

# Mandatory Reporting of Child Abuse and Research on the Effects of Prenatal Drug Exposure\*

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## INTRODUCTION

Research on the effects of prenatal drug exposure raises several serious legal issues. Many of these issues, such as informed consent and human subjects protection, have been explored extensively elsewhere and are not discussed here.<sup>1</sup> Instead, this chapter examines one important question that arises in this specific context, namely: Does prenatal drug exposure fall under mandatory child abuse reporting laws? Or to put it more directly, must researchers report the prenatal drug abuse revealed in their studies? A review of the applicable laws and court decisions indicates that, in most States, the answer is a qualified yes.

## MANDATORY REPORTING LAWS

All States have laws that require an array of professionals to report suspected child abuse and neglect. *Most professionals who serve children are required to report.* In every State, those required to report include physicians, nurses, emergency room personnel, coroners, medical examiners, dentists, mental health professionals (sometimes specified as "psychologists" or "therapists"), social workers, teachers and other school officials, day-care or child-care workers, and law enforcement personnel. In some States those required to report include pharmacists, foster parents, clergy, attorneys, day-care licensing inspectors, film or photograph processors (largely to detect cases of sexual exploitation), substance abuse counselors, counselors and staff at children's camps, family mediators, staff and volunteers in child abuse information and referral programs, and "religious healers" (usually Christian Science practitioners) (Besharov 1990, p. 24). Each year other professions are added to the list.

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\*SOURCE: Adapted from Besharov 1990

*Everyone must report in some States.* About 20 States require a report from any person who has reason to believe that a child is a victim of abuse or neglect, regardless of their professional status or relation to the child. This would include researchers. According to the National Center on Child Abuse and Neglect, as of 1988, the States that required all persons to report were Connecticut, Delaware, Florida, Idaho, Indiana, Kentucky, Maryland, Minnesota, Mississippi, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, Oklahoma, Rhode Island, Tennessee, Texas, Utah, and Wyoming.<sup>2</sup>

Of course, even those persons not legally required to report may do so. In all States, anyone *may* report suspected child abuse or neglect. Anonymous reports also are accepted in all States.

*Reporting is an individual as well as an institutional responsibility.* Most reporting laws do not lift the reporting obligations of staff members when they notify their superior of suspected child maltreatment. Therefore, staff members still may be civilly and criminally liable for not reporting if they knew or should have known that no report was made. Staff members who are falsely told that a report was made will have a defense against liability unless they knew or should have known that this was untrue.

## REPORTABLE SITUATIONS

*All forms of child maltreatment must be reported.* The Federal Child Abuse Prevention and Treatment Act of 1974 requires States to provide for the reporting of all forms of maltreatment to receive special grants.<sup>3</sup> The act provides that "child abuse and neglect" means the physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child . . . under circumstances which indicate that the child's health or welfare is harmed or threatened thereby . . ."<sup>4</sup>

This definition makes reportable *any parental act or omission that harms a child or threatens to do so*. As a result, just about every State now requires the reporting of all forms of physical, sexual, and emotional maltreatment. Reportable child maltreatment includes:

- Physical abuse: physical assaults (such as striking, kicking, biting, throwing, burning, or poisoning) that caused or could have caused serious physical injury to the child
- Sexual abuse: vaginal, anal, or oral intercourse; vaginal or anal penetrations; and other forms of inappropriate touching or exhibitionism for sexual gratification

- Sexual exploitation: use of a child in prostitution, pornography, or other sexually exploitative activities
- Physical deprivation: failure to provide basic necessities (such as food, clothing, hygiene, and shelter) that caused or over time would cause serious physical injury, sickness, or disability
- Medical neglect: failure to provide the medical, dental, or psychiatric care needed to prevent or treat serious physical or psychological injuries or illnesses
- Physical endangerment: reckless behavior toward a child (such as leaving young child alone or placing a child in a hazardous environment) that cause or could have caused serious physical injury
- Abandonment: leaving a child alone or in the care of another under circumstances that suggest an intentional abdication of parental responsibility
- Emotional abuse: physical or emotional assaults (such as torture and close confinement) that caused or could have caused serious psychological injury
- Emotional neglect (or "developmental deprivation"): failure to provide the emotional nurturing and physical and cognitive stimulation needed to prevent serious developmental deficits
- Failure to treat a child's psychological problems: indifference to a child's severe emotional or behavioral problems or parental rejections of appropriate offers of help
- Improper ethical guidance: grossly inappropriate parental conduct or lifestyles that pose a specific threat to a child's ethical development or behavior
- Educational neglect: chronic failure to send a child to school (Besharov 1990, p. 30)

The Federal Child Abuse Act contains an important limitation: Reportable situations are those in which "the child's health or welfare is harmed or threatened thereby." The injury must be sufficiently *serious* so that there is a danger to the child's health or welfare.<sup>5</sup> This limitation is meant to protect the rights of parents to exercise their best judgment about how to raise children and to protect regional, religious, cultural, and ethnic differences in such beliefs. It

means, for example, that parents who allow their children to watch hours of television are not considered neglectful, although many people think that the children would be better off doing something else. It also means that, absent specific legislation, a parent who is abusing drugs should not be reported unless there is reason to believe that the child is or will be seriously harmed thereby. Thus, for example, use of marijuana on weekends—in a way that does not seem to affect the child—is not generally reportable. (The few States that seem to require reports of such casual or recreational drug use are discussed below.)<sup>6</sup>

*"Threatened harm" must be reported.* Society does not wait until a child is seriously injured before taking protective action. The Federal Child Abuse Act states that reports and authorizes agency and court intervention to prevent future harm. Although statutory provisions vary, they commonly require action if a child "lacks proper parental care," is "without proper guardianship," has parents "unfit to properly care" for him or her, or is in an "environment injurious to his welfare." Such provisions authorize intervention before the child has been seriously injured, and even before he or she has been abused or neglected. Hence, injury is not a prerequisite to a report; abuse must be reported to the authorities if children are in danger of serious injury.

*Only "reasonable suspicion" is needed for a report.* Because of the difficulty in obtaining information about a child's maltreatment, reporting laws do not require potential reporters to be certain that a child is being abused or neglected or to have absolute proof of maltreatment. In all States, reports are to be made when there is "reasonable cause to suspect" or "reasonable cause to believe" that a child is abused or neglected.<sup>7</sup>

Requiring only reasonable suspicions of abuse relieves potential reporters of the need to make a final or definitive diagnosis of maltreatment, which usually requires a home visit, interviews with parents, and further investigation. After a report is made, the child protective agency is responsible for determining the child's true situation and, if protective intervention is needed, for taking appropriate action.

#### **LIABILITY FOR FAILURE TO REPORT**

*Almost all States have a specific law making it a crime not to report suspected child abuse and neglect.* Even in those that do not, the failure to report may be a crime under general criminal laws.<sup>8</sup> The criminal penalty is usually of misdemeanor level, with the potential fine ranging from \$100 up to \$1,000 and/or imprisonment ranging from 5 days up to 1 year in jail. Criminal prosecutions for not reporting have been brought against doctors,<sup>9</sup> psychiatrists,<sup>10</sup>

psychologists,<sup>11</sup> teachers (in one case, a nun),<sup>12</sup> social workers,<sup>13</sup> spouses,<sup>14</sup> and friends of the family.<sup>15</sup>

*There is also civil liability for failing to report.* A specific statute may establish civil liability for the failure to report. Under the common law, the violation of a statutory duty, in this instance the required reporting of suspected abuse and neglect, may be "negligence per se." No legislation specifically creating civil liability is needed; the failure to comply with a statutory mandate establishes the negligence.<sup>16</sup> In other situations, the negligent failure to report may be considered professional malpractice.

Criminal and civil liability can be based on circumstantial evidence, such as the child's "suspicious" or "apparently inflicted" injuries. In Los Angeles, for example, a doctor—who apparently knew that a 3-year-old child previously had been removed from her mother's custody—was prosecuted for not reporting repeated evidence of severe abuse. According to court documents, the doctor did not report evidence of abuse, which included "old burns on the chest and left leg, and the absence of the nasal . . . septum." His defense was that he wanted to "give the mother a chance" to avoid further contact with social service workers, and that he had attempted to treat the child in his office and at her home. "Thirteen days after [he] began treating her, she died of a massive chest infection resulting from pneumonia."<sup>17</sup> The doctor entered a no contest plea to involuntary manslaughter.<sup>18</sup>

*Liability can be extensive and long-lived.* Whatever theory of liability is applied, when the person who allegedly failed to report was employed by an agency or organization, the agency or organization also may be sued—and invariably is.<sup>19</sup>

Most nonlawyers know that there is a statute of limitations to the bringing of lawsuits. Generally, an action must be filed within 3 or 5 years of when the harm was done. In all but a few States, however, the statute of limitations usually does not take effect against minor plaintiffs until they reach age 18.<sup>20</sup> Thus, the failure to report the suspected maltreatment of an infant may result in a lawsuit up to 21 years later. Of course, an action may be initiated on behalf of a child who is still a minor if it is brought by a legal representative or a duly appointed guardian.

#### **LEGAL IMMUNITY**

*All States explicitly grant immunity from civil and criminal liability to persons who report.* Except in two or three States, immunity applies only to reports made in *good faith*.<sup>21</sup> There is no protection for reports made maliciously because of prejudice or personal bias or because of reckless or grossly

negligent decisionmaking. To reassure potential reporters even more, about half the States have laws that establish a *presumption of good faith*.

### ABROGATION OF PROFESSIONAL CONFIDENTIALITY

Physicians and many social service or mental health professionals, including drug treatment counselors, who are most likely to see abused and neglected children are subject to statutory privileges making their conversations with patients or clients confidential. Ordinarily, they are prohibited from divulging anything told to them within the scope of the privilege, unless the protected person gives permission or the communication involves information about a crime that will be committed in the future.<sup>22</sup> A professional who violates such privileges may be sued by the protected person. Thus, unless the privilege is lifted, many abused children could not be reported.

*Professional confidentiality is not a bar to reporting.* A legal mandate to report presumably overrides any other law creating a privileged communication—especially if the reporting law was enacted after the law creating the privilege. Nevertheless, to remove any question, most State reporting laws contain specified clauses abrogating statutorily created privileges. Some statutes abrogate only the privileges governing professionals required to report; others abrogate all privileges, even if the professionals involved are not required to report. In addition, almost every jurisdiction has a specific provision abrogating all or some privileges for the purpose of participating in judicial proceedings relating to abuse or neglect.

Federal laws also make some conversations and records confidential for schools,<sup>23</sup> drug treatment programs,<sup>24</sup> and alcohol treatment programs.<sup>25</sup> For each, exceptions have been made for reporting suspected child maltreatment. For example, the statutes concerning drug and alcohol treatment programs specify that "the prohibitions of this section do not apply to the reporting under State law of incidents of suspected child abuse and neglect to the appropriate State or local authorities."<sup>26</sup>

However, the rules concerning the release of information under these statutes are complex and vary from community to community.<sup>27</sup> (For further information on this subject, contact the local child protective agency, the particular Federal agency involved, or the US National Center on Child Abuse and Neglect.)

*Families already in treatment must be reported.* Some mental health and social service professionals feel that reporting parents already in treatment violates their ethical obligations toward the parents because, throughout their professional training and careers, great emphasis was placed on guarding the

privacy of their clients. They also fear that reporting the parents to a child protective agency and testifying against them in court may reinforce the insecurity and hostility many abusive and neglectful parents feel and may disrupt the treatment already in progress.

Three or four States give mandated professionals limited discretion not to report but only under extremely restricted circumstances.<sup>28</sup> In all the rest, persons mandated to report have no discretion; they must break confidentiality to report suspected child maltreatment.

### **EXPLICIT REQUIREMENTS TO REPORT PRENATAL DRUG EXPOSURE**

Researchers conducting studies of prenatal drug exposure are likely to belong to the professional groups legally required to report suspected child abuse and neglect. Moreover, in about 20 States, all persons—regardless of any professional status—are required to report. So if the researcher is mandated to report, the question is: Must prenatal drug exposure be reported? Depending on the State, the answer is a qualified yes.

*In a growing number of States, prenatal drug exposure or parental drug use is explicitly made subject to mandatory child abuse reporting statutes. Of those States having a law, the largest number require reporting of newborns who have been exposed to drugs.<sup>29</sup> In general, these States limit reporting to exposure to illegal substances. Sometimes prescription drugs or drugs taken pursuant to chemical dependency treatment programs are expressly excluded from reporting mandates, but most often the exclusion is accomplished by referencing the State's controlled substance statutes.<sup>30</sup> In all States, this apparently includes marijuana,<sup>31</sup> although child protective agencies rarely accept jurisdiction in such cases. One exception to these general rules is fetal alcohol syndrome, now required to be reported in about four States.*

The specified condition of an infant that establishes the duty to report varies among States. Some States require signs of dependence or physical addiction before invoking reporting mandates.<sup>32</sup> This requirement is problematic because of debate about the addictive qualities of cocaine. Others merely require a positive toxicology,<sup>33</sup> which can occur without any signs of dependency. A new development (enacted in one State and pending in others) is a statutory requirement that physicians perform toxicology screens on infants whom they suspect were exposed to drugs.<sup>34</sup>

Parental drug use is the focus of other State laws. Many States have enacted or are considering statutes that identify parental substance abuse as evidence of child abuse or neglect and, therefore, require a report to child protective

agencies.<sup>35</sup> Apparently, no State requires reports of all levels of drug use, no matter how minor. Minnesota, though, requires a physician to:

administer a toxicology test to a pregnant woman under the physician's care to determine whether there is evidence that she has ingested a controlled substance, if the woman has obstetrical complications that are a medical indication of possible use of a controlled substance for a non-medical purpose. If the test results are positive, the physician shall report the results under Section 5. A negative test result does not eliminate the obligation to report under Section 5, if other evidence gives the physician reason to believe the patient has used a controlled substance for non-medical purposes.<sup>36</sup>

Even if statutory mandates do not exist, many States have court decisions that hold that parental substance abuse is evidence of child abuse and neglect.<sup>37</sup>

A growing number of States will accept a report before the child is born to give child protective authorities time to mobilize. At least one State requires such reporting.<sup>38</sup>

#### **IMPLICIT REQUIREMENTS TO REPORT PRENATAL DRUG EXPOSURE**

Most States do not have legislation that explicitly addresses reporting of prenatal drug exposure. Even in these States, though, legal analysis indicates that reports of prenatal drug exposure are required when the exposure suggests that the parent is seriously addicted to a debilitating drug.<sup>39</sup> (The phrase "legal analysis" is used deliberately because there are few court decisions on the subject, and the practice seems to vary even within the same community.)

As described above, a mandated reporter must report when there is reasonable cause to suspect that "the child's health or welfare is harmed or threatened." Thus, the operative legal question becomes: Does prenatal drug exposure create reasonable cause to suspect that the child has been seriously harmed or is threatened thereby? The evidence is clear that, at least sometimes, the answer is yes.

*Severe parental drug or alcohol abuse is a reportable condition because it can so strikingly impair a parent's judgment and ability to cope that serious harm to the child becomes likely. Parents suffering from such severe drug habits that they cannot care for themselves also cannot care for their children.<sup>40</sup> Moreover, there is evidence that drug use can make parents more violent toward their*



children. A Ramsey County Minnesota Department of Human Services report, after reviewing 70 cases of "cocaine-attached" households in mid-1988, found that these parents are "extremely volatile with episodes of 'normal' behavior interspersed with episodes of unpredictable, dangerous and even violent behavior."<sup>41</sup>

In the absence of suitable arrangements for the children of these parents, State intervention is essential no matter how caring such parents may seem. A report should be made, even if the child is not yet harmed and even if the parent has never had custody of the child.<sup>42</sup> To wait until the child shows signs of abuse or neglect would unreasonably endanger many children and, as this chapter describes, may expose the professional to civil or criminal penalties.

There are many degrees of parental incapacity, however, and a prediction of future serious harm to the child—and, therefore, a report—is justified only in cases of regular or continuous drug or alcohol abuse that so severely impairs the parent's judgment or ability to function that future abuse or neglect is likely. Thus, in a statutory construction used in several States, the New York Family Court Act provides that:

proof that a person *repeatedly uses a drug*, or drugs or alcoholic beverages, to the extent that it has or would ordinarily have the effect of producing in the user thereof a *substantial state* of stupor, unconsciousness, intoxication, hallucination, disorientation, or incompetence, or a substantial impairment of judgment, or a substantial manifestation of irrationality, shall be prima facie evidence that a child [is neglected].<sup>43</sup>

Except in those States where any level of drug addiction must be reported, the parents' participation in a treatment or counseling program does not establish that a report should be made;<sup>44</sup> the parent, perhaps with outside help, may be adequately caring for the child.

*Some States consider the harm or threatened harm to the fetus as a form of reportable child abuse.* A pregnant woman who continues illicit drug or alcohol use may give birth to a child with severe problems. Untreated neonatal addiction to heroin, for example, can be fatal. The dangers encountered by heroin babies were described 20 years ago in a New York City case:

[The] baby was born normally without apparent symptoms until 24 hours after birth, [when] the baby began to exhibit unmistakable narcotic withdrawal symptoms; preconvulsive tremors, hyperactivity, incessant crying, ravenousness alternating with

vomiting . . . . Sedatives (phenobarbital), dark and quiet were required for seven days before the child became physically well. Without careful therapy, the child might have suffered convulsions and death.<sup>45</sup>

Neonatal exposure to heroin and methadone, if treated properly, appears to leave no lasting damage. However, cocaine is different because it constricts the blood vessels in the placenta and the fetus, thus cutting off the flow of oxygen and nutrients and creating a higher probability of miscarriages, stillbirths, and premature and low-birth-weight babies, often with various physical and neurological problems. Some cocaine-exposed babies have deformed hearts, lungs, digestive systems, or limbs; others have what amounts to a disabling stroke while in the womb.<sup>46</sup> Death rates may be twice as high for these babies as for others.

For these reasons, courts have held that prenatal exposure is a form of child neglect because it results in "actual impairment" of the children.<sup>47</sup> As one court held: "A new-born baby having withdrawal symptoms is prima facie a neglected baby."<sup>48</sup>

Basing reports on harm (or threatened harm) to the fetus makes many people uncomfortable because it comes so close to the abortion issue. Hence, it is important to mention that there is a second legal basis for reporting prenatal exposure to drugs: *Prenatal exposure can be circumstantial evidence of severe drug use, which, in turn, would be reportable because of the threat of serious harm to the baby when he or she goes home with the addicted mother.* Thus, prenatal use of dangerous drugs is probative of future neglect.<sup>49</sup> The reasoning behind such a conclusion is that:

To give rise to such symptoms, the mother must have been regularly using large quantities of heroin (as she substantiated by her history) for considerable time before [the child's birth]; the placenta permits ready transfer of heroin from mother to fetus. Had she injected heroin not habitually but only shortly before child's birth, massive doses may have killed her and the new-born child, or the baby would have been sedated instead of hyperactive and suffering withdrawal. Only a high tolerance (a strong and perhaps sufficient basis for a finding of narcotic addiction without additional history) for both mother and baby would cause the medically observed course of events found here.<sup>50</sup>

Not all babies born to heavy drug users exhibit withdrawal symptoms; anywhere from 30 to 50 percent do not. Although medical studies have yet to develop

specific measures of prediction. It appears that the existence and severity of withdrawal symptoms is a function of the type, dosage, and regularity of drug use. Hence, if there are other reasons to suspect that drug use renders the parent(s) unable to care for the infant, a report should be made.

*Demonstrated parental inability to care for a newborn should be reported.* Certain specific parental behaviors in the maternity ward provide additional reasons for a report. What parents are unable to do in the hospital, where they have help, they are unlikely to be able to do alone at home. Concrete examples of parental inability to care for a newborn should be reported (see Besharov 1990, pp. 131-133).

*The requirement to report "reasonable suspicions" means that there need not be a definitive determination of either the parent's drug abuse or its harmful effect on the child.* Some people point to the uncertainty that exists about parental drug use and its effect on children as a reason for not reporting. However, there have been several court cases holding professionals legally culpable for not reporting their reasonable suspicions and, instead, seeking absolute proof of child abuse before making a report.<sup>51</sup> It may be only a matter of time before some local prosecutor or plaintiff in a civil damage suit will use these precedents in a prenatal drug exposure case.

## CONCLUSION

In many States, researchers probably are required to report at least some of the prenatal drug exposure revealed in their studies to child protective agencies. First, a growing number of States have laws that expressly require such reports. Second, in many other States, the general child abuse reporting law implicitly requires such reports—at least when there is reasonable cause to suspect that a parent is *seriously addicted to a dangerous or debilitating drug*.

The existence of this requirement to report, though, does not mean that researchers and clinicians should ignore the trusting relationship they may have developed with parents. Unless it appears that doing so will endanger the child, they should prepare the parents for the consequences of the report. The necessity of the report, and the nature of the investigation that will follow, should be described honestly and supportively. If appropriate, the parents should be encouraged to report themselves to the child protective agency.

Reporting child abuse, moreover, does not necessarily mean that the child will be removed from parental custody. In many cases, supportive services provided by the child protective agency or another public or private agency may enable the parents to care for their children. Moreover, researchers can take

steps, such as developing cooperative agreements with child protective agencies, to increase the likelihood that a report will result in the provision of services to the family rather than the child's removal.

However, State laws vary, and they change almost constantly; therefore, it is impossible to provide definitive guidance here. And, although the State or local child protective agency may be of help in planning a response to child abuse reporting responsibilities, the issues are sufficiently complex, State laws sufficiently ambiguous, and the cost of a wrong decision sufficiently high that prudence dictates an early consultation with an attorney specializing in such matters.

## NOTES

1. E.g., Applebaum, P.S. *Informed Consent: Legal Theory and Clinical Practice*. New York: Oxford University Press, 1987; Morrissey, J.M. *Consent and Confidentiality in the Health Care of Children and Adolescents: A Legal Guide*. New York: Free Press, 1986; Barber, B. *Informed Consent in Medical Therapy and Research*. New Brunswick, NJ: Rutgers University Press, 1980; Rosoff, A.J. *Informed Consent: A Guide for Health Care Providers*. Rockville, MD: Aspen Systems Corp., 1980; Sharpe, S.B. *Informed Consent: Its Basis in Traditional Legal Principles*. Toronto: Butterworths, 1979; Ludlam, J.E. *Informed Consent*. Chicago: American Hospital Association, 1978; Annas, G.J. *Informed Consent to Human Experimentation: The Subject's Dilemma*. Cambridge, MA: Ballinger, 1977; Hershey, N. *Human Experimentation and the Law*. Germantown, MD: Aspen Systems Corp., 1976.
2. Clearinghouse on Child Abuse and Neglect Information. *State Statutes Related to Child Abuse and Neglect: 1988*, passim. U.S. Department of Health and Human Services, Office of Human Development Services, Administration for Children, Youth and Families, Children's Bureau, and National Center on Child Abuse and Neglect. June 1989.
3. See generally Besharov, D. The need to narrow the grounds for state intervention. In: Besharov, D. *Protecting Children From Abuse and Neglect: Policy and Practice*. Springfield, IL: Charles C. Thomas, 1988. pp. 47, 50 et seq.
4. Child Abuse Prevention and Treatment Act of January 31, 1974, codified as amended at 42 U.S.C. § 5102(1) (Suppl.1989).

5. For the definitive exposition of how severity of injury affects—and should affect—child protective decisionmaking, see Giovannoni, J.M., and Becerra, R.M. *Defining Child Abuse*. New York: Free Press, 1979. Reflecting the need to specify the level of severity, the National Center on Child Abuse and Neglect provides the following definitions: (1) "Physical injury" means death, or permanent or temporary disfigurement or impairment of any bodily organ or function and (2) "mental injury" means an injury to the intellectual or psychological capacity of a child as evidenced by an observable and substantial impairment in his ability to function within his normal range of performance and behavior, with due regard to his culture. National Center on Child Abuse and Neglect. *Child Protection: A Guide for State Legislation*, subsections 4(h) and (i) (Draft 1983).
6. See the text at note 38, *infra*.
7. Although there is a small, technical difference between the two phrases, most legal authorities have concluded that they are fundamentally equivalent and have the same impact on reporting decisions. [E.g., Op.Ill.Attorney General, S-1298 (October 6, 1977); Op.Mass.Attorney General 74/75-66 (June 16, 1975).] Since "reasonable cause to suspect" is the more common phraseology, it is adopted in this chapter.
8. For example, the failure to report may be misprision of a felony. Cf. *Pope v. State*, 38 Md.App.520, 382 A.2d 880 (1978); *modified*, 284 Md.309, 396 A.2d 1054 (1979), dismissed because the state's child abuse law did not apply and because there was no crime of misprision of felony in Maryland.
9. "Doctor, Parents Charged in Death of Abused L.A. Child." *Los Angeles Times*, December 3, 1983. Pt. 1, p. 1, col. 5; "MD Charged With Not Reporting Child Abuse." *Toronto Star*, June 2, 1983. p. A16, col. 1.
10. E.g., *Groff v. State*, 390 So.2d 361 (Fla. Dist.Ct.App. 1980), *State v. Groff*, 409 So.2d 44 (Fla. Dist.Ct. App. 1981), ultimately dismissed on the grounds that the Florida reporting mandate was limited to "any person . . . serving children," and, therefore, did not apply to the defendant psychiatrist who was treating the father, not the child and, in fact, had never met her.
11. *People v. Poremba*, 7 *Family Law Reporter* p. 2142 (1/1/81) (Denver County Court 12/17/80).

12. E.g., *People v. Sok* (for punching and pushing two children) and *People v. Molitor* (for not reporting the abuse) mentioned in, "Monk Seeks \$60 Million Damages for Lawsuit's Allegations of Racism." *Los Angeles Times*, June 23, 1982. Pt. 2, p. 12, col. 1. According to the Los Angeles District Attorney, both cases resulted in convictions.
13. E.g., "People v. Noshay." *NASW News*, February 1984. p. 21, and April 1984, p. 7, a case, later dismissed, charging the social worker for failing to report "immediately" because she worked with the victim's family for 5 weeks before a report was made by the family.
14. E.g., "2 Found Guilty of Not Reporting Child-Abuse Case." *Providence Journal*, December 4, 1981. p. A-3, col. 3. On appeal, the case was dismissed on procedural grounds. (The case was tried in the wrong court.) *State v. Boucher and Flinkfelt*, 468 A.2d 1227 (R.I. 1983).
15. E.g., *Pope v. State*, supra n. 8.
16. See Keeton, W.P., and Prosser, W.L. *Prosser and Keeton on Torts*. 5th ed. St. Paul/Minneapolis: West, 1984. p. 220.
17. All information and quotations from "Doctor, Parents Charged in Death of Abused L.A. Child," supra n. 10.
18. Metro section. *Los Angeles Times*, December 1, 1984. p. 1.
19. Such vicarious liability is based on the legal doctrine of "respondeat superior," under which the tortious conduct of a staff member may be imputed to the employer. See generally Keeton and Prosser, supra n. 16, at Chapter 12, p. 499, "Imputed Negligence." See also Note, "Agency: Liability of a hospital for negligent acts of a physician—employee," *Oklahoma Law Rev* 18:77, 1965; annotation, *American Law Reports 2d* 69:30, 1960.
20. A full discussion of these issues can be found in: Horowitz, R. "The Child Litigant." In: *The Legal Rights of Children* § 3.04; "Statutes of Limitation" (Horowitz, R., and Davidson, H., eds., 1984); *American Jurisprudence 2d ed.*, "Limitations of Actions," 51:§§ 181-185 (1970 and Suppl. 1981).
21. See Besharov, supra n. 3, p. 46.

22. See generally *Wigmore on Evidence* 8:§ 2380 (Suppl. 1981); *McCormick's Handbook of the Law of Evidence* § 95 (2d ed., E. Cleary 1972).
23. Family Educational Rights and Privacy Act of 1974 (FERPA), codified at 20 U.S.C. § 1232g(b)(1)(l) (1978).
24. Public Health Service Act, § 527, codified at 42 U.S.C. § 290ee-3 (1988 and Suppl. 1990).
25. Public Health Service Act, § 523, codified at 42 U.S.C. § 290dd-3 (1988 and Suppl. 1990).
26. 42 U.S.C. § 290dd-3(e); 42 U.S.C. § 290ee-3(e).
27. For a further discussion of these issues, see U.S. Public Health Service, Proposed regulations on confidentiality of alcohol and drug abuse patient records, *Fed Register* 48:38758, 38767 et seq, 1983, codified at 42 C.F.R. 2 (1985); National Center on Child Abuse and Neglect, *Impact of Federal Law on Provision of Child Protective and Related Services*, p. 16 et seq. (DHHS 1981); "Iowa Attorney General Issues Opinion On Dilemma In Child Abuse Reporting," 10 *Family Law Reporter* 1123 (January 3, 1984), discussing Iowa Attorney General's Opinion No. 83-11-3, November 9, 1983.
28. Maine mandates reports from therapists but requires the child protective agency to meet with the therapist and to consider the abuser's willingness to seek treatment before deciding what to do. [Me. Rev. Stat. Ann. tit. 22, § 4011 (1-A)(C) (Suppl. 1988).] Note that, before deciding not to report, the professional must determine that there is "little threat of serious harm to the child," a difficult decision in many cases and one that creates the threat of criminal and civil liability for not reporting. Maryland exemption is limited to health practitioners who specialize in psychiatric treatment of pedophilia. A report is not required if the report would be based solely on the statement of an abuser made while in treatment for past abuse. [Md. Fam. Law Code Ann. § 5-704 (Suppl. 1988).] See also Or. Rev. Stat. § 418.750 (1987), where mental health professionals, clergy, and attorneys are not required to report if such a report would disclose privileged communications, and Utah Code Ann. § 78-3c-4 (1987), abrogating the privilege between a victim and a sexual assault counselor at the counselor's discretion as established by statutory guidelines.

29. Generally, reports are required for any suspected child abuse or neglect, as defined in each state's statute; these statutes then specifically mention drug exposure in their definitions. E.g., Fla. Stat. Ann. § 415.503(7)(a) (Suppl. 1988). (Child abuse or neglect includes "physical dependency of a newborn infant upon any drug controlled in Schedule II of § 893.03 . . ."); Hawaii Rev. Stat. § 587-2 (1985). (Abuse includes "any case where the child is provided with dangerous, harmful, or detrimental drugs as defined by § 712-1240."); Ill. Rev. Stat. ch. 23, § 2053 (Smith-Hurd 1990). (Neglected children include "any newborn infant whose blood or urine contains any amount of a controlled substance as defined in subsection (f) of Section 102 of the Illinois Controlled Substance Act . . ."); Ind. Code Ann. § 31-6-4-3.1 (Burns 1987). (A child is in need of services if he or she is "born with fetal alcohol syndrome or an addiction to a controlled substance or a legend drug . . ."); Mass. Gen. Laws Ann. ch. 119, § 51A (West Suppl. 1988). (A report is mandated for any infant ". . . who is determined to be physically dependent upon an addictive drug at birth."); Minn. Stat. Ann. § 626.556(4)(2) (1988). ("Neglect includes prenatal exposure to a controlled substance . . ."); Okla. Stat. tit. 21, § 846(A) (Suppl. 1989). (A report must be made for "a child who appears to be a child born in a condition of dependence on a controlled dangerous substance . . ."); Utah Code Ann. § 78-36-3.5 (Cum. Suppl. 1989). (A report is mandated when a child "at the time of birth, has a fetal alcohol syndrome or fetal drug dependency.")
30. E.g., Hawaii Rev. Stat. § 587-2 (1985). (Harm to a child occurs in "any case where the child is provided with dangerous, harmful, or detrimental drugs, as defined by Section 712-1240 . . ."); Ill. Ann. Stat. ch. 37, § 802-3(1) (Smith-Hurd 1989). (Neglected children include "any newborn infant whose blood or urine contains any amount of a controlled substance as defined in subsection (f) of Section 102 of the Illinois Controlled Substance Act . . .")
31. Ind. Code Ann. § 31-6-4-3 (Burns 1987). (A child is in need of services if "the child is born with fetal alcohol syndrome . . ."); Nev. Rev. Stat. § 201.090 (1987). (A child is neglected if he or she "habitually uses intoxicating liquors . . ."); Utah Code Ann. § 78-3b-8 (1),(6) (1987). (The agency shall investigate "an oral or written report of alleged abuse, neglect, fetal alcohol syndrome, or dependency . . .")
32. Fla. Stat. Ann. § 415.503(8)(a)(2) (West Suppl. 1988). ("physical dependency of a newborn infant"); Mass. Gen. Laws Ann. Ch. 119 § 51A (West Suppl. 1989). ("physically dependent on an addictive drug at birth"); Okla. Stat. Ann. tit 21, § 846(A) (West Suppl. 1988). ("born in a



condition of dependence on a controlled substance"); Utah Code Ann. § 78-36-3.5 (Cum. Suppl. 1989). ("at the time of birth has a fetal alcohol syndrome or fetal drug dependency".)

33. Ill. Ann. Stat. ch. 37, § 802-3(1) (1990). ("any newborn infant whose blood or urine contains any amount of a controlled substance . . . or metabolite of a controlled substance, with the exception of . . . such substances, the presence of which in the newborn infant is the result of medical treatment administered to the mother or the newborn infant."); Minn. Stat. Ann. § 626.5562(2) (West Suppl. 1990). (Physicians are required to report as neglect the positive results of any toxicology tests.)
34. Minn. Stat. Ann. § 626.5562(6)(2) (1988). This section also requires a physician to report to the child protective agency even when the drug test is negative, if "other medical evidence of prenatal exposure to a controlled substance" exists.
35. Minn. Stat. Ann. § 626.5562(1) (West Suppl. 1990). (A report is required if "a woman is pregnant and uses a controlled substance for a non-medical purpose. . . ."); R.I. Gen. Laws § 40-11-2 (2), (3) (Suppl. 1988). (Evidence of an abused or neglected child includes parental "use of a drug, drugs or alcohol to the extent, that the parent . . . loses his ability or is unwilling to properly care for the child . . . ."); Nev. Rev. Stat. § 128.106 (1987). ("In determining neglect by or unfitness of a parent, the court shall consider. . . excessive use of intoxicating liquors, controlled substances or dangerous drugs which renders the parent consistently unable to care for the child."); N.Y. Fam. Ct. Act § 1012(e) (McKinney 1983 and Suppl. 1989). (A parent may neglect his child "by misusing a drug, or drugs; or by misusing alcoholic beverages to the extent that he loses self-control of his actions.")
36. Minn. Stat. Ann. § 626.5562(1) (1989).
37. *In Re Baby X*, 293 N.W.2d 736, 97 Mich. App. 111 (1980); *In Re Troy D.* 215 Cal. App. 3d 889, 263 Cal. Rptr. 869 (Ct. App. 1989); *In Re Stefanel C.*, N.Y. App. Div. 1st Dept., May 29, 1990; NYLJ May 31, 1990. Additional cases exist in Illinois, Alaska, Georgia, South Dakota, Montana, and Nevada. See Horowitz, R. Testimony before Subcommittee on Human Resources, Committee on Ways and Means, U.S. House of Representatives, April 3, 1990.
38. Minn. Stat. Ann. § 626.5561 (1989). (Physicians must report any pregnant women whom they suspect of using drugs. Child abuse

includes "prenatal exposure to a controlled substance used by the mother for a non-medical reason . . ."); (Delaware has a similar bill pending, H.B. 571, which would require reporting of "any woman suspected of using a controlled substance during pregnancy.")

39. See generally English, A. Prenatal drug exposure: Grounds for mandatory child abuse reports?" *Youth Law News* XI(1):3-8, 1990.
40. E.g., Ward, P., and Krone, A. Deadly deals: Child abuse and chemically dependent families. *Focus on Chemically Dependent Families* 10(6):16-17, 34-35, 1987; Coleman, E. Family intimacy and chemical abuse: The connection. *J Psychoactive Drugs* 14(1-2):153-158, 1982; Jones, C., and Lopez, R. "Direct and Indirect Effects on the Infant of Maternal Drug Use." In: *Component Report on Drug Abuse*. Expert Panel on Prenatal Care. U.S. Department of Health and Human Services and the National Institutes of Health. Pub. No. 7161M, July 15, 1988; Finnegan, L.P.; Oehlberg, S.M.; Regan, D.O.; and Rudrauff, M.E. "Evaluation of Parenting, Depression and Violence Profiles in Methadone Maintained Women." Paper presented at the Third International Congress on Child Abuse and Neglect, 1981.
41. Clement, D. Babies in trouble. *Minnesota Monthly* March:4S, 1989.
42. E.g., *Roberts v. State*, 941 Ga. App.268, 233 S.E.2d 224 (1977), where a baby born to a mentally retarded, 14-year-old mother was placed in foster care immediately after birth. Despite the absence of any "history of deprivation," the court held that, under the circumstances, parental rights could be terminated on the grounds that the child would suffer deprivation if the mother were given custody of him.
43. N.Y. Fam. Ct. Act § 1046(a)(iii) (McKinney 1988) (emphasis added).
44. E.g., N.Y. Fam. Ct. Act § 1012(e) (McKinney 1983 and Suppl. 1989) ("Where the respondent is voluntarily and regularly participating in a rehabilitative program, evidence that the respondent has repeatedly misused a drug or drugs or alcoholic beverages to the extent that he loses self-control of his actions shall not establish that the child is a neglected child in the absence of evidence that the child's physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired . . .")
45. *In the Matter of John Children*, 61 Misc.2d 347, 353, 306 N.Y.S.2d 797, 805 (Fam.Ct., N.Y.Co., 1969).

46. E.g., Zuckerman, B.; Frank, D.; Hingson, R.; Amaro, H.; Levenson, S.; Parker, S.; Vinci, R.; Aboagye, K.; Fried, L.; Cabral, H.; Timperi, R.; and Bauchner, H. Effects of maternal marijuana and cocaine use on fetal growth. *N Engl J Med* 320:762-768, 1989.
47. *In Re Stefanel C.*, N.Y. App. Div. 1st Dept; May 29, 1990, NYLJ May 31, 1990; see also *In Re Ruiz*, 500 N.E.2d 935 (Ohio Ct. Comm. Pls. 1986).
48. *In the Matter of Vanesa F.*, 76 Misc.2d 617, 620, 351 N.Y.S.2d 337, 340 (Surr.Ct., N.Y.Co. 1974).
49. *In Re Troy D.*, 215 Cal. App. 3d 889, 263 Cal. Rptr. 869 (Ct. App. 1989), basing its decision on "prognostic deprivation"; *In Re Baby X.*, 293 N.W.2d 736, 739, 97 Mich. App. 111 (1980), stating that "prenatal treatment can be considered probative of a child's neglect."
50. *In the Matter of John Children*, supra n. 46, 61 Misc.2d at 354, 306 N.Y.S.2d at 805.
51. Confidential material on file with the author.

#### REFERENCE

Besharov, D. *Recognizing Child Abuse: A Guide for the Concerned*. New York: Free Press, 1990.

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