sliding fee program or provides verification of participation in an authorized activity at the time of application and meets the program requirements.

Subd. 3. Eligible parent. A family is eligible for assistance under this section if one parent cares for the family's infant child. The eligible parent must:

(1) be over the age of 18;

(2) care for the infant full-time in the infant's home; and

(3) care for any other children in the family who are eligible for child care assistance under this chapter.

For the purposes of this section, "parent" means birth parent, adoptive parent, or stepparent.

Subd. 4. Assistance. (a) A family is limited to a lifetime total of 12 months of assistance under this section. The maximum rate of assistance is equal to 75 percent of the rate established under section 119B.13 for care of infants in licensed family child care in the applicant's county of residence. Assistance must be calculated to reflect the parent fee requirement under section 119B.12 for the family's income level and family size.

(b) A participating family must report income and other family changes as specified in the county's plan under section 119B.08, subdivision 3. The family must treat any assistance received under this section as unearned income.

(c) Persons who are admitted to the at-home infant care program retain their position in any basic sliding fee program or on any waiting list attained at the time of admittance. If they are on the waiting list, they must advance as if they had not been admitted to the program. Persons leaving the at-home infant care program re-enter the basic sliding fee program at the position they would have occupied or the waiting list at the position to which they would have advanced.

John L. Hougen
01/22/2001 02:12 PM

To: Sally M. Sandvig/NDLC/NoDak@NoDak
cc:
Subject: Child Care

Rep. Sandvig

In federal fiscal year 2000, $2,075,104 in state money was spent on child care. This represents the amount we had to spend to receive our full federal allocation.

I will give you the allowable maximum payments we make for child care. It varies by the age of the child and the type of facility.

Provider Type	Infant (Birth to 2 yrs)	Toddler (2 to 3 yrs)	Other (3 to 13 yrs)
Center/Group per month	$460 per month	$440 per month	$400
Licensed Family	$440 per month	$400 per month	$380 per month
Self-Certified Family/ Registered per month	$440 per month	$370 per month	$360
Approved Relative per month	$280 per month	$260 per month	$260

Please call if you have further questions.

Attachment E

PARENT RESPONSES TO AHIC EVALUATION
Answers to open-ended questions

Why did you choose to participate in the At-Home Infant Child Care Program?

Of the nineteen parents who responded to this question about what initially motivated them to participate in AHIC, nine gave developmental and bonding reasons for participating.

- I thought it would be a great opportunity for my kids and I to spend a little more time together especially with a new baby.
- We felt that is was extremely important to have a parent stay home with our child for the first year, the developmental advantages of a child staying at home are undeniable.
- Because I wanted to stay home with my child.
- I chose it because I like to stay at home with my baby since she was so young. But now I am working. I also chose it because it was helpful to me.
- Because I had one month without pay during my maternity leave from work and I would also be able to stay home a couple weeks longer with my infant.
- I wanted to be home with my child.
- To benefit my child. I felt it was better for my child to be cared for by me rather than daycare.
- So I could stay home with my daughter.
- Because I feel the first two years of a child's life are the most important to have at least one parent always there. Day care is so expensive and I don't trust anyone who watches more than one baby. A baby is a 24 hours job alone.

Another five gave financial reasons.

- I knew that my child care bills would be more than I could afford at the time.
- Supplement my income while on maternity leave
- I was not being paid my full salary while on leave and I needed the help financially.
- Financial help.
- Supplemental family income because I quit work when I had my baby.

Two merely stated that they participated because it was available.

- Because it was offered to me.
- Day care assistance worker notified me of the program while waiting for BSF.

The final three gave reasons that were either a combination of the above reasons, or ambiguous.

- AHIC sounded like a program that would help absorb some of the financial burden of being a stay at home mom. Cost of daycare is very expensive. Emotionally financially. So it is wonderful to be able to stay home during the first months.
- Maternity leave.
- To make it easier on my children and myself.

What were the benefits for you, your family and your infant in participating in the At-Home Infant Child Care Program?

Again, when listing the actual benefits, seven families stated bonding and developmental issues.

- Spending time with child/child spending time with me.
- My kids and I were able to spend more time together and more mother and newborn bonding.
- Having as much time as possible with my baby before returning to work.
- The benefits were that I got to stay home with my son and he didn't have to be in daycare. He would be at home with me.
- Able to take complete care of my child. Able to watch his first year of development. Child was healthier. Able to care for myself better. Less stress. It was wonderfull I loved and will cherish those memories forever, wish it lasted longer.
- No daycare.
- To see her grow.
- I got to stay home with my daughter. My husband know his daughter was in good hands and didn't have to worry about strangers watching her. My family says our daughter is so relaxed. I believe because she know mommy is there for her every need.

Six listed financial benefits.

- Income for my family while on maternity leave.
- Provided financial support for child's needs.
- Getting extra money.
- It was income to help pay for baby supplies while I was home with son without child support or work benefits.
- Helped out financially with rent while on maternity leave.
- I was able to stay home longer with my children and I was not under as much stress to get my bills paid for the month.

Four listed a combination of benefits, both bonding and financial.

- Financial made it possible to have a parent stay home with our child. It gave the "stay-at-home dad" a feeling of still financially providing for our household. It has been obvious that our baby was impacted, he is secure and developmentally excels. We have three other children that did not have to attend child care centers during the time on the program.
- It has made it possible to spend more time at home with my son [rather] than more time at work. It has also helped me to continue to go to college full-time.
- The benefits were that I got to stay home with my child and take care of her and it helped us buy stuff for our baby.
- So I didn't have to work -cash - spending more time together as a family.

One parent did not answer this question.

Was it difficult to participate in AHIC? If so why?

Two parents listed reasons why it was difficult (or somewhat difficult) to participate:

- Besides my not liking to get help from the county or other people nothing was difficult to participate.
- It was difficult because my income was substantially lower.

The other fifteen parents did not indicate that it had been difficult.

How could this program be improved?

Ten parents responded to the question about how this program could be improved.

Five made do not think it needs improvement:

- I don't think this program needs any improvement.
- AHIC is a good experience for me. I have no suggestions for improvement.
- It worked fine for me.
- I thought it was great program. It helped us so I could spend more time with my children and not a friend or family member to stay with them.
- I liked the program.

One indicated that more information needs to be distributed:

- More understanding of what AHIC is.

One stated that the age limit of twelve months should be extended.

- Extend it to 18 months.
- Go for at least two years and also have it for every child (newborn) in a family, instead of only one child.

Three stated that the subsidy level should be raised:

- Although the financial assistance made it possible to stay home with our children, we definitely struggled financially during this time period. An increase in subsidy may have made it possible to stay home the full first year. When our child was 10 months old, we financially had to have both parents work.
- I feel that parents should stay home with their children for the first year. I think this program would be improved by raising income per month so more parents can stay home with their children.
- Maybe you could pay more than $1.80 per hour. It just doesn't seem like a whole lot.

"Gary or Earleen Friez" <bigwhite@pop.ctctel.com>

02/19/2001 09:43 AM

To: "Tim Mathern" <tmathern@state.nd.us>
cc: "Sally Sandvig" <ssandvig@state.nd.us>, "Bette Grande" <bgrande@state.nd.us>, "Scot Kelsh" <skelsh@state.nd.us>, "Aaron Krauter" <akrauter@state.nd.us>, "David O'Connell" <doconnell@state.nd.us>
Subject: Testimony in favor of SCR3045

Sen. Mathern,

I am a Licensed Family Child Care Provider from Hettinger. I have been doing child care in my home for 26 years, and children in my care generally always includes three children under the age of 2.

I support SCR 3045 concerning study of feasibility and desirability of establishing an at-home infant child care program.

Since most low-income families access minimum wage jobs which generally include shift work, and weekends, it is hard for them to find a provider who is open all the hours that care is required. Therefore children are bounced from one care arrangement to another, which is difficult for all concerned. Children do best when there is consistency in caregivers which doesn't happen with shift work, since very few care givers offer 24 hour 7 day a week care. Consistency in care is important for all children, but is especially crucial for infants when basic bonding needs to occur. Without proper bonding, children have difficulty with their emotional development.

As the bill indicates, there is a shortage of infant care throughout North Dakota.

Earleen Friez, (701)567-2822

BUDGET ACTIVITY SUMMARY

Budget Activity: MFIP CHILD CARE, BASIC SLIDING FEE CHILD CARE, CHILD CARE INTEGRITY
Program: EARLY CHILDHOOD PROGRAMS
Agency: CHILDREN, FAMILIES & LEARNING

State Citation: M.S. 119B

Federal Citation: P.L. 104-193, Title VI P.L. 101-508

ACTIVITY PROFILE:

Studies indicate that success in school is directly related to a child's early childhood experience. Children with multiple risk factors (low income, poor access to health care and nutrition, unstable housing, etc.) are less likely to experience success in school unless they have access to comprehensive high quality child care that meets the child's developmental needs while their parents are working.

- Child care subsidies are available to low-income families who participate in welfare reform activities, Minnesota Family Investment Program (MFIP) child care, and families who are not connected to cash assistance programs (Basic Sliding Fee (BSF) child care).
- Child care assistance is designed to allow low-income parents to choose from the same child care providers that are available to private pay parents.
- County human service agencies administer the programs.

Minnesota Family Investment Plan (MFIP)

- The following families are eligible to receive MFIP or Transition Year (TY) child care assistance: 1) MFIP families who are employed or pursuing employment, or participating in employment, training, or social services activities authorized in an approved employment services plan; and 2) employed families who are in their first year off MFIP (transition year).

Basic Sliding Fee (BSF)

- BSF child care helps pay the child care costs of low-income families not participating in MFIP, and helps keep families off welfare. Families with incomes below 75% of the state median income who participate in authorized activities, such as employment, job search, and job training are eligible for BSF child care.

At Home Infant Child Care (AHICC)

- In 1997, the Minnesota legislature created the At-Home Infant Child Care program (AHICC). The program took effect 07-01-98. AHICC allows BSF eligible families with infant children to receive a portion of their regular BSF subsidy, for a period of up to 12 months, while staying at home with their infant (and any other children).

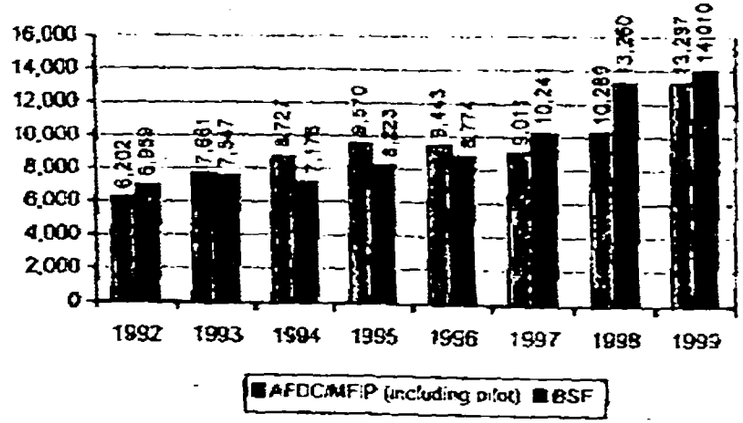
Child Care Integrity (Fraud Prevention)

- In 1999, the Minnesota legislature expanded the Fraud Prevention Investigation (FPI) program to include the child care assistance program to assure accountability in use of limited resources.

STRATEGIES AND PERFORMANCE:

- The Child Care Assistance Program (CCAP) helps families pay child care costs on a sliding fee basis. As family income increases so does the amount paid by the family, allowing families to see an increase in take-home pay and an incentive to increase their wages. This incentive translates into decreasing public costs as family income increases.
- Of those families receiving BSF in FY 1999, 67% had done so for 24 months or less, 81% for 36 months or less.
- For MFIP and BSF, the average number of children per family was 1.68 and 1.76, respectively in FY 1999.

Number of Families Served



KEY: ~~stricken~~ = old language to be removed
underscored = new language to be added

NOTE: If you cannot see any difference in the key above, you need to change the display of stricken and/or underscored language.

Authors and Status ■ List versions

H.F No. 504, as introduced: 82nd Legislative Session (2001-2002) Posted on Feb 1, 2001

A bill for an act

relating to family and early childhood education; modifying the at-home infant child care program; amending Minnesota Statutes 2000, section 119B.061, subdivisions 2 and 4.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2000, section 119B.061, subdivision 2, is amended to read:

Subd. 2. [ELIGIBLE FAMILIES.] (a) A family with an infant under the age of one year is eligible for assistance if:

(1) the family is not receiving MFIP, other cash assistance, or other child care assistance;

(2) the family has not previously received all of the one-year exemption from the work requirement for infant care under the MFIP program;

(3) the family has not previously received a life-long total of ~~12~~ 36 months of assistance under this section; and

(4) the family is participating in the basic sliding fee program or provides verification of participation in an authorized activity at the time of application and meets the program requirements.

(b) A family is limited to 12 months of assistance per child.

Sec. 2. Minnesota Statutes 2000, section 119B.061, subdivision 4, is amended to read:

Subd. 4. [ASSISTANCE.] (a) A family is limited to a lifetime total of ~~12~~ 36 months of assistance under ~~this section~~ subdivision 2. The maximum rate of assistance is equal to ~~75~~ 90 percent of the rate established under section 119B.13 for care of infants in licensed family child care in the applicant's county of residence. Assistance must be calculated to reflect the parent fee requirement under section 119B.12 for the family's actual income level and family size while the family is participating in the at-home infant child care program under this section.

(b) A participating family must report income and other family changes as specified in the county's plan under section 119B.08, subdivision 3. The family must treat any assistance received under this section as unearned income.

(c) Persons who are admitted to the at-home infant care program retain their position in any basic sliding fee program

or on any waiting list attained at the time of admittance. If they are on the waiting list, they must advance as if they had not been admitted to the program. Persons leaving the at-home infant care program re-enter the basic sliding fee program at the position they would have occupied or the waiting list at the position to which they would have advanced. Persons who would have attained eligibility for the basic sliding fee program must be given assistance or advance to the top of the waiting list when they leave the at-home infant care program. Persons admitted to the at-home infant care program who are not on a basic sliding fee waiting list may apply to the basic sliding fee program, and if eligible, be placed on the waiting list.

(d) The time that a family receives assistance under this section must be deducted from the one-year exemption from work requirements under the MFIP program.

(e) Assistance under this section does not establish an employer-employee relationship between any member of the assisted family and the county or state.

Sec. 3. [EFFECTIVE DATE.]

Sections 1 and 2 are effective July 1, 2001.