Amer. J. Orthopsychiat. 52(1), January 1982

CHILD ABUSE AND NEGLECT STATUTES: Legal and Clinical Implications

Melvin J. Guyer, Ph.D., J.D.

Family and Law Program, Department of Psychiatry, University of Michigan, Ann Arbor

Each of the 50 states has enacted some version of a "mandatory reporting act," which requires mental health professionals to report instances of suspected child abuse or neglect. Requirements of these statutes may supersede patient-therapist confidentiality in the interest of protecting children. Clinical and ethical dilemmas created for the therapist by mandatory reporting requirements are explored.

The last several decades have seen some dramatic changes in the law as it affects the American family. A number of Supreme Court cases have examined intrafamily relations, and as a consequence there has been an erosion of the tradition of family privacy that had characterized Anglo-American law for centuries.

The famous case, *In re Gault*,[5] for example, established the right of minors facing criminal charges in a juvenile proceeding to due process rights commensurate with those afforded adults. Though *Gault* was a criminal case in the narrow sense, it served the purpose of strengthening the legal rights of children and acknowledged their due process rights in instances that touched upon their "liberty interest." The progeny of *Gault* have led to a considerable expansion of the concept of legal rights of minors in a variety of contexts, both criminal and civil.

An inevitable consequence of this expansion of children's rights has been a collision of the claims of children's advocates on the one hand with the prerogatives of parental authority on the other. This collision of claims is now loudly heard in the courts and legislatures as an attempt is made to find a social policy that fairly balances these competing rights, taking cognizance of changing social realities and values.

Legal contests between parent and child now cover diverse areas, which include privacy rights, right to medical treatment, right to abortions, access to birth control information, and right to an

Submitted to the Journal in February 1980.

0002-9432/82/010073-09$00.75

independent review of a parent's decision to commit a child to a mental hospital.[17]

One especially important aspect of this ongoing emergence of children's rights has been in the area of child abuse and neglect. The new legislation in this area has had broad implications which touch upon some of the most immediate issues concerning the balance of the rights of parents to privacy in the family, the rights of children to be afforded protection by the state from harm inflicted by others, including parents, and the degree to which standards for child-rearing are to be set by state administrative agencies and enforced through judicial proceedings in juvenile or criminal courts.

One fact has become obvious even in the present state of tension between the competing interests of children, parents, and the state: the states, through the mechanism of their child abuse/neglect legislation, have clearly established their power to regulate intrafamily interactions and enforce such regulation by means of restricting or terminating the rights of parents to the possession and custody of their children.

In this advancement of the power of the state to regulate within the family, the mental health practitioner has been "recruited," sometimes willingly, sometimes reluctantly, into the service of the state and its designated administrative and judicial agencies. The means of recruitment has been through the enactment, in every state, of one or another version of what has come to be called a "mandatory reporting law." These laws require that designated professional groups report instances of suspected child abuse/neglect to appropriate authorities or agencies. Such reporting may lead to administrative or court-ordered investigations. This in turn can result in the filing of a formal petition or complaint against a parent and, in effect, a trial on the allegations of abuse/neglect.

Among those groups "recruited" by child abuse/neglect legislation are the mental health specialists. The reasons for this are evident. In the course of their work with families, they become privy to information that is useful in detecting or signaling the presence of an abuse/neglect problem in a family. Although the obligation to report is intended to be in the service of children, the mandatory reporting acts, their administration and their judicial interpretation have created a number of dilemmas, both clinical and ethical, for the mental health practitioner. This is especially so for those professionals whose activities include providing psychotherapy or counseling to clients who voluntarily seek treatment. The mandatory reporting acts, which specify an intrusion into the privacy of the family in the service of its children, necessarily intrude upon another sort of privacy—that which has traditionally existed between patient and therapist. This latter invasion has been subject to close examination on the part of individual therapists, notwithstanding the "mandatory" nature of the reporting acts, with respect to whether, when, and under what circumstances they will comply with "the letter of the law."

Before undertaking a review of the legal-historical background of the existing child abuse/neglect legislation to see how it affects the various professions required to report, several of the

broad issues it raises for the mental health practitioner will first be mentioned.

CLINICAL ISSUES

The most central issue raised by the new mandatory reporting acts involves their abrogation of the privileged or confidential nature of communications that take place in the context of the therapeutic or counseling relationship. For many, this confidentiality is seen as an essential aspect of the therapeutic interaction, providing the patient with an assurance of privacy and a sense of trust, which permit the most open and intimate expression of thoughts and feelings. Such free expression by the patient is generally regarded as a necessary condition for a successful course of psychotherapy. The mandatory reporting acts, by conditioning this confidentiality at least in some circumstances, thereby weaken one of the foundations upon which the therapeutic relationship is constructed.

An especially difficult situation arises when, in the therapist's judgment, the psychotherapy with an abusing parent is in the long-range service of the child of that parent. In such an instance it may be that the act of reporting, while serving the *letter* of the mandatory act, does so at the expense of the *intent* of the legislation. It is this circumstance that creates the most difficult dilemma for the therapist, both legally and clinically. One can always be "conservative," abdicating individual professional judgment to legislative decree, and automatically report suspected abuse/neglect. Alternatively, the therapist can attempt an independent and individual assessment of the special factors in any particular instance and make a discretionary judgment as to whether or not reporting should be undertaken. Of course, it is just this sort of discretion that legislatures wished to deny to those professionals covered by the reporting acts. One needn't look far for the reason. The intent of the legislature in removing discretion to report is to remove the therapist from the sort of conflict of interest situation that arises when the interests of the patient are in partial or total opposition to those of some third party.

Traditionally, little or no duty to third parties has been recognized by mental health practitioners, the "best interests" of the individual patient serving as the sole standard for the professional conduct of the therapeutic interaction. Though the law in effect has spoken, professional judgment and personal ethics still foster individual deliberation. This in turn creates and calls for an assessment of a number of clinical issues, since clinical consequences must certainly enter the calculus of discretion which the professional chooses to reserve to himself. These will be discussed in somewhat greater detail later in this paper. We turn next, however, to a review of mandatory reporting legislation; this may serve to inform some of the considerations affecting the clinician's decision to report suspected child abuse or neglect.

THE SOCIAL CONTEXT

The American social consciousness has only recently become concerned with the problem of child abuse and neglect as a "societal" issue. While there is little question that, in the context of the family unit, some children have always

been subject to abuse it has not been *perceived* as a national problem requiring state intervention and the formulation of a public policy. (It should be noted that "spouse abuse" is an event of even more recent impact upon the national conscience.) Prior to the last few decades, the protection of children from intrafamily abuse came about only through the exercise of informal mechanisms of social control unbuttressed by formal state involvement. Traditionally, other family members, neighbors, and townspeople, church, and community leaders served as a child's line of defense against abuse/neglect.

The absence of formal intervention by the authority of the state reflected the long tradition of Anglo-American legal history in which parents were delegated virtually total discretion over matters within the family. More precisely, consistent with the patriarchical character of English society, the delegation of authority over children by the state (crown) was made to the father of the family. The family existed, for centuries of English law, as an almost indivisible legal entity. Thus, for example, one member of a family could not bring a civil action against another in court—allowing intrafamily suits was seen as little different than allowing an individual to sue himself. (It is only recently that the doctrine of intrafamily immunity to tort actions has been struck down in state jurisdictions in this country.)

The problem of "child neglect" presents special difficulties and is of more recent vintage than child abuse as a matter of social concern. The term "neglect" has come to constitute a broad rubric incorporating a conglomeration of acts of omission. In attempting to articulate its definition, the community seeks to establish minimal thresholds of acceptable child-rearing conduct and standards for the physical environment provided for children. Sometimes, disturbingly, this process of definition-seeking touches upon differences in manners, folkways, and mores among the heterogeneous social and ethnic groups that comprise American society. This spectre of cultural relativity poses the risk that subjective, class-based social preferences regarding child-rearing practices will become legislatively, judicially, or administratively incorporated into the body of law that controls intrafamily interactions. The special problems created by attempts to broadly and categorically define "neglect" will be returned to later in this discussion. For the present, it should be noted that courts in a number of jurisdictions are beginning to give close scrutiny to interventions into the family by state and county agencies when such interventions are triggered by administratively imposed and arbitrarily defined standards of "neglect." For example, the New Jersey Supreme Court, in *Dow vs. Downey*,[3] held that a parent's failure to provide an "adequate education" to her three-year-old child was not a sufficient basis for the child's removal from the home and return of the child was ordered. In a similar vein, the California Court of Appeals held that the state's interference with a "neglectful" parent's right to child custody could be accomplished only upon a stringent ("clear and convincing") standard of proof of neglect. The burden of such proof was placed upon the state social welfare agency.[6]

The concern of the present paper is twofold: First, to provide a description of the *legal* framework of existing child

abuse/neglect legislation, including an overview of its judicial interpretation as defined by recent appellate decisions that set out the ambit of the newly enacted legislation. Second, to address the special problems that mandatory reporting acts create for the mental health professional. These include problems of a clinical, legal, and ethical nature.

CHILD ABUSE STATUTES

Existing legislation dealing with child abuse/neglect has a short history. Most statutes date back only a decade or two.[8,18] It is stated, for example, in an excellent review article,[7] that the *first* child abuse legislation was written at the turn of the century in New York and was of a form much weaker than today's existing legislation. Apparently, the rapid increase of awareness and interest in the child abuse problem was stimulated by the now classic article by Kempe, "The Battered Child Syndrome."[9] The contemporary concern of judges, legislators, and social service agencies has led to the current form which child abuse/neglect legislation has taken: what are referred to as "mandatory reporting acts."

MANDATORY REPORTING ACTS

Present day legislation in the area of child abuse/neglect has as its purpose the identification of instances of child abuse and neglect and, as its policy orientation, providing aid, assistance, and social services to families affected.[7,16] The legal mechanism designed to facilitate the detection of child abuse/neglect, the mandatory reporting act, operates by imposing an affirmative obligation upon the members of various professions to report suspected instances. The particular professions singled out for this obligation differ somewhat from state to state but are intended to include those persons whose professional activities bring them into close and regular contact with children and their families. Typically included are teachers, nurses, social workers, child care workers, physicians, psychologists, and psychiatrists. Commonly excluded, however, are attorneys since long tradition and the constitutional guarantees of "due process" and right to counsel of criminal defendants would be jeopardized if an individual's attorney were required to breach the confidentiality of a client. It should be noted here, and will be returned to more extensively later, that the privilege of communication between physician and patient is not beyond the reach of most abuse/neglect reporting statutes. Unlike the attorney privilege, the physician-patient relationship is not founded upon a fundamental constitutional basis as is the case with the attorney-client privilege.

Since the purpose of mandatory reporting acts is to provide "incentives" so that members of the relevant professional groups will contact the appropriate authorities, the legislation relies upon the traditional legal devices for influencing the behavior of individuals; namely, sanctions. The sanctions available are of two sorts, civil and criminal. In the first instance, through civil sanctions, individuals (or other legal entities) are made liable for any negative consequences, damages, or losses that their proscribed behavior causes to others. The liability is imposed through the setting of a monetary value upon the loss or damage caused to another, and the party held liable is required to pay over to the party that suffered the loss.

This type of sanction is essentially the traditional "tort" action, in which the injuries or loss imposed upon one party through the negligent acts of another are remedied by requiring the negligent party to pay compensation for the losses caused. Many state child abuse/neglect statutes make use of this form of civil sanction to encourage reporting. Members of the designated professional groups are, through this type of incentive, made liable for any losses or injuries resulting from their failure to report suspected instances of abuse or neglect. An illustration of such a civil sanction is found in Michigan's Child Protection Act,[14] where it is stated:

> A person required to report an instance of suspected child abuse or neglect who fails to do so is civilly liable for the damages proximately caused by the failure.[12]

In actual practice, it is difficult to assess the impact upon the reporting behavior of professionals by the aforementioned civil liability created by Michigan's (and other states') Child Protection Act. This writer, for example, knows of no instance, in Michigan, in which a plaintiff has succeeded in obtaining a judgment against a defendant under the civil remedy section of the Act. While there is little question that the mere passage of a mandatory reporting act will increase the rate of reporting, this comes about more through the "raising of consciousness" that such new legislation fosters than through the actual civil liability it creates. It should be pointed out that the legal mechanism of a civil action in tort is somewhat cumbersome and presents an array of problems, which include evidentiary and procedural difficulties.

In the area of child abuse a civil suit has special difficulties. The nominal plaintiff typically is a child who suffered injury at the hands of a parent; thus, it is not likely that the parent could be relied upon to initiate a suit against a third-party professional whose only legal liability arose from a failure to report that parent, as an actual or potential child abuser, to the proper authorities. Another difficulty in relying upon a civil remedy, from a legal perspective, turns on what *standard* of risk, or degree of certainty of harm or threatened harm to a child, must be met before the obligation to report can be reasonably imposed. Certainly, at one extreme the physically battered child brought to an emergency room leaves the attending physician little room to equivocate as to whether or not there is reason to believe that the child is at risk and abuse had occurred. At the other extreme are those instances in which a professional made responsible under a mandatory reporting statute has to make an estimate or prediction of *threatened* harm or injury. Such prediction is difficult for several reasons; the *level* of tolerable risk is not spelled out in any easily quantifiable manner in the statutory language. Michigan's statute, for example, uses the phrase ". . . reasonable cause to suspect child abuse or neglect . . ."[10] Such language places the burden of assessing risk upon the professional but gives little guidance as to just how much concern or "evidence" is required to reach the threshold of "reasonable cause to suspect." In ordinary civil law cases the generally used "reasonable" standard is left for determination, in any specific instance, as a question of fact to be decided by a jury. Juries, in deciding whether a "reasonable" standard has been breached, are instructed to the effect that "reasonable cause to suspect"

means that amount of evidence which would lead a "reasonable man" to have suspected. The obvious circularity of such definitions does little to assist a professional struggling with the decision as to whether to report a specific instance of suspected abuse/neglect. Knowing that, potentially, a jury might second-guess the quality of the decision according to what a "reasonable man" would have done in similar circumstances is of little help.

A second problem accompanying the "reporting" decision-process involves the ability of professionals to make valid and accurate predictions of future behavior, including determinations of prospective risks, on the basis of clinical observations and assessments of current circumstances.[1,2] While it is obvious that some situations leave little doubt as to the risk to which a child is subjected, the gradient of certainty falls off when one is called upon to evaluate the threat of future emotional harm that might result from ill-defined "emotional neglect." It is in this latter situation that the mental health practitioner must confront the clinically and legally difficult tasks of balancing the respective costs vs. benefits of reporting an instance of suspected emotional neglect. A fair balancing requires, at a minimum, some information concerning the impact upon family and child of reporting as against not reporting. Especially so when the balancing must be undertaken where a therapeutic alliance has been established between the professional and the person whom he might report.

In its most difficult stance, the problem of noncompliance with a mandatory reporting act is presented when the professional, in good faith, believes that the net consequences of reporting would be more detrimental to the child than failure to report. The issues to be grappled with here are ethical, legal, and clinical. The consequences of each case makes any simple rule of thumb a poor guideline for action. For the individual mental health practitioner, it is very much an individual decision whether to comply with a mandatory reporting act. Further, with only a civil sanction as the penalty for failure it is not difficult to make the judgment in certain cases that the interests of the child (and perhaps the professional as well) are best served by not reporting. Consequently, while the enactment of mandatory reporting acts incorporating civil sanctions have greatly increased the frequency of reporting, it is evident that considerable discretion is being exercised by those whose reporting, in keeping with the intent of the legislation, is to be removed from the realm of individual discretion. This has led some jurisdictions to rely upon criminal as well as civil sanctions. Michigan's Child Protection Law provides an example of this buttressing of sanctions. Michigan's mandatory act, with its civil sanction cited above, was enacted in 1975. In 1978, several revisions were made in the 1975 law,[15] one of which was the addition of a criminal sanction. The statute now includes the following language:

> A person required to report an instance of suspected child abuse or neglect who *knowingly* fails to do so is guilty of a misdemeanor.[13]

This new language is intended to decrease the incidence of nonreporting, that is, to eliminate the exercise of whatever individual discretion is still being exercised in spite of the mandatory reporting requirements. There is little doubt that the addition of a criminal

sanction will increase the rate of reporting. Unlike the civil sanction, the criminal one does not rely upon a private party to initiate a legal action. It avoids, too, the various expenses associated with civil actions (*i.e.*, retaining counsel, discovering evidence, etc.). Instead, it is the obligation of public law enforcement officials to enforce the criminal sanction, and they may do so even though there is an inability or reluctance on the part of the "plaintiff" to pursue a civil remedy. In addition, a criminal sanction carries with it a societal expression of moral condemnation that is not associated with a civil sanction.

Confidentiality

For the mental health practitioner, mandatory reporting acts create a conflict between the private confidential nature of the psychotherapeutic process and the requirement to report instances of child abuse/neglect. In its most difficult form this dilemma arises when, during the course of psychotherapy, the therapist learns that a patient is currently engaging in child abuse. Such a revelation creates a clinical crisis and can place the therapist upon the horns of a dilemma. If the admission is reported, the therapist in effect becomes a witness against his patient and the therapeutic alliance may be destroyed, to the ultimate detriment of the child as well as the patient-parent. Alternatively, failure to report places the therapist squarely in opposition to the letter of the law and opens him to the sanctions previously discussed.

The language of the typical reporting statute comes down squarely *against* preserving confidentiality. The Michigan statute, for example, deals with the confidentiality question in the following manner:

> Any legally recognized privileged communication except that between attorney and client is abrogated and shall neither constitute grounds for excusing a report otherwise required to be made nor for excluding evidence in a civil child protective proceeding resulting from a report made pursuant to this act.[11]

It is clear that the letter of this law leaves no loophole preserving the usual patient-therapist confidentiality. Thus, the legal dilemma is lessened and the focus of attention must more appropriately shift to the clinical considerations and management of the reporting obligations. Several points may be of use in providing guidance so that the clinical process can be made to accommodate the strictures placed upon it by the mandatory reporting acts. Several options are available to the clinician-therapist:

1. One can make the decision in any particular instance to ignore the requirement of a reporting statute. In effect, one can engage in "civil disobedience," ignoring the letter of the law in service of a higher ethical imperative.

2. One can inform each patient, at the outset of treatment, of the reporting obligation. This serves to put the individual "on notice" and any subsequent need to report will not be perceived as a betrayal of the confidentiality of the therapeutic relationship.

3. One can use the obligation to report, in the context of the therapeutic relationship, to "coerce" a patient to stop abusive behavior by indicating that failure to stop will require that the therapist comply with the letter of the law.

4. One can simply comply with the mandate of the reporting law and deal with the therapeutic consequences on

an *ad hoc* basis since the particular consequences of reporting are in most instances not easily anticipated.

CONCLUSION

The foregoing discussion has attempted to set out the nature of the recently enacted mandatory reporting acts and some of the difficulties they create for the mental health practitioner. An issue implicit in this discussion concerns the moral obligation that a therapist owes to third parties. In the present context this refers to the children suffering abuse or neglect at the hands of parents in treatment. This problem has begun to be addressed in an analogous context as exemplified by the famous *Tarasoff vs. Regents of California et al* case.[19] There, the Supreme Court of California held that a therapist, under certain circumstances, does owe an obligation to third parties which outweighs the duty to preserve the confidentiality of the therapeutic relationship.[4] Certainly, the California decision must be regarded as a national bellwether, and the problems that *Tarasoff* created for therapists are little different than those that are now arising from the enactment of mandatory reporting acts. It is evident that shifting public policy is calling for an intrusion by the state into the previously sacrosanct relationship between patient and therapist. The ability of therapists to deal fairly and reasonably with this shift in policy may well affect whether further intrusions will be legislatively or judicially mandated.

REFERENCES

1. COCOZZA, J. AND STEADMAN, H. 1974. Some refinements in the measurement and prediction of dangerous behavior. Amer. J. Psychiat. 131:1012–1014.
2. COCOZZA, J. AND STEADMAN, H. 1976. The failure of psychiatric predictions of dangerousness: clear and convincing evidence. Rutgers Law Rev. 29:1084–1101.
3. *Dow vs. Downey*, 3 FLR, 3179 (1977).
4. FLEMING, J. AND MAXIMOV, B. 1974. The patient or his victim: the therapist's dilemma. Calif. Law Rev. 62:1025–1068.
5. *In re Gault*, 387 U.S. 1 (1967).
6. *In re Terry D.*, 148 CAL RPTR 221 (App. 1978); Juv. Law Digest, 10, 11–309–312 (Nov. 1978).
7. KATZ, S. ET AL. 1977. Legal research on child abuse and neglect: past and future. Fam. Law Quart. 11(2):151–184.
8. KATZ, S., HOWE, R. AND MCGRATH, M. 1975. Child neglect laws in America. Fam. Law Quart. 9(1):1–362.
9. KEMPE, H. 1962. The battered child syndrome. JAMA 181:17–24.
10. Michigan Complied Laws Annotated, Section 722.623(1).
11. Michigan Compiled Laws Annotated, Section 722.631.
12. Michigan Compiled Laws Annotated, Section 722.633(1).
13. Michigan Compiled Laws Annotated, Section 722.633(2).
14. Michigan Public Act 1975 No. 238.
15. Michigan Public Act 1978 No. 252.
16. NAGI, S. 1975. Child abuse and neglect programs: a national overview. Child. Today 4(3):13–17.
17. *Parham, Commissioner, et al. vs. J. R. et al.*, 442 U.S. 584, 99 S.Ct. 2493 (1979).
18. SUSSMAN, A. 1974. Reporting child abuse: a review of the literature. Fam. Law Quart. 11:245–313.
19. *Tarasoff vs. Regents of California, et al.*, 131 CAL RPTR 14; 51P 2d 334 (CAL. 1976).

For reprints: Melvin J. Guyer, Ph.D., J.D., Children's Psychiatric Hospital—Box 052, University of Michigan Medical Center, Ann Arbor, Mich. 48109