

Task Force on the Prevention of Sexual Abuse of Children

2014 Report



State of Nevada
Department of Health and Human Services
Division of Child and Family Services

Executive Summary

During the 77th session of the Nevada Legislature, Erin Merryn provided testimony to members of the Nevada Legislature and the attending public, in the hopes that Nevada would join other states in the development of a task force on the prevention of the sexual abuse of children. Providing estimations around the number of children who are sexually abused is difficult. Definitions of sexual child abuse differ, many cases go unreported, and the time frames by which cases are measured are sometimes different. With this in mind, Finklehor, Hammer, and Sedlak (2004) suggest that 4% of adult males and 17% of adult females report contact sexual abuse as a child. Erin herself was one of these alarming statistics. With over 43 million survivors of child sexual abuse in America, this is not a problem that is going to go away without the intervention of citizens and lawmakers alike.

Child sexual abuse crosses all socioeconomic lines; no child is immune. Equally disturbing statistics lie in the fact that children are most often abused by those they know, trust and often love. This provides a measure of clarification for the fact that the vast majority of children never disclose their victimization. Of those victims that do disclose, only a fraction files an official report. Research estimates that official reports (or police reports) are filed in only 30% of the cases of abuse and exploitation (Darkness to Light, 2012).

According to a study by the National Institute of Justice (1996), the *reported* cases of child sexual abuse costs our country \$35 billion a year. That number has increased significantly over the years. The immediate economic impacts are obvious: medical care, emergency services; victim services; and the cost to the judicial system. Often, the impacts of the long term costs are forgotten. For victims, the future lack of productivity, long term poor physical health, school failure, high risk behaviors such as substance abuse, behavioral problems as well as long term mental health costs all represent an additional and significant cost.

Several months after Ms. Merryn's testimony, Governor Brian Sandoval added Nevada to the group of states who are fighting to end this horrendous crime and ensure a brighter and safer future for our children. The Nevada Task Force on the Prevention of the Sexual Abuse of Children was established through the passage of Senate Bill 258, now codified into NRS 432B.700-730. The Task Force was charged with studying and identifying strategies, goals and recommendations for preventing child sexual abuse. Task Force members carefully examined a balance of research and real life experience, and have made recommendations to educate children, school staff, families and communities on child sexual abuse.

The Task Force recommendations are based on what was learned through research and testimony, and have been grouped into two main categories: Primary and Secondary/Tertiary Prevention. The recommendations born out of these two emergent categories serve to move Nevada closer to achieving the following goals: 1) Improved education of lawmakers and the public; 2) Prevention of occurrence and reoccurrence of abuse; and, 3) Provision of crucial support to victims and their families.

Members of the Task Force share the common vision of a world where children have the opportunity to grow up safe, healthy, and whole. Child sexual abuse threatens this vision and the Task Force worked diligently to provide recommendations that would, if implemented go far to eliminate this terrible crime.

The Task Force recognizes that many of the recommendations made may present fiscal, programmatic and logistical challenges in implementation. While recognizing these challenges, we must remember that if child sexual abuse were a disease, it would be one of the largest epidemics in our country, and resources would be allocated to eradicate it. It is unacceptable for the State of Nevada to fail to move forward as a leader in our commitment to protect Nevada’s children by doing as much as we can to eliminate child sexual abuse. It is with the hope for a positive, productive and secure future for all of Nevada’s children, that this report is respectfully submitted.

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**The Nevada Task Force on the Prevention of Sexual Abuse of Children gratefully acknowledges the work and research done by the States of Missouri, New York and Illinois in their respective task force reports. Some of the analysis and discussion are quoted in whole or in part within this report.*

Nevada Task Force on the Prevention of Sexual Abuse of Children

Final Report to Governor Sandoval

NRS 432B.730

Background

During the 77th (2013) Legislative Session, Governor Brian Sandoval signed Senate Bill 258 (NRS 432B.700-730) which created the Task Force on the Prevention of Sexual Abuse of Children. The Task Force, created within the Division of Child and Family Services consisted of members representing the Nevada Legislature; Attorney General's Office; Department of Education; Division of Child and Family Services; representatives from agencies and organizations involved in the prevention, investigation, prosecution and/or treatment of cases of child abuse in Nevada; and, appointed members of the Nevada public with an interest in the prevention of child sexual abuse.

The Task Force was charged with studying and identifying strategies, goals and recommendations for preventing child sexual abuse based on the following activities:

- Gathering information concerning the sexual abuse of children in this State;
- Receiving reports and testimony from persons, State and local governmental entities, community-based organizations and other public and private organizations;
- Consulting with employees of the Division of Child and Family Services, the Department of Public Safety, the Department of Education and any other State agency or department as necessary to accomplish the duties of the Task Force; and
- Recommending goals and policies to prevent the sexual abuse of children in this State.

The Statute also provided the following opportunities with regards to the recommendations, allowing for:

- Age-appropriate curriculum for pupils in prekindergarten through grade five;
- Training for school personnel;
- Providing educational information in school handbooks, pamphlets and other materials, for parents and guardians, including, without limitation:
 - The warning signs of sexual abuse of children; and
 - Assistance, referral or information concerning resources.
- The provision of:
 - Counseling and other resources available to any child in this State affected by sexual abuse; and,
 - Emotional and educational support for any child in this State who has experienced sexual abuse, to allow the child to succeed in school.
- Policy recommendations which may address, without limitation:

- Methods to increase awareness in teachers, students and parents of issues regarding the sexual abuse of children, including, without limitation, warning signs that a child might be a victim of sexual abuse;
- Actions that a child who is the victim of sexual abuse can take to obtain assistance and intervention; and
- Counseling options available for students affected by sexual abuse.

The Task Force was granted a two month extension for the submission of the report, and met ten times, listening to the testimony of experts and collaborating on the recommendations presented in this report. The meetings were conducted pursuant to the Open Meeting Law (NRS 241).

Nature and Dynamics of Child Sexual Abuse

Child sexual abuse is often referred to as a silent epidemic either due to ignorance or denial of the problem. Child sexual abuse is any interaction between a child and an adult (or an older juvenile) in which the child is used for the sexual gratification of the adult. It can include contact (touching of the vagina, penis, breast or buttocks, oral-genital contact or sexual intercourse) and non-contact behaviors (voyeurism, exhibitionism, or exposing the child to pornography). Force, as it is typically understood, is often not involved, but perpetrators use deception, threats and other forms of coercion (NCTSN, 2009).

According to the Centers for Disease Control and Prevention (2006), one in four girls and one in six boys will be the victim of child sexual abuse by the time they turn 18 years old. This means there are more than 42 million adult survivors of child sexual abuse in the United States and three million of these survivors are still children. It is estimated that only one out of every ten victims ever disclose their abuse and that 93% of these victims are abused by someone they know; someone in a position of trust or authority (CACI, 2011).

It is difficult to recognize a child sex offender. They cannot be picked out of a crowd. Offenders come from every socio-economic class, race, gender, profession, and religion. They have the title of dad, step-dad, grandpa, uncle, coach, lawyer, babysitter, police officer, fire fighter, judge, Boy Scout leader, pastor, teacher, mom, and step-mom. Shockingly, 93% of the time children are abused by a person who is supposed to protect them; a person in a position of trust or authority. These offenders are generally viewed by their peers as law abiding citizens, are well educated, and have a strong religious background (CACI, 2011).

In almost every case, the only witnesses to this crime are the perpetrator and the victim. Perpetrators often tell the child this is a secret and no one will believe them. Children rarely report abuse immediately. Often, they feel a sense of guilt or shame surrounding the abuse and in these cases, delayed disclosure is the norm. Most victims remain silent until several years after the abuse, if they ever tell at all (APA, 2005).

The High Cost of Child Sexual Abuse

Darkness to Light (2012) reported child sexual abuse costs our country \$35 billion a year which is a number that has only increased since the date of the report. While the financial burden of this problem is important, it does not speak to the additional loss to those who experience sexual abuse and the personal cost of the multitude of adverse outcomes that many victims suffer. Adverse childhood events, such as child sexual abuse are closely associated with the 10 most common causes of adult death (Felitti, et al., 1998). Threats to a survivor's health and well-being include: High risk of school failure, self mutilation, persistent post traumatic stress disorder, drug and alcohol abuse, a significantly increased risk for abuse in subsequent relationships, difficulty in forming meaningful and trusting relationships, cognitive deficits, depression, dissociative symptoms, and suicide (CAIC, 2011). Adverse consequences of child sexual abuse for children and society can last a lifetime, depriving a child of their full potential.

Child Sexual Abuse Statistics and Research

Accurate statistics on the prevalence of child and adolescent sexual abuse are difficult to collect due to underreporting and the lack of a cohesive and consistent definition of what constitutes such abuse. Despite these challenges, research has provided a great deal of information that can be used to prevent and intervene in child sexual abuse. Below are just *some* of the facts that have emerged as a result of research conducted by nationally recognized organizations such as the American Psychological Association, National Center for Victims of Crime, Center for Disease Control and Prevention and the National Sexual Violence Resource Center.

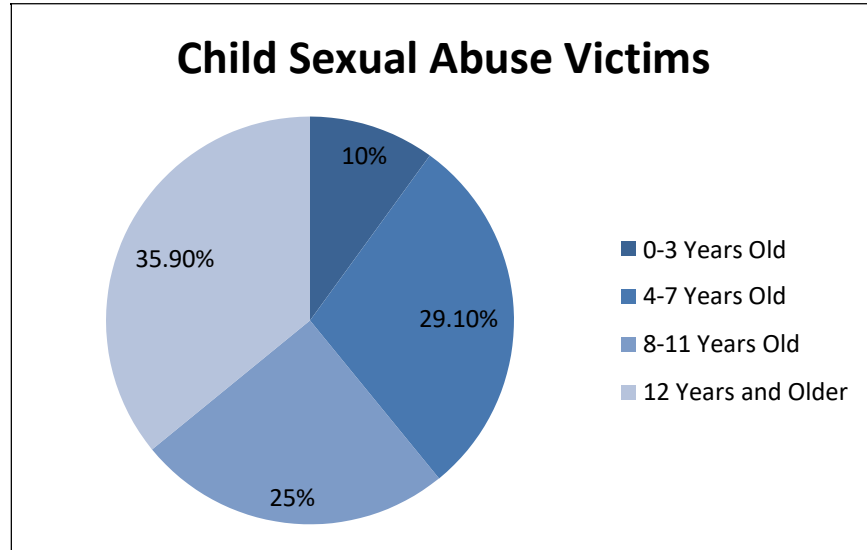
- Research has defined the characteristics of those who abuse children.
- Research shows that children are most often abused by those they know, trust and often love.
- Research has identified the personality, socio-economic, racial and environmental characteristics of children at greatest risk for abuse.
- Research shows that those who abuse children groom their victims and manipulate them into silence.
- Research reveals the nature of potentially abusive adult/child relationships within youth-serving organizations.
- Research identifies what signs to look for in a child we suspect may be the victim of sexual abuse or exploitation.
- Research provides methods to assist adults in overcoming the barriers to taking action to protect and prevent child sexual abuse.

Additional research supports the following statistics:

- Governmental research has estimated that approximately 300,000 children are abused every year in the United States.
- Children with disabilities are at a 5 fold increased risk of abuse, particularly if their disability impairs their perceived credibility, e.g., blindness, deafness, speech delay or disorder and developmentally delayed (Sullivan & Knutson, 2000; and Stirling & Flaherty, 2010).
- Those with a prior history of sexual victimization are extremely likely to be revictimized.

- School-aged children tend to be at greater risk for sexual abuse as illustrated in Figure 1 below.

Figure 1



- Boys (and later, men) tend not to report their victimization, which may affect statistics. Some men even feel societal pressure to be proud of early sexual activity regardless of whether it was unwanted.
- Boys are more likely than girls to be abused outside of the household.

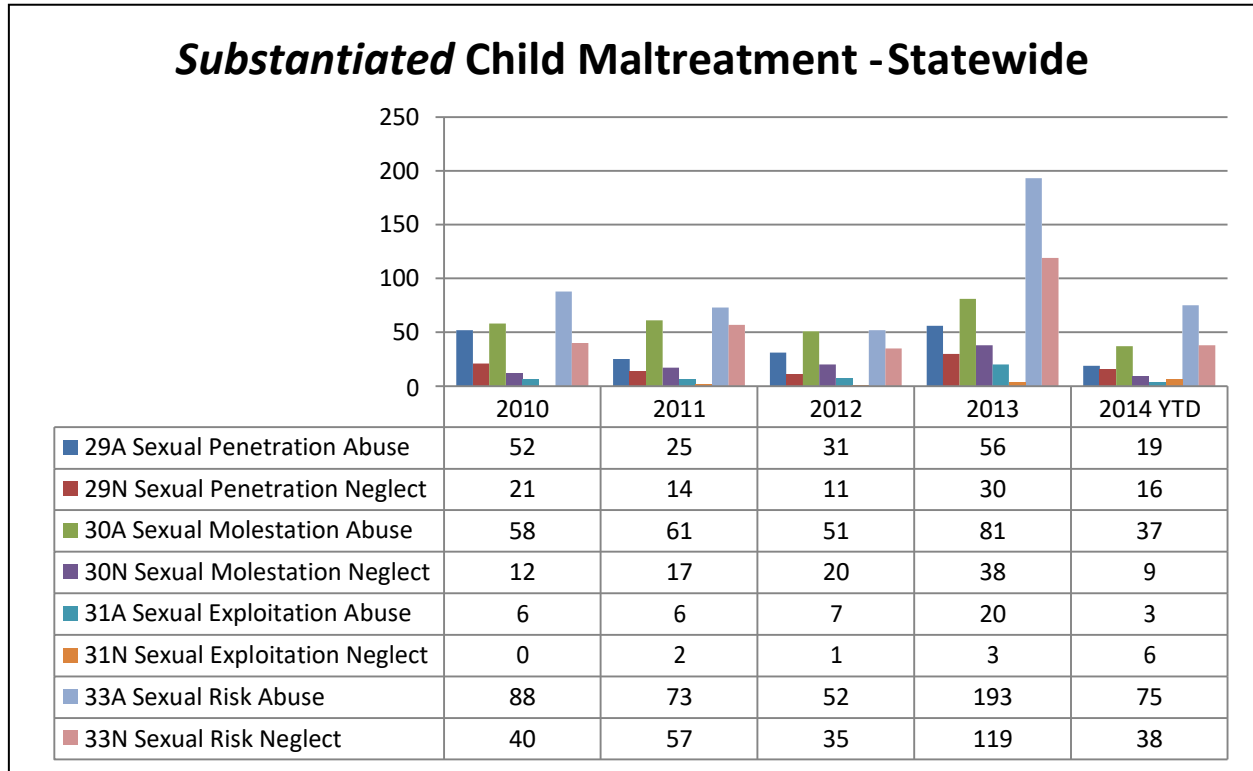
I was babysitting (I was probably around 12 or 13) and the dad made a pass at me when he was giving me a ride home. I refused and he didn't press me. I didn't say anything to anyone, but never babysat for that family again. I have often wondered if he did things to anyone else, including his children. When you keep abuse silent, it may endanger others.

*Nevada Victim and Survivor
of Child Sexual Abuse*

Child Sexual Abuse in Nevada: *Reported and Substantiated Cases*

Figure 2 below illustrates the statewide reported and substantiated cases of child sexual abuse over the last four state fiscal years. These numbers are a perfect example of the challenge in obtaining accurate numbers. While these numbers reflect an important population that deserves our attention and services, it does not represent the true picture of child victims in Nevada. Causes for underreporting are addressed throughout this report.

Figure 2



Conclusion

Child sexual abuse exploits and degrades children and can cause lifelong damage to cognitive, social, and emotional development of a child. As a society, we have a collective responsibility to prevent child sexual abuse. To accomplish this, we must initiate and support services and policies that enhance children’s development as well as health and safety. We must advocate for policies and programs to help meet the basic needs of children and families. We must promote research, training, and public education to strengthen protective factors that not only buffer the negative effects of sexual abuse but also directly reduce the prevalence of those risk factors. If we engage adults in removing or reducing opportunity for victimization, preparing children appropriately, and employing protective strategies for high-risk children who may not have strong home support, it is logical to assume that there will be fewer incidents of child sexual abuse. If we use this knowledge to identify children who demonstrate signs of sexual abuse, it is reasonable to believe that there will be improved interventions for victimized children, as well as reduction in re-victimization.

Task Force Recommendations

PRIMARY RECOMMENDATION

Create a continuing Statewide, multi-discipline task force to begin the implementation of the proposed recommendations, including the research around costs to implement, funding resources, designating lead agencies and setting priorities. Ensure that part of this task force's continued mission is to work with local communities either with existing coalitions (e.g. Prevent Child Abuse Nevada, Domestic Violence and Sexual Assault Coalition, Child Welfare Network, Rape Crisis Center), or to establish local coalitions focused on eliminating child sexual abuse. This task force should work to further inform the other recommendations listed in this report in order to identify and reduce the factors that fuel the demand for children to be sexually exploited and abused. Stakeholders from all interested/relevant agencies, task forces, committees, and groups would organize efforts in order to increase impact.

***Discussion:** The research and discussion contained in this report not only highlights the frightening prevalence of child sexual abuse in our society but also brings to focus the underlying message that many children are unaware of the threat that sexual abuse poses, and are uneducated on how to stop the abuse from occurring. It is our duty to take proactive steps towards changing our State's response to this horrific trend. It is estimated that 325,000 children per year are currently at risk of becoming victims of commercial child sexual exploitation (Estes & Weiner, 2002). More can be accomplished by combining knowledge, skills and resources. Coalitions can achieve more widespread reach within a community than any single organization and provides a forum for information sharing.*

Nevada must have the courage to openly discuss and address child sexual abuse. Within our reach is the opportunity to become a State that is known for protecting and prioritizing its children. Children who grow up with bodily and psychological integrity become productive adults with the full capacity to serve their families, communities and State. A report is just a report and the proposed recommendations are the starting point towards Nevada's efforts towards eradicating child sexual abuse. Efforts must continue towards the implementation of these recommendations, including exploring fund sources, as well as identifying agencies and organizations to take the lead in certain areas.

PRIMARY PREVENTION

“Primary prevention involves strategies that stop violence before it initially occurs. These strategies reduce the factors that put people at risk for experiencing violence. They also increase the factors that protect people or buffer them from risk.” (CDC, 2014)

Child sexual abuse prevention is the responsibility of every adult. However, prevention methods must be comprehensive in nature and target children, parents and staff in youth-serving organizations, schools and the community at large. Research shows that investing in child abuse prevention programs not only results in making children less vulnerable targets for abuse, but yields a 19 to 1 savings over the long-term costs to society from child abuse (SFCAPC, 2014). Ultimately, by utilizing primary prevention methods in the education of children about self protection and speaking out, they will be able to protect themselves. As adults, they will be able to protect their own children and end the intergenerational code of silence that pervades our society regarding childhood sexual abuse. These programs have the potential to substantially reduce child sexual abuse in Nevada.

“Abuse can start out in such subtle ways that it doesn't even seem wrong. I really didn't feel like a victim with my grandpa for so many years. He started abusing me so young. He let me cuss, let me drink, let me do whatever I wanted when I spent the summers there. As the abuse progressed, I would tell myself he didn't mean to touch me there when he hugged me, or tickled me, etc. When I turned 18, he forced me into something that I could no longer say he didn't mean to do. Being 18, I felt more responsible, more guilty. As I looked back over the years, I realized how much he had abused me my whole life - and it felt like a set-up.”

Nevada Victim and Survivor of Sexual Abuse

Pre-K - 12th Grade Education

RECOMMENDATION #1

The task force should work in collaboration with the Department of Education as well as other early childhood education providers to recommend, require (when appropriate) and establish statewide standards for childhood sexual abuse prevention curriculum from pre-kindergarten through 12th grade. Curriculum should include age appropriate training for students at every grade level about sexual abuse prevention, covering topics such as: safe and unsafe touching; media literacy; bystander support; personal boundaries; risk factors to avoid; dating violence; internet; social media and smart phone safety; grooming tactics used by pedophiles and online predators; where to go for help for self or others; and, opportunities for students to participate in extracurricular activities, volunteer and mentoring programs designed to provide and promote self-esteem and assertiveness. Selected curriculum should have research to support its effectiveness (evidence based, research based, promising practice). A parent prevention portion should also be included in the adopted curriculum.

***Discussion:** Very few cases of child sexual abuse involve force. These are most often cases of manipulation, where the abuse begins with grooming, followed by inappropriate sexual contact and more significant contact over time. By proactively building competencies in children regarding sexual abuse prevention, several important goals may be achieved: (1) Children are less likely to be sexually abused; (2) Children are more likely to come forward immediately if they are sexually abused; and (3) Children are more likely to be referred to appropriate services and less likely to suffer long term negative effects, thereby consuming societal resources (CACI, 2011). Discussion and research has revealed that child sexual abuse prevention training in Nevada's schools is lacking, particularly in the middle school grades (See **Appendix A**). It is critical that age appropriate curriculum be provided at each grade level.*

Almost half our middle and high school students are involved in some type of sexual relationship with peers. These relationships are significant in a student's life, based on their developmental stages, and they may not be prepared for the overwhelming emotions and results that come from these relationships.

Parents can be ideal messengers for prevention efforts. They can have a direct effect on their children, other parents and many professionals with whom they deal with on a daily basis. For some adults, being a protective parent comes naturally because it was modeled by caregivers in their formative years. Other parents need more assistance in learning how to become protective parents. One of the most important strategies for parents is to observe and monitor the relationships their children have with adolescents and adults and understand steps to take for support and assistance. Invitation to attend a prevention program should come from schools, doctors or other professionals and not from public advertising.

RECOMMENDATION #2

Pre-K-12 prevention curriculum standards should be accessible and available to all school formats in Nevada including private and home school programs and there should be recommended adaptations and implementation for private, charter, online schools, and home schooling organizations.

***Discussion:** Not all children attend public schools; according to the 2013 Nevada Education DataBook, 5.5% of Nevada’s children are enrolled in private schools. It is also important to remember that not all children are enrolled in a traditional school day format. It is critical that a wide net be cast in order to ensure all children receive information and, in turn, the prevention efforts become a collaborative effort. This can be accomplished by bringing together a diverse group of stakeholders from the community, school, youth services providers, coalitions, etc. to collaboratively set a community prevention vision, conduct needs assessments and identify trainings.*

RECOMMENDATION #3

Offer access to enhanced professional development in this field to both the public and private school sectors as well as protocols for dealing with disclosures or suspected abuse. Protocols should include steps and processes for sharing alleged abuse information should a student transfer to a new school.

***Discussion:** Professionals new to their field often have little practical experience with addressing barriers to the recognition and subsequent reporting of child sexual abuse. Ongoing training will provide tools necessary to overcome these obstacles.*

RECOMMENDATION #4

Policies should be developed within educational institutions designed to prevent child sexual abuse by educational professionals.

***Discussion:** Shakeshaft (2003) found that 9.6 percent of students in a national survey reported experiencing educator sexual abuse (of contact and non-contact types) at some point in their previous k-12 school years. Data suggest more female perpetrators (42.8% compared to 57.2% male) than is commonly assumed (Educator Sexual Misconduct, 2004). The same report also summarizes evidence that 28.3% of this sexual abuse is same-sex abuse (15.2% male-male and 13.1% female-female).*

I had a relationship with my teacher for three years: 6th, 7th and 8th grade. The thing is, I didn't feel like a victim. I wanted and welcomed the attention from him. I really believed him when he said he would leave his wife and marry me when I turned 18.

Nevada Victim and Survivor of Child Sexual Abuse

Community Partners and Programs

RECOMMENDATION #5

Recommend licensing agencies such as the State Board of Health adopt prevention curriculum standards for child care or early childhood education centers, community centers, teen pregnancy centers, faith-based organizations, and libraries.

***Discussion:** According to the Centers for Disease, Control and Prevention (2006), there has been a decline in child sexual abuse since certain youth serving organizations such as Scouts, summer camps and after school programs have implemented prevention policies. The more agencies that deal with children and youth are educated about child sexual abuse including recognizing the signs of active or potential abuse and the more they are able to educate children about these same issues, the more these programs will reduce the potential pool of victims for sexual predators. It is also important for these organizations to have screening, training and prevention policies in place so children are not placed at unnecessary risk when taking part in the programs.*

RECOMMENDATION #6

Require institutes of higher education in Nevada to provide training to future providers (e.g. psychology, social work, human services, nursing, public health, education, medical), focused on increasing community resilience and healthy sexuality that is linked to professional accreditation.

***Discussion:** According to the Prevention Institute (2009), with appropriate training, providers can become highly effective advocates for prevention policies. By expanding the notion of provider, it is possible to mobilize a broader group in advancing sexual abuse prevention. These professionals will have access to youth and families within communities, and can serve as leaders in prevention, particularly when they begin their profession with this mission in mind.*

RECOMMENDATION #7

Assist schools and community agencies to promote and expand recreation programs for adolescents during after-school care for children of working parents, as an effective way of helping them to avoid sub-par care situations.

***Discussion:** Sexual assaults on children are most likely to occur at 8 a.m., noon and between 3 and 4 p.m. For older children, ages 12-17, there is a peak in the assaults in the later evening hours (Snyder, 1999). 1 in 7 incidents of sexual assault perpetrated by juveniles occur on school days in the after-school hours between 3 and 7. After school care is an essential and important part of many working families and a luxury that some cannot afford. The provision and expansion of programs not only limits exposure to potential perpetrators by providing a higher standard of care for children, but provides an opportunity for providers to teach social and emotional (prevention) skills.*

RECOMMENDATION #8

Encourage programs and providers that include or conduct home visits to include sexual abuse prevention as well as promoting overall sexual health as a part of their mission and staff training.

***Discussion:** There are many programs and services where professionals conduct in-home visits to provide medical treatment, and/or some type of education to the family. Examples include evidence based home visitation programs such as Nurse Family Partnership, Healthy Families America, and Home Instruction for Parents of Preschool Youngsters (HIPPOY). Home-visiting programs are interventions where professionals come into the homes of families and provide social support, case management and education about child development and parenting over an extended period of time. Home visiting professionals who have been trained on the signs of active or potential sexual abuse can intervene and/or mitigate the abuse.*

Public and private agencies alike offer home visiting programs, which have been found to effectively reduce the risk of abuse (Olds, Eckenrode, et al). One example of the success that a home visitation program can have has been the Nurse Family Partnership. Through this program, nurse home visitors work with low-income young women who are pregnant with their first child, helping these vulnerable young clients achieve healthier pregnancies and births, stronger child development, and a path toward economic self-sufficiency. The Nurse-Family Partnership is a rare community health program that has been documented to achieve lasting and significant effects through multiple, well-designed randomized, controlled trials. Among the significant findings and outcomes that have been observed are the reduction in child abuse and neglect and the reduction in health-care encounters for injuries. The Nurse-Family Partnership program began serving as a Nevada charity in 2008.

RECOMMENDATION #9

Collaborate with an existing hotline, providing assistance for victims of child sexual abuse.

***Discussion:** Hotlines are utilized for cases of child abuse and neglect as well as for suicide prevention and other mental and physical health emergencies. This would serve as an additional resource for individuals providing information to help them report, providing support if they are hesitant to report, and providing information regarding counseling or other victim resources.*

RECOMMENDATION #10

Create a list of effective child sexual abuse prevention programs publically available and easily accessed for those entities wanting to implement a program. For programs funded with state dollars, use of an evidence based program should be required as well as including an evaluation component, and reporting of all data collected. Funding sought outside the state to implement prevention programs should be highly encouraged to use evidence based prevention programs

to include an evaluation of effectiveness component, and share relevant data to others working on child sexual abuse prevention when appropriate.

Discussion: *Few actually report sexual abuse, and there remains a need to track and evaluate program effectiveness in order to ensure measures are having an impact and to provide for continuous improvement. Multiple data sources allow for more comprehensive understanding of the issues and multiple avenues for raising awareness and implementing change.*

Health Care Providers

RECOMMENDATION #11

Facilitate access to training materials and opportunities for primary care providers to assist them in the incorporation of sexual abuse prevention into routine wellness visits for children. Training should include the promotion of sexual health and safety; how to talk to patients and families about sexual abuse; the main risk factors for child sexual abuse and how to identify families (including higher risk families of children with disabilities) in need of supports in these areas; how to report suspected abuse; the resources available for families and children in regard to sexual abuse prevention; and, protection from sexual abuse by health care providers. This may be accomplished through passive methods, such as the provision of brochures and pamphlets and more direct training including a personal introduction to websites and available resources (such as Nevada 211). Resources should be provided for providers and patients.

I do NOT feel equipped or prepared to handle sexual abuse of a child in my office. I feel like I am taking a shot in the dark and I am hoping that I do not destroy someone's life in the process.

Doctor who has been in practice for 27 years.

Discussion: *Primary medical providers interact with families from the first days of their children's lives. These providers develop a relationship with families and have multiple contacts over multiple years. They routinely speak to families about intimate and stressful topics, including normal and abnormal sexual behaviors. A primary care provider may be the first or only line of defense, intervention, and mitigation of child sexual abuse. Incorporating a discussion of this topic into the wellness visit may go far in the prevention of child sexual abuse. Physicians and medical students alike have identified that they do not feel that they have received adequate training in the identification of child maltreatment (Flaherty et al., 2008; Jones et al. 2008), and many are unfamiliar with the precise guidelines for mandatory reporting (Ward et al., 2004). Physicians who had received formal education in child maltreatment following their residency program, were 10 times more likely to report concerns to CPS than providers who had not received any formal training (Flaherty et al., 2008).*

Public Awareness Campaigns and Social Media

RECOMMENDATION #12

Implement a comprehensive child sexual abuse prevention campaign in Nevada that targets general community members, policy makers, families, professions (mental health, medical, educators), etc. This comprehensive campaign should include strategies to educate the community (all members) about the nature and scope of the program and how to be involved, communicate key prevention messages that can be shared to reduce risk to children, and advocacy for prevention trainings and policies. Strategies may include:

- An interactive social media focused marketing campaign to engage 1) youth and provide them with information about child sexual abuse and sexual violence; and, 2) bystanders in the prevention of child sexual abuse and to draw community awareness to steps they can take to help prevent child sexual abuse.
- A single, web-based repository of promising practices links to resources, and organizations working on the issue. Include information detailing how communities and states can localize best practices, provide information on evidence based prevention and treatment programs and potentially providers, and include information for distinct groups such as parents, educators, healthcare providers, etc.

Discussion: *In order to make a real community impact, a comprehensive prevention campaign is needed in each community. “Complex public health problems such as child sexual abuse require comprehensive solutions that go beyond simple education programs” (Enough Abuse Campaign, 2014). Campaigns need to address the individual, the community, and society.*

Facebook has more than 500 million active users worldwide. YouTube has one billion unique users each month. Google has three billion searches daily. Attention to media and the impact it plays in daily lives is critical when attempting to create a climate of intolerance for child sexual abuse. When linking media to behavior change the goal is to engage the readers to read and respond, rather than just read. Interactive technology has the capacity to engage the audience and not only teach but spread messages widely and instantly. In addition, according to the NSVRC (2011) 90% of 13-17 year olds have used some form of social media, and 75% have a profile on a social networking site. Integrating new technologies and using social media websites, applications for cell phones, online interactive games, etc. may be particularly relevant for prevention efforts targeting teenagers. If these approaches were implemented and coordinated on a broad scale, they may have a greater impact on the number of victims.

There are still many individuals, including victims and offenders who are reluctant in stepping forward to ask for assistance or information. A comprehensive repository of information provides an anonymous way for any individual to obtain prevention and treatment resources. In addition, given that lack of comfort with the material and lack of knowledge of how to make referrals for services or reports is the primary barrier for pediatricians and family practice doctors, a one stop shop that is updated with easy links would help lower these barriers. Creation and maintenance of a website would be significant, but could be combined with community and educational prevention and referrals, increasing its reach.

Community education should not just be about what we say but also about what we stop saying. Ads aimed at children reinforce skewed gender roles, prescribing how youth should look and what they should buy to accomplish that look. This is helping to create a generation of young people who find value in commodities, who view the human body as a sexual object, and learn to develop relationships based on sexual desire rather than on connection.

It is estimated that \$17 billion is spent annually by companies marketing all types of products to children. Children see an average of 30,000 ads per year. Exposure to this marketing encourages children to see themselves as commodities and view sexual objectification as normal. Studies have found that adolescents commonly stumble upon sexually explicit material while searching for different information on the Internet. In one study, 42% of adolescents reported exposure to pornography online with 66% of those teens describing such exposure as unwanted. The Internet is only one source of exposure to sexual content. A study of randomly selected youth showed that music contained the most sexual content (40%) followed by movies (12%) and television (11%). Awareness of what children are seeing online and what offenders may also be sharing with our children is critical (Groux, 2009).

RECOMMENDATION # 13

Explore potential policies and/or regulations for community businesses and other appropriate entities that limit access to pornographic sites by children and teens.

Discussion: *Recent research suggests that male youth who view pornography may develop unrealistic sexual values and beliefs. In addition, some adolescents are normalizing sexual abuse done to them because of pornographic exposure (NSVRC, 2011). 75% of pornographic websites display teasers on the homepage before asking if viewers are of legal age. Only 3% of these websites require proof of age before granting access to sexually explicit materials. 66% of pornographic*

websites do not have any adult-content warnings and smart phones and media tablets do not have effective filtering systems for internet access.

RECOMMENDATION #14

Increase and explore opportunities for access to training and promote best practices for journalists covering stories about child sexual abuse and exploitation. Encourage the media to go beyond the individual portrait to show the landscape of environmental attributes and norms impacting the issue.

***Discussion:** Often times, the sensational details of a sexual child abuse story can take precedence over the pervasive and horrendous nature of the crime itself. Well-written, fact based stories that place a particular incident in a broader context can go a long way toward educating the public. This type of reporting can be part of a much bigger campaign aimed at prevention.*

SPECIAL POPULATIONS

Because child sexual abuse happens to children from all socio-economic and ethnic groups, it is important that we target our efforts at *all* children and adults in Nevada. Attitudes that child sexual abuse does not occur in specific communities are ill-informed and harmful to children. At the same time, certain groups can be at greater risk for abuse and deserve special consideration when designing and implementing interventions.

Children with disabilities are at a particularly high risk for being sexually abused because of the vulnerabilities created by their disability (Jones, et al. 2012). Their physical dependency decreased ability to communicate and increased caretaker demands make them vulnerable. Children with disabilities also have additional barriers in disclosing abuse. Individuals and agencies that work with this population have a particular obligation to actively address child sexual abuse in ways that are developmentally appropriate.

Children living in poverty are often at increased risk for child sexual abuse (Hussey, Chang, & Kotch, 2006). This does not mean that poor people are more likely to abuse their children than families with resources. Families living in poverty often have to rely on sub-standard childcare which can increase a child's risk for being sexually abused. When individuals can't afford childcare and don't have a strong family or support network, they are more inclined to leave their child with a "helpful" neighbor, boyfriend or partner. Sexual predators often seek out families in crisis because they know these families are more likely to have a decreased capacity to protect their children. Finally, the isolation and lack of resources that result from poverty can make it more difficult for help to reach children being harmed.

Missouri Prevention of Child Sexual Abuse Task Force Report, 2012

SECONDARY AND TERTIARY PREVENTION

“Secondary prevention focuses on the immediate responses to violence. These efforts may include emergency services or medical care for victims. Tertiary prevention involves long-term approaches that occur in the aftermath of violence. These may include efforts to rehabilitate the perpetrator or services that lessen the emotional trauma to the victim” (CDC, 2014).

Treatment of child sexual abuse is a complex process. Orchestration of treatment in the child's best interest is a genuine challenge because it occurs in a larger context of intervention. The complaint of many victims is that when the sexual abuse is discovered, things get worse rather than better because their lives continue to be controlled by others, and they experience a myriad of additional traumas. These may be repeated, insensitive, and humiliating interviews; a frightening medical exam; a confrontation involving the perpetrator or the victim's family; an unpleasant placement experience; treatment that the child finds unhelpful or traumatic; and court testimony. Often the most problematic aspects of intervention are not knowing what is going to happen and having no say in decisions. It is important that the intervention not exacerbate the child's sense of powerlessness.

Coordination is of utmost importance and ideally is provided by a multidisciplinary team and wrap around services. Treatment issues are often handled by teams as part of overall intervention. This may require collaboration between schools, child welfare agencies, medical providers, churches, law enforcement and others. Difficult decisions must be made concerning the child's safety such as separation of the child from their environment which can cause further problems for the child. Once a victim has disclosed or has been identified, a myriad of mental and behavioral health issues may emerge. Parents are not usually equipped to handle this difficult and dynamic situation. While not all victims of child sexual abuse suffer long lasting and devastating effects, many do. Studies have consistently shown there is one major difference: the support of the mother. Society would expect parents to always support their child. However, in cases of child sexual abuse, this frequently does not happen. Often times, the child's greatest fears come true. They are not believed or supported by those they love and trust the most.

“My parents and other family strongly supported me when I confessed all that had been happening (and there was a lot). My grandpa disowned my family. My grandma tried to stay in touch with us, but it was really hard. She chose to stay with him. I am sure she couldn't support herself financially and was scared to be on her own. My grandma knew of some of the things that were happening to me so, in a way, I feel abused by her, too. She did not protect me!”

Nevada Victim and Survivor of Sexual Abuse

Pre-K - 12th Grade Education

Recommendation #15

Mental health providers, both public and private should partner with school systems to increase access to mental health treatment for victims of abuse. Processes will be need to be developed to ensure the confidentiality of victims and limit access to only those who have a need to know in order to provide services.

***Discussion:** Victims of abuse have high incidents of mental health problems. School based mental health professionals have an opportunity to get to know families and to view how a child's mental health is impacting daily activities. Schools need to be supported by community agencies to provide referral opportunities, but must maintain wraparound supports in order to include prevention practices in the school. This will also maintain a consistent message between providers, school and family. By exploring community resources, memorandums of agreements between public and private entities and a policy of "No Wrong Door," increased and more efficient access to mental health supports for students in need may be realized.*

Recommendation #16

Partner with school systems to provide school-based mental health treatment or mental health referrals for students who are offenders. Just as with victims, processes for offenders will be need to be developed to ensure confidentiality and limit access to only those have a need to know in order to provide services.

***Discussion:** Children's brains are still very "plastic" and can learn new neural pathways in regards to victimizing others. According to research (Bourke and Donohue, 1996), participation in child sexual abuse offending peaks in adolescents and early adulthood. Estimates show this age group may be responsible for 30-50% of all child sexual abuse offenses. A meta-analysis has concluded that treatment reduces sexual re-offending as much as 37% and shown that cognitive-behavioral therapy can prevent additional reports of abusive or inappropriate behavior by preadolescents who are exhibiting such behavior. As with Recommendation #14 above, exploring community resources, memorandums of agreements between public and private entities and a policy of "No Wrong Door," increased and more efficient access to mental health supports for students in need may be realized.*

Even today, I feel love and hate for my grandpa because there are a lot of good memories too. I tried to reconcile with him many times after everything was out, but to him, I (and my family) no longer existed - which was just fine with my dad. He never wanted to see him again anyway, but I was sad for a long time. I was so sad that my little brother lost his grandpa. Now I see that my brother was actually protected. In confessing, I felt sad and guilty, but I came to learn how much my confession protected my brother and all my cousins.

Nevada Victim and Survivor of Sexual Abuse

Community Partners and Programs

RECOMMENDATION #17

Agencies that work with children should have minimum guidelines to screen, select, and train staff and volunteers to ensure appropriate employee/volunteer interactions with each other and the community, and to ensure the employees/volunteers are knowledgeable about child sexual abuse.

***Discussion:** Organizations need to have policies in place to screen, select, and train employees and volunteers. Policies should address unacceptable interactions between individuals, and how to respond to allegations of child sexual abuse.*

“When I was in elementary school, I went to a Campfire Girl's camp. One of the female leaders got into my sleeping bag with me to keep me warm. I don't remember anything happening, but feel this was very inappropriate. I did tell my mom about it and she filed a complaint - and I never went back to that camp.”

RECOMMENDATION #18

Reduce barriers to reporting and follow-through by the state and county agencies receiving reports.

***Discussion:** Ease of access to training and resources for professional organizations will decrease resistance to the incorporation of training for both accreditation and ongoing training.*

RECOMMENDATION #19

Increase public awareness about mandatory reporters including making training regarding mandatory reporting more widely available and accessible. This will include access to trainings for professional organizations that are willing to incorporate mandated reporting into their internal trainings.

***Discussion:** At least two-thirds of children suspected of having been the victims of maltreatment may not be reported to CPS by mandatory reporters (Sedlak et al., 2010). Misconceptions exist about who is a mandated reporter, when to report, how to make a report and what happens after a report. Many mandated reporters believe that if they don't have “proof” of the abuse, they will get in trouble for reporting. Coordinated and standardized as well as maintenance training could address these barriers. (See **Appendix B**)*

Health Care Providers

RECOMMENDATION #20

Offer any child in whom there is suspicion of sexual abuse an exam by a specially trained pediatrician, nurse practitioner or RN. Exams involving child cases (17 and under) should have access to review by a pediatrician with board certification or added qualification in child abuse and neglect who performs a volume of greater than 25 cases per year; be conducted according to the national gold standards; and be conducted at a child-friendly neutral location, such as a Children's Advocacy Center. Medically fragile children should be seen in a clinical location (ex: ER, psych facility) when necessary.

***Discussion:** Child abuse is a medical problem. Medical professionals and licensing bodies should decide who is qualified to perform these exams, which are not physically traumatic to the victim, can sometimes obtain critical evidence for law enforcement and provide crucial emotional and mental reassurance to the child that his or her body is "ok." Often, these physical exams also provide insight into other critical problems such as suicidal thoughts, domestic violence, untreated sexually transmitted infections and other medical conditions.*

Currently law enforcement and CPS/child welfare agencies are the only agencies allowed to order these exams. Allowing other members of a multi-disciplinary child abuse team to request an exam would serve to expedite an exam, ensure all children receive the offer of an exam and expand the accountability, responsibility and authority of other agencies.

Best Practice

Just as you would take your child 2 hours away to see a cancer specialist, you may need to take your child 2 hours away to see a child sexual assault specialist. Just as you would not want your OB GYN to perform surgery on your ear, you would not want an adult internist to perform a child sexual assault exam. Best practice dictates a timely exam performed by an abuse pediatrician or other clinician with nationally recognized qualifications in child sexual abuse, coordinated with an interviewer by a skilled child forensic interviewer.

RECOMMENDATION #21

Facilitate the development of distance medicine (Telemedicine) networks in Nevada's rural hubs to provide local exams when possible, decreasing travel to Reno or Las Vegas.

Discussion: Nevada has vast rural underserved areas, resulting in some of the most vulnerable children not receiving care they deserve. Telemedicine has proven to be a successful alternative to in-person exams. It has proven to increase the number of children receiving services by over 3 fold by reducing the geographic barriers, time lost from work, keeping medical dollars in the home community and increasing the confidence of families and law enforcement that the child will not be re-traumatized. Telemedicine is accomplished through rural clinicians with adult sexual assault, trauma or pediatric experience being trained through a nationally recognized, multi-day course.

A Telemedicine Child Sexual Abuse program is currently functioning in Elko with significant success due to a dedicated partnership between the University of Nevada School of Medicine and state and community agencies. Rural grants and/or other funding is available to provide start up costs and/or training.

RECOMMENDATION #22

Provide state and county funding for incentives or financial assistance for mental health practitioners in each community to access therapists with Trauma Focused-Cognitive Behavior Therapy (TF-CBT) training or other evidence based trauma-specific therapy.

Discussion: All children with whom there is a suspicion of sexual abuse deserve access to appropriate mental health services. Focused TF-CBT has shown the most evidence-based promise as a form of therapy to decrease the debilitating symptoms of trauma associated with child abuse. TF-CBT is relatively short, requiring on average 18 sessions to complete (NTCSN, 2009).

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APPENDIX A

Rural District's Child Sexual Abuse Curriculum				
	K-3	4-6	Middle School	High School
Carson City School District			<p>Written permission is required, and the following topics are covered in Family Life education:</p> <ul style="list-style-type: none"> • I can advocate for healthy alternatives for myself and those around me. • I can choose an appropriate person to seek help from and can describe situations that require assistance. • I can claim responsibility for my personal health behaviors by evaluating the short and long term impacts of my decisions. • I can critique internal and external influences on my health. • I can examine the cause and effect of illness or disease due to risky behaviors. • I can identify personal behaviors that affect the development and functioning of the body system. • I can explain the parts and functions of both male and female reproductive systems. 	<p>Students learn and study about relationships, and are exposed to the topic of date rape and the cycle of violence as well as safety in dating. (9th grade health)</p> <p>Written permission is required, and the following topics are covered in Family Life education:</p> <ul style="list-style-type: none"> • Students will describe essential functions of the male and female reproductive systems. • Students will identify ways to keep the male and female reproductive systems healthy. • Students will identify risky behaviors and prevention behaviors associated with the current epidemic of sexually transmitted infections. • Students will identify and explain four risks of sexual intimacy. • Students will explain why emotional intimacy is important to close relationships. • Students will identify four skills that help you choose abstinence.

<p>Clark County School District</p>	<p>Schools are encouraged to use the CAP program through the Rape Crisis Center to discuss "good touch", "bad touch", and "secret touch". In addition, the following standards are addressed:</p> <ul style="list-style-type: none"> • Discuss good and bad decisions and give an example of each • Identify the steps of the decision-making process as related to a health issue. Steps include: identify the problem, consider your values, list the options, weigh the consequences, decide and act, evaluate your 	<p>Schools are encouraged to use the CAP program through the Rape Crisis Center to discuss "good touch", "bad touch", and "secret touch". In addition, the following standards are addressed:</p> <ul style="list-style-type: none"> • Discuss good and bad decisions and give an example of each • Identify the steps of the decision-making process as related to a health issue. Steps include: identify the problem, consider your values, list the options, weigh the consequences, decide and act, evaluate your decision. • Apply the steps of the decision-making process to an identified health-related situation to avoid or reduce health risks. 	<p>The following standards are addressed:</p> <ul style="list-style-type: none"> • Define health peer relationships. • Evaluate influences on relationships. • Compare a healthy versus an unhealthy dating relationship. • Apply conflict management techniques. • Understand family relationships. • Define bullying, cyber-bullying, sexting, and harassment. • The student will define domestic violence, sexual assault, and human trafficking. • Evaluate the impact domestic violence, sexual assault, and human trafficking has on the individual, family, and society. • The student will identify ways to protect him/herself from domestic violence, sexual assault, and human trafficking. • Relate steps he/she can take to help protect him/herself from unintentional injuries and violence. 	<p>The following standards are addressed:</p> <ul style="list-style-type: none"> • Describe how healthy relationships develop over time. • Define sexual harassment. • Demonstrate internet safety. • Understand the consequences of bullying, cyber bullying, and sexting. • Differentiate between domestic violence, sexual assault, and human trafficking. • Describe preventative measures that could protect against abusive situations. • List various community resources available to help people who have experienced domestic violence, sexual assault, and/or human trafficking.
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	<p>decision.</p> <ul style="list-style-type: none"> • Apply the steps of the decision-making process to an identified health-related situation to avoid or reduce health risks. • Recite first and last name, names of parents/guardian, address, telephone number, and the use of "911" for emergencies . • Explain ways to help oneself and others when in a dangerous situation. • Discuss when to recognize potentially violent or unsafe situations and describe 	<ul style="list-style-type: none"> • Recite first and last name, names of parents/guardian, address, telephone number, and the use of "911" for emergencies. • Explain ways to help oneself and others when in a dangerous situation. • Discuss when to recognize potentially violent or unsafe situations and describe ways to protect oneself. • Identify family members who are trusted adults. • Discuss "stranger danger." • Identify other trusted adults and their jobs in your community, such as teachers, crossing guards, doctors, fire fighters, and 		
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	<p>ways to protect oneself.</p> <ul style="list-style-type: none"> • Identify family members who are trusted adults. • Discuss "stranger danger." • Identify other trusted adults and their jobs in your community, such as teachers, crossing guards, doctors, fire fighters, and police officers. • Discuss the need to seek help from a trusted adult when in a dangerous situation. • Discuss refusal skills that would be used when confronted with a 	<p>police officers.</p> <ul style="list-style-type: none"> • Discuss the need to seek help from a trusted adult when in a dangerous situation. • Discuss refusal skills that would be used when confronted with a dangerous situation. • Practice refusal skills that would be used when confronted with a dangerous situation. 		
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	<p>dangerous situation.</p> <ul style="list-style-type: none"> Practice refusal skills that would be used when confronted with a dangerous situation. 			
Churchill County School District		<p>5th grade: Written permission is required. While not specifically addressed with a particular curriculum, the topic is covered in the health class.</p>	<p>7th grade: Written permission is required. While not specifically addressed with a particular curriculum, the topic is covered in the health class.</p>	<p>9th grade: Written permission is required. While not specifically addressed with a particular curriculum, the topic is covered in the health class.</p>
Douglas County School District	<p>Elementary counselors are holding meetings to discuss this and establish a consistent curriculum.</p>	<p>Elementary counselors are holding meetings to discuss this and establish a consistent curriculum.</p>		
Elko County School District	<p>Using the combined resources of classroom instructors, counselors, Physical Education Specialists and school nurses, the students will: ☐ <i>acquire and evaluate health-related information;</i> ☐ <i>make</i></p>	<p>1.5.1 Describe the relationship between health behaviors and personal health. 2.5.1 Identify how various sources affect thoughts, feelings and health behaviors. 4.5.1 Model effective verbal and non-verbal communication skills. ** **Reference NRS.389.065 to include</p>	<p>(Permission to Participate) Course is designed to introduce students to the mental, physical, social, emotional aspects of human wellness. The course will include concepts for achieving a healthy body and healthy mental attitudes. Other topics studied are body systems, health hazards, diseases, safety, and first aid. Human sexuality and sexually transmitted infections disease education, within established</p>	<p>(Permission to Participate form signed) This one-semester course is designed to introduce students to the intricate relationships between the structural and physiological functions required for the mental, social, and physical wellness of the individual. The course includes health awareness, body functions, human development, use of community health resources, first-aid techniques, and the relationships of these to the total health and fitness of the individual. Human sexuality and sexually</p>

	<p><i>knowledgeable decisions to improve student health;</i> <i>☐ apply their decisions to improve their physical, mental and social well-being and that of their peers, families and communities.</i></p> <p>4.2.1 List healthy ways of communication/listening to express needs, wants, and feelings</p> <p>5.2.1 Discuss Healthy options vs. unhealthy options.</p> <p>6.2.1 Define a short-term and long-term personal health goal.</p> <p>7.2.1 Identify responsible personal health behaviors.</p> <p>8.2.1 Identify ways to promote personal and family health</p> <p>1.2.8 Identify school staff and community health helpers (i.e. law enforcement, emergency personnel)</p> <p>4.2.5 Identify ways to respond/report when in an unwanted,</p>	<p>sexual responsibility content/communication</p> <p>5.5.1 Apply a healthy choice when making personal decisions.</p> <p>6.5.1 Set a personal health goal through tracking progress toward its achievement.</p> <p>7.5.1 Demonstrate behaviors that avoid or reduce health risks.</p> <p>8.5.1 Describe ways to influence and support others to make positive health choices.</p> <p>Growth and Development</p> <p>1.5.2 Explain the basic structure, function, and developmental processes of human body systems. **</p> <p>**Reference NRS.389.065 to include sexual responsibility content/communication</p> <p>1.5.3 Describe various physical, emotional, intellectual differences and how they affect a child's overall well being.</p> <p>4.5.2 Discuss ways to communicate with others about stages of growth and development. **</p> <p>**Reference</p>	<p>guidelines, will be an integral part of this course. Instructional practices will incorporate integration of diversity awareness including appreciation of all cultures and their important contributions to our society. The appropriate use of technology is an integral part of this course.</p> <p>1.8.1 Analyze the relationship between health behaviors and personal health.</p> <p>2.8.1 Explain how various sources affect individual health practices and behaviors. **</p> <p>**Reference NRS.389.065 district guideline for sexual responsibility content/communication</p> <p>2.8.2 Explain how the perception of norms influences healthy and risky behaviors. **</p> <p>** Reference NRS.389.065 district guideline for sexual responsibility content/communication</p> <p>4.8.1 Practice refusal and negotiation skills that avoid or reduce health risks.</p> <p>5.8.1 Defend healthy alternatives over unhealthy alternatives when making a decision.</p> <p>6.8.1 Apply time management strategies and skills needed to attain a personal long-term health goal.</p> <p>7.8.1 Explain the importance of assuming responsibility for personal health behaviors.</p> <p>8.8.1 Demonstrate ways to</p>	<p>transmitted infectious disease education, within established guidelines, will be an integral part of this course. Instructional practices will incorporate integration of diversity awareness including appreciation of all cultures and their important contributions to our society. The appropriate use of technology is an integral part of this course. The course will fulfill the one-half credit of health required for graduation.</p> <p>1.12.1 Evaluate the impact of family history, health choices, and stress on individual health.</p> <p>2.12.1 Analyze how various sources support and challenge health beliefs, practices, and behaviors.</p> <p>2.12.2 Analyze how personal perception of norms influence healthy and risky behaviors.</p> <p>4.12.1 Apply refusal, negotiation and collaboration skills to enhance health.</p> <p>5.12.1 Formulate an effective plan for personal health enhancement.</p> <p>6.12.1 Implement strategies to monitor progress towards achieving a personal health goal</p> <p>7.12.1 Analyze a variety of behaviors that avoid or reduce health risks to self and other.</p> <p>8.12.1 Implement activities that influence and support others to make positive health choices.</p> <p>Growth and Development</p> <p>1.12.2 Formulate a personal health strategy utilizing self-reflection to achieve overall wellness.</p> <p>4.12.2 Communicate acceptance of</p>
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	<p>threatening, or dangerous situation. 7.2.5 Identify basic safety measures (i.e. sun safety, helmet use, pedestrian safety, seatbelts, gun safety, 911 procedures, fire safety, universal safety precautions).</p>	<p>NRS.389.065 to include sexual responsibility content/communication 1.5.7 Describe ways to prevent common childhood injuries 1.5.8 Explain personal safety procedures when confronted with violence or other hazards. 4.5.5 Demonstrate non-violent strategies to manage or resolve conflict. 7.5.5 Describe basic first aid procedures and responses to common emergencies. 7.5.6 Assess safe/unsafe situations and practices</p>	<p>influence and support others to make positive health choices. Growth and Development 1.8.2 Identify personal behaviors that affect the development and functioning of the body systems. ** ** <i>Reference NRS.389.065 district guideline for sexual responsibility content/communication</i> 1.8.3 Explain the interrelationships of emotional, intellectual, physical, and social health in adolescence. ** ** <i>Reference NRS.389.065 district guideline for sexual responsibility content/communication</i> 4.8.2 Express ways to communicate with others about perceived body image. 1.8.7 Develop a personal safety plan to reduce or prevent injuries. 1.8.8 Examine the likelihood of serious injury or illness if engaging in risky behaviors. 4.8.5 Implement refusal and negotiation skills necessary to resolve conflict. 7th Grade: Personal Health, Growth and Development (Body Systems); Nutrition/Physical Activity, Injury/Violence Safety 8th Grade: Growth and Development (Human Sexuality/Adolescence); Disease Prevention/Control, Substance Use and Abuse, Environmental/Consumer Health</p>	<p>physical and developmental characteristics of self and others. 1.12.7 Examine ways to reduce or prevent injuries and violence. 1.12.8 Analyze personal susceptibility to injury, illness, or death if engaging in risky behaviors. 4.12.5 Apply strategies to prevent or resolve interpersonal conflicts without harming self or others. 7.12.5 Demonstrate a variety of practices and behaviors that will avoid injury and reduce risks of injury to self and other. (i.e. impaired driving, seatbelt usage, fighting, self-harming behaviors). Grade 11 Lifetime Health Holt, Rinehart and Winston Student ISBN: 13-978-0-03-096219-6 TE ISBN: 13-978-0-03-096220-2</p>
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			Text Book: Decisions for Health (Blue Level) Holt, Rinehart and Winston Student ISBN: 13-978-0-030-96158-8 TE ISBN: 13-978-0-03-096161-8	
Esmeralda County School District		Community Health Nurse is hired from Nye and teaches puberty course for all 4 th graders and anyone who missed the class in the 5 th through 7 th grades.	Community Health Nurse is hired from Nye and teaches a puberty course for all 8 th graders who didn't attend earlier.	
Eureka County School District	<p>Good touch/bad taught by the school counselor, teaching with age appropriate videos. As part of that, the students are taught to tell someone the trust if they feel uncomfortable with any touch.</p> <p>Taught through <u>Your Body Belongs to You</u> by Cornelia M. Spelman, Publisher: Albert Whitman & Company (1997).</p> <p>Don't present a particular or consistent curriculum.</p>	<p>Good touch/bad taught by the school counselor, teaching with age appropriate videos. As part of that, the students are taught to tell someone the trust if they feel uncomfortable with any touch</p> <p>Health and Safety Fair at the elementary school and the sheriff's office presented a video on Stranger Danger: <u>The Safe Side – Stranger Safety: hot Tips to Keep Cool Kids Safe with People They Don't Know and Kinda Know</u></p>	Emphasis shifts to broader sexual harassment issues, but inappropriate touching is a part of this too. Again the students are advised to report it to someone they trust.	Emphasis shifts to broader sexual harassment issues, but inappropriate touching is a part of this too. Again the students are advised to report it to someone they trust. (Done as an in-house presentation, not presented this year.)

<p>Humboldt County School District</p>	<p>Elementary Counselors address this issue in their schools.</p> <p>1.2.1 Identify health behaviors that impact personal health. (DARE, Counseling, CT)</p> <p>1.2.6 Identify school staff and community health helpers. (DARE, Counseling, CT)</p> <p>3.3.1 Identify trusted individuals who can help promote health. (DARE, Counseling, CT)</p> <p>4.2.1 List healthy ways of communication/listening to express needs,</p>	<p>Elementary Counselors address this issue in their schools.</p> <p>1.5.1 Describe the relationship between health behaviors and personal health. (HG&D, DARE, Counseling, CT)</p> <p>1.5.6 Explain personal safety procedures when confronted with violence or other hazards. (DARE, CT, Counseling)</p> <p>2.5.6 Describe how various sources influence individual practices and behaviors. (HG&D, DARE, CT, Counseling)</p> <p>3.5.1 Locate resources from home, school, and community that provide reliable health information. (HG&D, DARE, CT, Counseling)</p> <p>4.5.1 Model effective</p>	<p>1.8.1 Analyze the relationship between health behaviors and personal health. (HG&D, YRPC, DARE, CT, LS, Counseling)</p> <p>1.8.8 Examine the likelihood of serious injury or illness if engaging in risky behaviors. (HG&D, YRPC, DARE, CT, LS)</p> <p>1.8.10 Discuss how personal health behaviors can impact risk for illness/disease. (HG&D, YRPC, DARE, CT)</p> <p>2.8.3 Explain how the perceptions of norms influence healthy and risky behaviors. (HG&D, YRPC, DARE, CT, LS)</p> <p>24.8.1 Practice refusal and negotiation skills that avoid or reduce health risks. (HG&D, YRPC, DARE, LS)</p> <p>4.8.2 Practice appropriate methods of response to negative risk taking situations including alcohol, tobacco, and other drugs. (HG&D, YRPC, DARE, LS)</p> <p>4.8.3 Demonstrate how to ask for assistance to enhance the health of self and others. (DARE, LS)</p> <p>5.8.1 Defend healthy alternatives over unhealthy alternatives when making a decision. (DARE, LS)</p> <p>5.8.2 Compare the short and long term impact of health</p>	<p>1.12.2 Formulate a personal health strategy utilizing self reflection to achieve overall wellness. (HG&D, YRPC, Health Curr, LS)</p> <p>1.12.5 Analyze personal susceptibility to injury, illness, or death if engaging in risky behaviors. (HG&D, YRPC, Health Curr, LS, Laws Guest)</p> <p>2.12.3 Analyze how personal perception of norms influence healthy and risky behaviors. (HG&D, YRPC, Health Curr, LS)</p> <p>4.12.1 Apply refusal, negotiation, and collaboration skills to enhance health. (YRPC, Health Curr, LS)</p> <p>5.12.2 Determine the value of applying a thoughtful decision making process in health related situations. (HG&D, YRPC, Health Curr, LS, Laws Guest)</p> <p>7.12.1 Analyze a variety of behaviors that avoid or reduce health risks to self and others. (HG&D, YRPC, Health Curr, LS, Laws Guest)</p> <p>7.12.2 Demonstrate a variety of practices and behaviors that will avoid injury and reduce risks of injury to self and others. (HG&D, YRPC, Health Curr, LS, Laws Guest)</p> <p>7.12.3 Evaluate personal responsibility in promoting health and avoiding or reducing risky behaviors to self and others. (HG&D, YRPC, Health Curr, LS, Laws Guest)</p> <p>8.12.1 Implement activities that influence and support others to make positive health choices. (HG&D, YRPC, Health Curr, LS, Laws Guest)</p>
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	<p>wants, and feelings. (Counseling, CT)</p> <p>4.2.4 Identify ways to respond/report when in an unwanted, threatening, or dangerous situation. (DARE, Counseling, CT)</p> <p>7.2.1 Identify responsible personal health behaviors. (DARE, Counseling, CT)</p> <p>S&DFS Advisory Committee Recommendation- The learner will be able to recognize positive methods of dealing with anger issues. <i>(Counseling)</i></p> <p>S&DFS Advisory Committee Recommendation- The learner will be</p>	<p>verbal and non-verbal communication skills. (DARE, Counseling)</p> <p>4.5.2 Demonstrate refusal and negotiation skills. (DARE, Counseling)</p> <p>4.5.3 Recognize refusal skills when confronted with unhealthy situations including alcohol, tobacco, and other drugs. (DARE, Counseling)</p> <p>7.5.1 Demonstrate behaviors that avoid or reduce health risks. (DARE, Counseling, CT)</p> <p>7.5.2 Develop coping behaviors in response to various substance use situations. (DARE, Counseling)</p> <p>S&DFS Advisory Committee</p>	<p>decisions. (HG&D, YRPC, DARE, CT, LS)</p> <p>5.8.4 Apply a decision making process to a significant health issue or problem. (HG&D, YRPC, LS, DARE)</p> <p>7.8.1 Explain the importance of assuming responsibility for personal health behaviors. (HG&D, YRPC, DARE, LS, CT)</p> <p>7.8.2 Demonstrate methods of response to risk taking behaviors including alcohol, tobacco, and other drugs. (DARE, LS)</p> <p>7.8.4 Evaluate personal risk taking behavior. (DARE, LS)</p> <p>8.8.1 Demonstrate ways to influence and support others to make positive health choices. (DARE, LS, YRPC, CT)</p> <p>S&DFS Advisory Committee Recommendation- The learner will explore the importance of maintaining individual identity. <i>(HG&D, Counseling)</i></p> <p>S&DFS Advisory Committee Recommendation- The learner will explore positive resolutions and alternatives to negative and risk taking behaviors. <i>(HG&D, Counseling, LS)</i></p> <p>S&DFS Advisory Committee Recommendation- The learner will be able to recognize positive methods of dealing with anger issues. <i>(Counseling, LS)</i></p>	<p>S&DFS Advisory Committee Recommendation – The learner will be informed of laws pertaining to substance use, and juvenile and adult legal consequences of substance use. S&DFS Advisory Committee Recommendation – The learner will be able to identify risk factors of substance use. <i>(Health Curr., LS)</i></p> <p>S&DFS Advisory Committee Recommendation- The learner will be able to recognize positive methods of dealing with anger issues. <i>(LS)</i></p> <p>S&DFS Advisory Committee Recommendation- The learner will be able to recognize the progression of addiction and explain how lifelong addiction may affect an individual. <i>(YRPC Pres.)</i></p> <p>S&DFS Advisory Committee Recommendation – The learner will be able to analyze the physiological effects of substances. <i>(YRPC Pres.)</i></p> <p>S&DFS Advisory Committee Recommendation – The learner will be encouraged to utilize the above skills to facilitate life transitions. <i>(YRPC Pres.)</i></p>
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	<p>able to identify positive responses to stress. (<i>Counseling, CT</i>)</p> <p>*All standards credited to Nevada Department of Education Health Standards () represent party responsible for instruction</p> <p>HG&D – Human Growth and Development</p> <p>YRPC Pres.- Youth Risk Prevention Coordinator Presentation</p> <p>DARE- Drug Abuse Resistance Education by Humboldt County Sheriff's Office or Winnemucca Police Department</p> <p>Health Curr- HCSD Health Curriculum</p> <p>LS- Life Skills Curriculum in 8th Science, Health, PASS classes</p> <p>Laws Guest – Substance abuse laws/legalities Guest Speaker from Winnemucca Police Department</p>	<p>Recommendation – The learner will understand change is a normal process for all people. (<i>HG&D</i>)</p>		
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	<p>implemented in Lowry Health Classes Counseling – School Counselors CT – Classroom teachers</p>			
	<p>Good Touch/Bad Touch taught by the nurse and counselor. They use videos from empowerkids.com followed by discussion. The videos are different for each grade level. Kindergarten uses "What Tadoo", 1st use "Time to Tell", 2nd uses "What Tadoo with Secrets", 3rd uses "Believe Me". We do not require parent permission for the classes but videos are available at any time for parents to view if they wish. As for the effectiveness, in the 8 years I have been at this job and doing this, I have had probably 5 or 6 disclosures right after the classes.</p>	<p>Good Touch/Bad Touch taught by the counselor</p>		

Lincoln County School District	<p>Male and female students are taught together at grade levels.</p> <ol style="list-style-type: none"> 1. Acceptable social student interactions: <ol style="list-style-type: none"> a. Kindness b. Helpfulness c. Respectfulness 2. Appropriate or Inappropriate touching by anyone: i.e. <ol style="list-style-type: none"> a. Adult or another student b. Differences of physical expressions between friends, strangers, and family members that are adult verses brothers or sisters c. Social norms 3. Social and Emotional: Growth and development <ol style="list-style-type: none"> a. Child development 	<p>Male and females taught separately, but as a group of 4th through 6th graders.</p> <ol style="list-style-type: none"> 1. Anatomy: Reproductive and Endocrine Systems (Urinary System) <ol style="list-style-type: none"> a. Identification of body parts with visual representations b. Scientific terms and vocabulary (Be a facilitator between students and parents to use anatomical vocabulary) c. Avoid using slang terms d. Control tangent discussions that digress into explicit, indecent, lewd, offensive, obscene, crude, rude or vulgar representations 2. Maturation: Physical growth and development <ol style="list-style-type: none"> a. Maturing and changing male and female 	<p>One to three weeks, with more in-depth discussion on the previous categories.</p>	<p>More in-depth discussion on the previous categories, semester long courses.</p> <ol style="list-style-type: none"> 1. Transitioning into adult roles (students approaching 18 years old) – Prevention of sexual abuse is reviewed here. “Now You’re 18 – Adult Responsibility” <ol style="list-style-type: none"> a. The law associated with sexual behaviors b. Legal consequences depending on age c. Insurance responsibilities d. Selective Service (Males only)
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	<p>t, K-3rd</p> <ol style="list-style-type: none"> 1) Manage personal feelings (understand personal temperament) 2) Understand and others' feelings and needs 3) Interact positively with others 4) Awareness of cultural influences 	<p>bodies with age</p> <ol style="list-style-type: none"> b. Identify the changes that will take place with the body parts found in the reproductive and endocrine systems 3. Physiology: (Age appropriate structure and function) 4. Social and Emotional: Growth and development <ol style="list-style-type: none"> a. Youth adolescent development, 4th-12th <ol style="list-style-type: none"> 1) Manage the child development above 2) Search for identity (who they want to be when they grow up) 3) Emotional regulation 4) Independence 5) Individuality 6) Self- 		
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		<p>esteem, body image</p> <p>b. Behaviors associated with reproductive parts (Age appropriate may exclude 4th graders depending on physical maturation.</p> <ol style="list-style-type: none"> 1) Strong emotions 2) Adult responsibility 3) Sexual behaviors 		
Lyon County School District	<p>Child Assault Prevention Project in Washoe County provides students with information about good touch/bad touch and preventing child assault. The Project is providing instruction to second graders this year with hope to expand in the future. They focus on teaching that students have the right to be safe,</p>	<p>Sex education curriculum is currently being revised</p>	<p>Sex education curriculum is currently being revised</p>	<p>Sex education curriculum is currently being revised</p>

	strong, and free. They also teach students to take three giant steps away from danger and help them identify three safe adult helpers to turn to when they are uncomfortable.			
Mineral County School District	The counselor has visited K and 1st grade classrooms to specifically discuss these issues. Our counselor has identified a specific program focused on good/bad touch, reporting, understanding, etc. that he can integrate into his current program. I've told him to see our ES principals about ordering the program, so I expect this should be in place shortly.	The counselor works with all of our ES students with formal curriculum on empathy, problem-solving, consequences, reporting issues to adults, assertive problem resolution, etc. The sexual-related issues come up within the context of the general decision-making curriculum, but there is not an explicit unit on these issues.	There have been community programs with speakers for JHS in the past, but not in the last two years.	Child abuse not a formal part of Health class curriculum though does come up as discussion topic. There have been community programs with speakers for HS in the past, but not in the last two years.
Nye County School District	<i>The Great Body Workshop</i> curriculum- Personal Safety chapter that starts in Kindergarten and appropriately goes up to 5th grade.	<i>The Great Body Workshop</i> curriculum- Personal Safety chapter that starts in Kindergarten and appropriately goes up to 5th grade.	<i>The Puberty Workshop</i> and curriculum and in one of the video's it talks about those same topics listed above	Relationships Curriculum in a Box for our High Schools along with other pamphlets from Channing Bete about healthy dating relationships. They cover topics about dealing with types of Abuse and Sexual Harassment

	<p>It starts with:</p> <ul style="list-style-type: none"> · Safe and unsafe touches · Private body parts · Types of touches · How to yell and tell · Refusal skills · Safe, unsafe, and confusing touches · Practicing personal safety · Using refusal skills · Types of abuse · Right to privacy · Sharing with a trusted adult · Personal safety · Sexual harassment · Assertiveness 			
Pershing County School District	They are including some content objectives in the revision of the HIV/sexuality curriculum, but not a formal program.			
Storey County School District	<ol style="list-style-type: none"> 1. Child Assault Prevention of Washoe County present, annually, a one hour classe to 1st/3rd grades at Hugh Gallagher Elementary and 1st/2nd grades at Hillside Elementary. 	Counselor led guidance lessons (K-5 th) in March to prepare the students for April's Child Abuse Awareness Month as mentioned previously.		

	<p>2. Counselor led guidance lessons (K-5th) in March to prepare the students for April's Child Abuse Awareness Month. The guidance lessons inform the students as to what child abuse can look like (Physical, Emotional, Neglect and Sexual/Bad Touch) and what they can do if they or someone they know is being abused. At the end of the guidance lessons the students make "Pinwheels for Prevention", which are then displayed in the schools and in many locations in the community. The counselor says, "The kids look forward to making the</p>			
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	<p>pinwheels each year (this was my third year doing it) and although this is tough and difficult subject to discuss I find that making the pinwheels helps to deliver the message in a fun and engaging way.”</p>			
<p>Washoe County School District</p>	<p>Counselors teach Better Safe than Sorry in grades K, 1, 3.</p> <p>They also arrange and co-facilitate: Child Assault Prevention in grade 2.</p>	<p>Counselors teach Better Safe than Sorry in grade 5.</p> <p>They also arrange and co-facilitate: Child Assault Prevention in grades 4 and sometimes 6.</p> <p style="text-align: center;">4th grade SHARE</p> <ul style="list-style-type: none"> • Lesson 4 Peer Pressure and Refusal Skills, Identifying Risky Behaviors, Refusal Skills, Recognizing and Dealing with Peer Pressure, Steps for Saying “NO” to Trouble. <p style="text-align: center;">5th grade</p>	<p style="text-align: center;">7th grade SHARE</p> <ul style="list-style-type: none"> • Lesson 3- Sexual Responsibility, Abstinence, Building Relationships, Resisting Peer Pressure <p style="text-align: center;">8th grade SHARE</p> <ul style="list-style-type: none"> • Lesson 1- Relationship Skills, Healthy Relationships, Safety, Respect, Values, Abusive Relationships, Verbal and Abusive Relationships, Sexual Pressure, Refusal Skills 	<p style="text-align: center;">High School SHARE</p> <ul style="list-style-type: none"> • Lesson 7- Sexual Assault, Statistics, Prevention, Awareness

		<p style="text-align: center;">SHARE</p> <ul style="list-style-type: none"> • Lesson 1- Self Esteem and Influences, How Self Esteem Develops, Building a Positive Self-Image, How Self-Esteem influences decision making and risk taking • Lesson 2- Media and Refusal Skills, Media defines, Media Influences, Rising above negative media influences, Refusal Skills and Peer Pressure <p style="text-align: center;">6th grade SHARE</p> <ul style="list-style-type: none"> • Lesson 4- HIV/AIDS Review and Intro to STI (Sexually Transmitted Infections), Prevention, Decision Making, Personal Responsibility, Safety, Non-sexual ways to express love 		
White Pine County School District	No information available			

APPENDIX B NRS 432B.220

NRS 432B.220 Persons required to make report; when and to whom reports are required; any person may make report; report and written findings if reasonable cause to believe death of child caused by abuse or neglect; certain persons and entities required to inform reporters of duty to report.

1. Any person who is described in subsection 4 and who, in his or her professional or occupational capacity, knows or has reasonable cause to believe that a child has been abused or neglected shall:

(a) Except as otherwise provided in subsection 2, report the abuse or neglect of the child to an agency which provides child welfare services or to a law enforcement agency; and

(b) Make such a report as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the child has been abused or neglected.

2. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that the abuse or neglect of the child involves an act or omission of:

(a) A person directly responsible or serving as a volunteer for or an employee of a public or private home, institution or facility where the child is receiving child care outside of the home for a portion of the day, the person shall make the report to a law enforcement agency.

(b) An agency which provides child welfare services or a law enforcement agency, the person shall make the report to an agency other than the one alleged to have committed the act or omission, and the investigation of the abuse or neglect of the child must be made by an agency other than the one alleged to have committed the act or omission.

3. Any person who is described in paragraph (a) of subsection 4 who delivers or provides medical services to a newborn infant and who, in his or her professional or occupational capacity, knows or has reasonable cause to believe that the newborn infant has been affected by prenatal illegal substance abuse or has withdrawal symptoms resulting from prenatal drug exposure shall, as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the newborn infant is so affected or has such symptoms, notify an agency which provides child welfare services of the condition of the infant and refer each person who is responsible for the welfare of the infant to an agency which provides child welfare services for appropriate counseling, training or other services. A notification and referral to an agency which provides child welfare services pursuant to this subsection shall not be construed to require prosecution for any illegal action.

4. A report must be made pursuant to subsection 1 by the following persons:

(a) A person providing services licensed or certified in this State pursuant to, without limitation, chapter 450B, 630, 630A, 631, 632, 633, 634, 634A, 635, 636, 637, 637A, 637B, 639, 640, 640A, 640B, 640C, 640D, 640E, 641, 641A, 641B or 641C of NRS.

(b) Any personnel of a medical facility licensed pursuant to chapter 449 of NRS who are engaged in the admission, examination, care or treatment of persons or an administrator, manager or other person in charge of such a medical facility upon notification of suspected abuse or neglect of a child by a member of the staff of the medical facility.

(c) A coroner.

(d) A member of the clergy, practitioner of Christian Science or religious healer, unless the person has acquired the knowledge of the abuse or neglect from the offender during a confession.

(e) A person working in a school who is licensed or endorsed pursuant to chapter 391 or 641B of NRS.

(f) Any person who maintains or is employed by a facility or establishment that provides care for children, children's camp or other public or private facility, institution or agency furnishing care to a child.

(g) Any person licensed pursuant to chapter 424 of NRS to conduct a foster home.

(h) Any officer or employee of a law enforcement agency or an adult or juvenile probation officer.

(i) Except as otherwise provided in NRS 432B.225, an attorney.

(j) Any person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding abuse or neglect of a child and refers them to persons and agencies where their requests and needs can be met.

(k) Any person who is employed by or serves as a volunteer for a youth shelter. As used in this paragraph, "youth shelter" has the meaning ascribed to it in NRS 244.427.

(l) Any adult person who is employed by an entity that provides organized activities for children.

5. A report may be made by any other person.

6. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that a child has died as a result of abuse or neglect, the person shall, as soon as reasonably practicable, report this belief to an agency which provides child welfare services or a law enforcement agency. If such a report is made to a law enforcement agency, the law enforcement agency shall notify an agency which provides child welfare services and the appropriate medical examiner or coroner of the report. If such a report is made to an agency which provides child welfare services, the agency which provides child welfare services shall notify the appropriate medical examiner or coroner of the report. The medical examiner or coroner who is notified of a report pursuant to this subsection shall investigate the report and submit his or her written findings to the appropriate agency which provides child welfare services, the appropriate district attorney and a law enforcement agency. The written findings must include, if obtainable, the information required pursuant to the provisions of subsection 2 of NRS 432B.230.

7. The agency, board, bureau, commission, department, division or political subdivision of the State responsible for the licensure, certification or endorsement of a person who is described in subsection 4 and who is required in his or her professional or occupational capacity to be licensed, certified or endorsed in this State shall, at the time of initial licensure, certification or endorsement:

(a) Inform the person, in writing or by electronic communication, of his or her duty as a mandatory reporter pursuant to this section;

(b) Obtain a written acknowledgment or electronic record from the person that he or she has been informed of his or her duty pursuant to this section; and

(c) Maintain a copy of the written acknowledgment or electronic record for as long as the person is licensed, certified or endorsed in this State.

8. The employer of a person who is described in subsection 4 and who is not required in his or her professional or occupational capacity to be licensed, certified or endorsed in this State must, upon initial employment of the person:

(a) Inform the person, in writing or by electronic communication, of his or her duty as a mandatory reporter pursuant to this section;

(b) Obtain a written acknowledgment or electronic record from the person that he or she has been informed of his or her duty pursuant to this section; and

(c) Maintain a copy of the written acknowledgment or electronic record for as long as the person is employed by the employer.

(Added to NRS by 1985, 1371; A 1987, 2132, 2220; 1989, 439; 1993, 2229; 1999, 3526; 2001, 780, 1150; 2001 Special Session, 37; 2003, 910, 1211; 2005, 2031; 2007, 1503, 1853, 3084; 2009, 2996; 2011, 791, 1097; 2013, 957, 1086)

APPENDIX C RESOURCES

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