Child Abuse Reporting: The Rules Change Again

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Background on reporting child abuse and neglect.

Since the early 1970s, health care professionals in Minnesota and elsewhere have had the legal and professional duty to make reports to county or state officials concerning possible neglect or abuse of children. This duty supersedes the client's privacy rights, whether the client is the child or a parent, guardian, or other family member. In Minnesota and many other jurisdictions, these laws are frequently amended.

Unfortunately, there seems to be no comprehensive way that either the public or mandated reporters are informed when such changes are made. This is a significant social and legal problem, in my opinion, in that those affected often do not know of key changes in the law.

For example, when in 2007 the Minnesota legislature decided that it was child neglect for a pregnant woman to use marijuana or its derivatives there was no publicity to inform parents. Likewise when professionals such as psychologists suddenly had the duty to report any use of alcohol by a pregnant woman that was deemed to be "excessive" or "habitual," the state did not inform psychologists of this and many had to learn of it from an article in the *Minnesota Psychologist* (Schoener, 2008). The current article was prompted by a statement from a workshop participant who indicated she had just heard that a key provision of the law had changed.

In some states (such as our neighbor, Wisconsin) the law specifies that the information must come from an examination of the child or the report of the child, but in Minnesota (and many other states) it can come from any number of sources.

According to the Minnesota Department of Human Services:

> The purpose of child protection services is to help protect children from physical abuse, neglect, and sexual abuse, and to help families and get the services they need to change their behaviors. (DHS Web site)

Beyond the statutory duties connected with the reporting of child abuse or neglect, *if a failure to report leads to harm to the child, a civil suit is possible*. For example, in a Missouri case a jury awarded $5 million in damages to a woman who was abused for an additional two years after two psychologists agreed to counsel the abusive father without reporting the case to child protection. (*Bradley v. Ray, 904 S.W.2nd 302 Missouri Ct. of Appeals 1995*)

A licensure complaint that claims a failure to make a mandatory child abuse report virtually always leads to discipline if it is founded. So, a failure to file a mandated report can lead to discipline from the Board of Psychology. In custody disputes some parents will attempt to "set up" a professional who is "on the other side" by making a claim that while possibly bogus probably requires a report.

On the other hand, one can be sued if one makes a complaint. The law requires that the complaint be "good faith," and that is not itself well-defined. Within this past decade a hospital social worker was sued for filing a report to Hennepin County Child Protection regarding an allegation by an adolescent that she was sexually touched by her father. The girl retracted her story and the issue of "good faith" became an issue. Eventually good records saved the social worker.

But there can be other consequences of a report. The client may lose trust in the reporter and it may disrupt the therapeutic services. Depending on how the case is handled, the intervention by protective services can be traumatic.

Our changing statutes

Over the past 35 years, there have been many amendments and changes to Minnesota's child abuse and neglect reporting statute. Minnesota is not unique in this regard—these are laws that are changed as various cases test the standards. In fact, when they were first passed many opposed them fearing that such a duty would push abuse and neglect underground and thus defeat the intention of such laws.

Until the early 1980s, psychologists and others working in substance abuse evaluation or treatment programs were actually not permitted to report child abuse or neglect. Code of Federal Regulations (CFR) 42 which governed those programs did not authorize such a breach in privacy. A Minnesota Supreme Court decision based on a Ramsey County case challenged this, and the federal government changed CFR 42 in 1987 to allow substance abuse personnel to follow whatever state statutes exist concerning child abuse and neglect. (As a point of interest, CFR 42 still does not contain an authorization for vulnerable adults act reports or *Tarasoff* type warnings of dangerousness.)

Continued on page 16

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The State of Minnesota Web site has the statute and a good deal of information concerning child abuse and neglect. You go to http://www.dhs.state.mn.us and then follow the links to services for children. It in turn links you to the law—626.556 Minnesota Statutes 2010—as well as a good deal more information. It has a tutorial for mandated reporters, *but do not assume that the tutorial is up to date and reflects recent changes in the law.*

Changes in the Reporting of Maltreatment of Minors Act

As of August 1, 2007, the Minnesota Statute has a new section dealing with mandatory reporting of mothers who are using alcohol or non-medically prescribed drugs during pregnancy. In the past, non-medical use of a controlled substance required a mandated report to child protection. Notably absent was use of the one substance that accounts for the most birth defects—alcohol. In 2007, this changed with the addition of two common "social drugs"—Tetrahydrocannabinol and its derivatives (e.g. marijuana, hashish) and alcohol. The statutory language was:

> 626.5561, Minnesota Statutes 2007
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> 626.5561 Reporting of Prenatal Exposure to Controlled Substances.
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> Subdivision 1. Reports required. A person mandated to report under section 626.556, subdivision 3 , shall immediately report to the local welfare agency if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy, including, but not limited to, tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive. Any person may make a voluntary report if the person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a nonmedical purpose during the pregnancy, including, but not limited to, tetrahydrocannabinol, or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive. An oral report shall be made immediately by telephone or otherwise. An oral report made by a person required to report shall be followed within 72 hours, exclusive of weekends and holidays, by a report in writing to the local welfare agency. Any report shall be of sufficient content to identify the pregnant woman, the nature and extent of the use, if known, and the name and address of the reporter.
>
> Subd. 2. Local welfare agency. Upon receipt of a report required under subdivision 1, the local welfare agency shall immediately conduct an appropriate assessment and offer services indicated under the circumstances. Services offered may include, but are not limited to, a referral for chemical dependency assessment, a referral for chemical dependency treatment if recommended, and a referral for prenatal care. The local welfare agency may also take any appropriate action under chapter 253B, including seeking an emergency admission under section 253B.05. The local welfare agency shall seek an emergency admission under section 253B.05 if the pregnant woman refuses recommended voluntary services or fails recommended treatment.
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> Subd. 3. Related provisions. Reports under this section are governed by section 626.556, subdivisions 4, 4a, 5, 6, 8, and 11.
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> Subd. 4. Controlled substances. For purposes of this section and section 626.5562, "controlled substance" means a controlled substance listed in section 253B.02, subdivision 2.
>
> Subd. 5. Immunity. (a) A person making a voluntary or mandated report under subdivision 1 or assisting in an assessment under subdivision 2 is immune from any civil or criminal liability that otherwise might result from the person's actions, if the person is acting in good faith. (b) This subdivision does not provide immunity to any person for failure to make a required report or for committing neglect, physical abuse, or sexual abuse of a child.
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> History: 1989 c 290 art 5 s 5; 1990 c 542 s 27-30; 2007 c 69 s 3,4

Reporting duties defined

As of 2007, for scheduled drugs or marijuana, the reporting duty seems triggered by use—so that a single instance of non-medical use of an amphetamine or cocaine or marijuana would, under the letter of the law, potentially require a report to child protection. Second, as of 2007 the use of alcohol has been added to the law, but with a condition that is not required for use of the other substances listed, that the pregnant woman *has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive.*

The law contains no definition of the two operative terms:

1. Habitual
2. Excessive

Even today, the state's training materials on the Internet frankly acknowledge this fact. I noted in my earlier article (Schoener, 2008) that since the implied purpose of the statute is to provide for intervention aimed at pre-

Continued on page 17

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vention of harm to the developing fetus, it would seem to be important to review the scientific evidence for the impact of alcohol during pregnancy so as to determine what if any guidelines might be useful in making such determinations. I called without success for an advisory group or task force with a mixture of healthcare professionals to discuss this issue and attempt to develop some sort of advisories or guidelines.

The state training Web site, which frankly acknowledges the lack of a legal or scientific definition of the terms "excessive" or "habitual," offers the following guidance: *A pregnant (sic) having a single glass of wine would probably not merit the definition.* In general it indicates that the threshold for reporting is *if the reporter is concerned about the damaging effects on the fetus.*

The 2010 changes in the reporting standards

Although the 2010 changes in the statute have not altered the reporting standards in terms of threshold for reporting, and still have made no effort to offer guidance or definition about the meaning of the terms "excessive" or "habitual" when applied to alcohol use by pregnant women, the legislature may have removed the reporting mandate. These changes were signed into law on May 14, 2010. The following new language was added to Minnesota Statutes 2008, Section 626.5561, subdivision 1:

> (b) A health care professional or social service professional who is mandated to report under section 636.556, subdivision 3, is exempt from reporting under paragraph (a) a woman's use or consumption of tetrahydrocannabinol or alcoholic beverages during pregnancy if the professional is providing the woman with prenatal care or other healthcare services.
>
> ...
>
> (d) For purposes of this section, "prenatal care" means the comprehensive package of medical and psychological support provided throughout the pregnancy.

Based on (b) above, it would appear that there is an exemption from the reporting mandate that is very broad given the term "other healthcare services." However, there is some ambiguity created by the definition under (d) of "prenatal" services. If the legislature meant to include all healthcare services, why the need for the specification of "prenatal"? Of even greater concern is that this is ambiguous as concerns social services and also the situation where one is serving another family member, such as a spouse or child in the family, and then learns of use of marijuana or alcohol. *At present, it would appear that if a psychologist is treating a pregnant woman there would not be a requirement of mandatory reporting of child abuse or neglect in an instance where the woman has made use of alcohol or marijuana during pregnancy. Remember that this limitation does not apply when there is non-medical use of controlled substances.*

Alcohol and pregnancy

The well-informed psychologist would still do well to learn about the impact of alcohol in pregnancy. I recommend the chapter on "Maternal and Neonatal Effects of Alcohol and Drugs" (Finnegan & Kandall, 2005) for a good overview of the impact of a variety of substances on the developing fetus. Beyond long-term harm, there are syndromes observed in neonates that are caused by withdrawal from narcotics. Minnesota, like most other states, requires professionals involved in the delivery of babies to report indicators (e.g. blood levels of chemicals) that the birth mother had non-medical drugs in her system.

Fetal alcohol syndrome occurrence has been estimated in the United States to be from 0.2 to 2.0 cases per thousand. It is thought to be the leading cause of developmental disabilities (other than inherited ones) in the West, and has been observed in all societies where alcohol is consumed. As a result of this risk, the Surgeon General of the United States has advised pregnant women to abstain from alcohol consumption.

Prohibitions concerning alcohol use during pregnancy go back to ancient times (Abel, 1999), although Sullivan (1889) is often credited with being the first physician to notice alcohol as a major source of damage to offspring, and the syndrome wasn't described until 1968 by Lemoine and then five years later by Jones & Smith (1973).

When I trained in the 1960s, Goddard's (1912) famous study of the Kallikak family was still cited to illustrate the hereditability of mental retardation. Far more recently, this supposed family hereditary history was challenged as possibly the result of the impact of fetal alcohol exposure rather than hereditary factors (Karp et al., 1995).

While this has been researched worldwide, the breadth of this work has actually illustrated the complexity of the topic. First of all, even what is considered a unit of alcohol varies around the world. While standards have shifted over the years, in many countries the standard advice for pregnant women is abstinence from

Continued on page 18

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Child abuse, continued from page 17

alcohol—often under the premise that the exact level of alcohol which might cause damage is unknown.

Full-blown fetal alcohol syndrome has been observed in about one-third of the offspring of alcoholic women who have reportedly consumed 10 standard units of alcohol on a daily basis. (In the U.S., a "standard unit" is 0.5 ounces of alcohol, so this would be 5 ounces of alcohol per day—roughly five mixed drinks or shots.) However, lesser levels of intake are associated with an increase in fetal alcohol-related symptoms, reduced birth weight, and behavioral changes in the baby. (Blume & Zilberman, 2005, p. 1061)

In recent presentations to groups of healthcare professionals, audience questions and discussion have noted that there is considerable perceived variability in the medical community concerning the degree to which social drinking is discussed and as to what sort of advice is given to pregnant women. Very frankly, many have noted that the perinatal advice that their family received was vague about alcohol use. "A glass of wine with dinner," for example, was not viewed as a problem.

Although I do not have any survey data on this point, a number of professionals have indicated to me in calls, e-mails, and discussions that they are unsure at what point they would have a reporting duty in a situation where they have suggested that the pregnant woman abstain or greatly limit her intake.

The references that follow include some readings on the impact of various drugs on the developing fetus. These are worth an examination—although it is the use of alcohol that the scientific literature links to the vast majority of drug-induced birth defects.

The purpose of this article, like my previous one (Schoener, 2008), is to both inform about the new reporting guidelines and also to encourage professional dialogue. I would also hope that next session there is a serious effort to clarify the requirements of this statute.

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