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LEGAL ISSUES IN MANAGING CHILD ABUSE PROGRAMS: AN ATTORNEY'S PERSPECTIVE

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LEGAL ISSUES IN MANAGING CHILD ABUSE PROGRAMS: AN ATTORNEY'S PERSPECTIVE

When child abuse programs are established in children's hospitals, a number of legal issues arise. Typically those of special concern to psychologists involve questions of informed consent, psychological evaluations of parents that may be used in litigation, child abuse reporting laws and the limits of confidentiality, and liability for negligence in evaluating situations of possible maltreatment. However, there are other legal issues that also affect the success of the program: the development and implementation of hospital procedures for evidence collection and clinical interviewing that minimize pain and stress for the child and family; the development of interagency protocols between the program and those public agencies responsible for investigating, prosecuting, and ameliorating child maltreatment; the cultivation of amicable relationships between the program staff and attorneys who are regularly involved in these cases; and establishment of a quality assurance program and other steps to manage risk of liability for the hospital.

To illustrate how a number of these interact, let us imagine a situation in which a three year old child is brought to the emergency room because her father, who has visits with her only on the weekend and lives in a neighboring county, suspects that she has been molested by her step-father. The father is extremely upset and is making vague threats of what he might do to the step-father, but the child appears calm and rather disinterested. The father describes continued conflict with his ex-wife over custody and visitation, and reports that her attorney intimidates medical and mental health professionals into withdrawing their reports to child protective services agencies. The father therefore insists that if the staff believe that the child has been molested, they must discuss it with his attorney prior to reporting it to the child protective services agency or police. The emergency room staff do not know whether the non-custodial father can provide informed consent for the child to be medically examined and interviewed regarding the alleged sexual abuse, whether the father should be evaluated for possible psychosis, whether the step-father must be warned or the police notified of the father's threats, and whether the father's wishes regarding the report to his attorney must be honored. They are also concerned that the mother and the step-father might sue the hospital for battery, invasion of privacy, defamation, and negligence.

In analyzing this illustration, let us begin by saying that in an emergency situation, a non-custodial parent clearly has lawful authority to provide informed consent for medical and mental health services for his/her child. The issue is whether an emergency exists, and the answer to that question may depend on how soon the child's visit will end and the type of maltreatment that has occurred and may allegedly reoccur. The hospital could be sued by the mother for an unauthorized medical examination (battery) or for interference with her custody if it relies on an erroneous belief that the father has lawful authority to provide informed consent; on the other hand, if the hospital decides that the non-custodial parent has no authority to

provide informed consent, the hospital could be sued by him or by the child through a court-appointed "next friend" for failure to protect the child from additional maltreatment if that occurs. There is no unequivocal answer as to whether the father can provide informed consent, but as an element of risk management, the program may have a policy that encourages the staff to accept the non-custodial parent's informed consent as valid, since it is more likely that the hospital would be sued for failure to protect the child than for unauthorized services or for interference with custody.

If the staff can provide services, the second issue is the quality of their medical examination and the interview with the child. Frankly, the task of devising a good protocol for the medical examination and evidence collection and having it routinely followed by the medical staff is one of understanding the hierarchy of the hospital and the procedures used to approve medical procedures, of providing ample references from other institutions' protocols and the forensic literature, and of identifying allies among physicians and nurses, especially in the emergency room, outpatient clinic, adolescent clinic, radiology, laboratories.

It is also important to work with the hospital's attorney in this process. A protocol is evidence of the hospital's standard of care, and the physician who testifies in a child maltreatment case may be questioned about the reasons why certain steps were included in lieu of alternative procedures and the forensic significance of the results. Since it reflects a standard of care, the protocol will be especially relevant to claims of negligence in failing to report child maltreatment or in inappropriately reporting situations that were not maltreatment.

Standardization of interviewing procedures is similarly important. Guidelines for interviewing the allegedly maltreated child help minimize allegations that the interviewer was biased, was leading the child into making false accusations, or was otherwise creating a situation where the veracity of the account may be questionable. Such standardization should take into account at least the following four situations, which affect the extent to which the interviewer is acting as an investigator and the extent to which the credibility of the child must be explored:

1. The child has already disclosed the maltreatment to an investigator from an official agency;
2. The child has already disclosed the maltreatment to another medical or mental health professional consulted for evaluation or treatment;
3. The child is the subject of custody litigation (e.g., attorneys are already involved); and
4. The child is silent or is too young to give a narrative based on free recall.

The interviewing protocol should discuss the use and non-use of dolls with sexual features, puppets, drawings, standard psychological tests, video tape or audio tape, etc. from the standpoint of their validity

and reliability in ascertaining whether maltreatment has occurred and the admissibility and relevance of the results in legal proceedings. For example, a videotaped interview of the child cannot replace a child's testimony in court since it is hearsay, but it may be admissible in addition to the child's testimony. Knowledge of this difference can help the interviewer in discussing the case with the parent and the need for preparing the child to testify if the official investigation leads to the initiation of court proceedings.

Both the medical and inteviewing protocols should discuss the importance and style of documentation, and should make it clear that when the professional deviates from the protocol, he/she should be prepared to justify the deviation in court, and to vouch for the accuracy of the results of the procedures actually followed. At this point it is obvious that it is also important for the program to have a quality assurance program that reviews all of the program's cases for adherence to the protocols and considers protocol adherence in staff performance reviews. It is also obvious that the program needs an active research component that collects and evaluates the data emanating from the protocols to help identify those areas that may need revision.

Occasionally in the course of providing services to a child, it becomes apparent that a parent is mentally ill. This may create conflict between the child protection unit and other hospital staff. From the child protection program's perspective, the issues are whether the parent's mental or emotional problems so clearly detract from the parent's ability to adequately care for the child that (1) it must be reported as neglect and (2) the child should not be discharged to the parent. From the perspective of the physicians and nurses, the issue is how to keep the parent from being disruptive or interfering with treatment. From the perspective of the hospital administration, there are a number of issues. First, the state child maltreatment law may not give the hospital authority to admit an allegedly neglected child into inpatient status over parental objection, which may subject the hospital to liability for false imprisonment if it admits the child; conversely, the hospital may face imputations of negligence if releases the child and the parent injures him/her. Another issue is whether the hospital is licensed to provide mental health services to adults and whether the parent consents to have the screening evaluation performed by its staff; a negative answer to either may mean that a request should be made to an appropriate public agency to perform such an evaluation over the parent's objection. Further, the hospital may have concerns about whether the parent was competent to provide informed consent and whether the concern regarding the parent's mental status is documented in a potentially libelous fashion.

Both hospital administrative and professional staff are generally conversant with the legal obligation to report their reasonable belief that a child is abused or neglected to an appropriate governmental agency. State child abuse reporting laws typically provide immunity from suit for making a report of child abuse in good faith which turns out to be unsupported. Such immunity is not absolute, however. The

professional may still be liable for negligence in failing to exercise due care in considering whether the belief that maltreatment existed was a reasonable one before having reported the case to child protective services. Unfortunately, medical and mental health professionals frequently lack knowledge of what constitutes reportable maltreatment. For example, some physicians and nurses apply a standard of parenting based on middle class family life, and are likely to view a hospitalized child whose parent doesn't visit as neglected. The child protection unit can be helpful as a consultant to screen these concerns to make sure that the belief that the child is abused or neglected is reasonable, based on experience with the investigating agencies' requirement that the parent have failed to meet a minimum--not an optimal--standard of parenting. In the example here, the parent may have failed to visit because he/she has no transportation, or cannot get a babysitter for other young children in the family. The consultative role of the child protection unit can thus reduce the potential for hospital liability.

Along the same lines, hospital administrative and professional staff are generally unfamiliar with the roles and procedures of the child protective services and law enforcement agencies in the immediate area, let alone those from outlying areas. Frequently hospital staff assume that every maltreated child will be removed from the parents, placed in foster care, and have all visiting privileges terminated. However, an important mandate of child protective services agencies is to provide supportive and ameliorative services to families to avoid the necessity of foster care. The agency may expect the nurses to be monitoring parental visits to a hospitalized child and documenting the parent-child interaction for the agency to use in formulating a case plan. Frequently there is confusion as to whether the agency may receive hospital records without a subpoena; it may as a part of the original report, but thereafter a subpoena is required.

The child protection unit can develop and maintain cooperative relationships with those agencies that will benefit the hospital. For example, it is advisable for the unit to circulate the drafts of protocols and their revisions to such investigative agencies for comment, and to make sure that the final version is disseminated to them. The child protection unit can apprise the child protective services agency of the anticipated date, time, and home care needs of maltreated children awaiting discharge to foster care to avoid an unnecessarily long hospital stay. If the child protection unit will insure that all records and staff are immediately provided in court when needed, County attorneys are generally willing to subpoena hospital staff on an "on call" basis so that they go to court only when their testimony is needed, which minimizes disruption of hospital acitivities.

In the case of the father and his allegedly sexually molested child, the development of interagency policies on allegations of child maltreatment in custody disputes will enable the staff to deal with the father's request regarding his attorney's involvement and the concerns about the father's threats towards the step-father. (As a

general rule, the hospital should not accede to such a request since its primary obligation is to report to the child protective services agency.)

Finally, the child protection unit must become knowledgeable about the laws regulating confidentiality of the jurisdiction. For example, if the jurisdiction has a statute protecting medical and mental health records from disclosure in criminal proceedings, neither the prosecutor nor the attorney representing an individual accused of maltreating a child is not entitled to the child's medical or mental health records just because the attorney subpoenaed them. If the subpoena was not accompanied by a release signed by the child's parent, the hospital cannot comply since it would violate its fiduciary duty of confidentiality to the patient. Instead, the hospital should file a motion to quash the subpoena and make a copy of the records to be preserved under seal of court. The judge will review the records and authorize disclosure of only those portions relevant to the proceedings. In custody disputes a parent may want the hospital to deny the other parent access to the child's records, but the parent should be informed that this will be a fruitless gesture, since every jurisdiction has the requirement that both parties in a civil lawsuit have access to all evidence under the control of the other party.

This brief overview illustrates the complexity of legal issues in the functioning of child protection programs in children's hospitals. Psychologists in such programs should become familiar with the more common legal issues, and should seek the assistance of an attorney for guidance in program development and whenever a particular legal problem arises.