

Mandatory Reporting Laws Intersection with Minor-Survivor Access Laws



NATIONAL CRIME VICTIM LAW INSTITUTE

1130 SW Morrison St., Suite 200, Portland OR 97205

MEMORANDUM

TO: File
 FROM: NCVLI
 RE: Intersection of Mandatory Reporting Laws and Minor-Survivor Access to Medical/Mental Health Treatment Laws
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INTRODUCTION

Mandatory child-abuse reporting statutes aim to protect children from abuse. Medical emancipation statutes aim to remove barriers for mature-minors seeking health care. These statutory purposes may come into conflict when a mandatory reporting provision requires a treatment provider to report a minor's victimization that was disclosed in the course of treatment. When such a conflict presents, a mature-minor seeking treatment is faced with a Hobson's choice: forego treatment, mislead the provider as to the circumstances necessitating treatment, or divulge the victimization and forfeit privacy. A narrowly tailored exception to mandatory reporting requirements that exempts health care providers who treat mature-minor victims can reduce this tension.

I. OVERVIEW OF MANDATORY REPORTING, MATURE-MINOR PROVISIONS AND VICTIMS' RIGHTS.

A. Mandatory Reporting

The state's interest in protecting the welfare of children is well-recognized. *See Santosky v. Kramer*, 455 U.S. 745, 766 (1982) (noting that the state has a compelling interest in the health, education and welfare of children as future citizens); *Global Newspaper v. Super. Ct. Norfolk*, 457 US 596, 607-08 (1982) (finding that safeguarding the physical and psychological well-being of a minor is a compelling state interest.). Mandatory reporting statutes, which are in effect in all fifty states and the District of Columbia¹, are intended to serve this interest by requiring the reporting of child-abuse.

¹ See NCVLI's 50 State Survey of Key Mandatory Reporting & Medical Emancipation Statutes.

While the statutes vary as to who is mandated to report and the standard that triggers the reporting duty, the provisions have several commonalities. For instance, most of these statutes (1) impose a duty to report on medical and mental health practitioners (*e.g.*, nurses, physicians, social workers, counselors, psychologists)²; (2) require reporting when the victim is a person under the age of eighteen³; (3) provide that the duty (when it applies) abrogates most privileged communications⁴; and (4) provide immunity for a good faith reporter.⁵ Notably, in some states all persons are designated as mandatory reporters.⁶ The legal standard for the level of knowledge or suspicion that triggers the duty to report varies from state to state.⁷ For example, in Arizona the duty to report is triggered when the mandatory reporter “reasonably believes” the child is a victim of abuse⁸; in Alabama the duty is triggered when a mandatory reporter “suspects” the child is a victim of abuse or neglect⁹; in still other jurisdictions a standard of “reasonable cause” to believe the child is a victim of abuse is used.¹⁰

² *See id.*

³ *See id.* Notably, if a minor does not disclose until they are eighteen years of age or older, then the mandatory reporting statutes may be nullified. *See, e.g.*, Colo. Rev. Stat. Ann. § 19-3-304(b) (exempting abuse reporting if the mandatory reporter does not learn of the abuse until the victim is eighteen); *Baselice v. Franciscan Friars Assumption BVM Province, Inc.*, 879 A.2d 270, 280 (Pa. Super. Ct. 2005) (same). *See also* Nev. Op. Att’y. Gen. Opinion No. 2016-08, 2016 WL 6433788, at *3 (2016) (opining that that Nevada’s mandatory reporting law does not apply when a psychologist knows or has a reasonable cause to believe that an adult client was the victim of abuse if a psychologist learns that an adult client was abused or neglected as a child); Ohio Op. Att’y. Gen. No. 2001-035, 2001 WL 987491, at *5 (2001) (same); Tex. Att’y. Gen. Op. No. GA-0944, 2012 WL 1980383, at *2 (2012) (same). *But see* *Griffin v. State*, 454 S.W.3d 262, 268 (Ark. Ct. App. 2015) (holding that duty to report was triggered despite teacher not discovering the reportable conduct until the child was the age of majority); *Gross v. Myers*, 748 P.2d 459, 462 (Mont. 1987) (holding that therapist’s suspicion that child abuse may reoccur with other children, despite the fact that the abuse occurred sixteen years ago and the abused children were adults at the time of the report, was reasonable); 78 Md. Op. Att’y. Gen. 189 (Md.A.G.), 1993 WL 523406, at *7 (opining that reporting is required whenever an act of prior child abuse or neglect occurred, no matter the present age of the victim).

⁴ Notably, privileged attorney-client and clergy communications are well-recognized exceptions to this lawful privilege piercing. *See, e.g.*, Del. Code Ann. tit 16 § 901 (“No legally recognized privilege, except that between attorney and client and that between priest and penitent in a sacramental confession, shall apply to situations involving known or suspected child abuse, neglect, exploitation or abandonment and shall not constitute grounds for failure to report as required by § 903 of this title or to give or accept evidence in any judicial proceeding relating to child abuse or neglect.”); Ky. Rev. Stat. Ann. § 620.030 (same); N.C. Gen. Stat. Ann. § 7B-301 (no privilege-exception other than attorney-client and that privilege is limited to communications from the client during representation in the abuse, neglect or dependency case.).

⁵ *See, e.g.*, Ariz. Rev. Stat. Ann. § 13-3620(J) (“A person who furnishes a report, information or records required or authorized under this section, or a person who participates in a judicial or administrative proceeding or investigation resulting from a report, information or records required or authorized under this section, is immune from any civil or criminal liability by reason of that action unless the person acted with malice or unless the person has been charged with or is suspected of abusing or neglecting the child or children in question.”); N.C. Gen. Stat. Ann. § 7B-301 (same); Wyo. Stat. Ann. § 14-3-209 (same).

⁶ *See* NCVLI’s 50 State Survey of Key Mandatory Reporting & Medical Emancipation Statutes.

⁷ *See id.*

⁸ Ariz. Rev. Stat. Ann. § 13-3620.

⁹ Ala. Code § 26-14-3(a).

¹⁰ *See* NCVLI’s 50 State Survey of Key Mandatory Reporting & Medical Emancipation Statutes.

B. Mature-Minor Medical and Mental Health Emancipation

Medical emancipation statutes and case law across the country are a patchwork of provisions governing access to physical and mental health, and addiction treatment by minors of varying ages. For instance, in Maine the state supreme court held that a seventeen-year-old minor had the right to refuse life-sustaining treatment.¹¹ In Rhode Island any minor over sixteen or married may consent to routine emergency medical or surgical care.¹² In Oregon a minor who is fifteen years or older may consent to medical, vision or dental treatment without parental consent.¹³ In Washington a thirteen-year-old may consent to outpatient mental health treatment.¹⁴ In Wisconsin a minor who is at least twelve can consent to diagnosis and treatment for drug or alcohol dependency.¹⁵

A common policy thread of these provisions is the recognition that despite the fact that minors are peculiarly vulnerable, less mature and benefit from parental involvement¹⁶, as they mature they become increasingly capable of independently consulting with their health provider, understanding a diagnosis, and weighing the long term consequences of treatment options.¹⁷ In addition, protecting the minor's right to privacy is critical in ensuring access to treatment.¹⁸

¹¹ *In re Swan*, 569 A.2d 1202, 1205 (Me. 1990) (minor had right to refuse lifesaving treatment; prior to accident minor made statement that he would not want to live on life-sustaining treatment in a vegetative state).

¹² 23 R.I. Gen. Laws § 23-4.6-1.

¹³ Or. Rev. Stat. Ann. § 109.640.

¹⁴ Wash. Rev. Code Ann. §71.34.530.

¹⁵ Wis. Stat. Ann. § 51.47.

¹⁶ *See Bellotti v. Baird*, 443 U.S. 622, 634 (1979) (noting “[w]e have recognized three reasons justifying the conclusion that the constitutional rights of children cannot be equated with those of adults: the peculiar vulnerability of children; their inability to make critical decisions in an informed, mature manner; and the importance of the parental role in child rearing.”)

¹⁷ *See, e.g., Cardwell v. Bechtol*, 724 S.W.2d 739, 744–45 (Tenn. 1987) (noting that the “recognition that minors achieve varying degrees of maturity and responsibility (capacity) has been part of the common law for well over a century.”)

¹⁸ In a different context Congress found that confidentiality is essential to attract adolescents to family planning clinics. In fact, the D.C. Circuit put particular emphasis on Congress' finding that “confidentiality [is] essential to attract adolescents to the Title X clinics,” without which the availability of family planning services to teenagers would be “severely undermined.” *Planned Parenthood Federation of America v. Heckler*, 712 F.2d 650, 660 (2nd Cir. 1983). Under current federal regulations, a recipient of Title X funds may not require, whether pursuant to state law or otherwise, that parents give consent, or even be notified of, the services being provided. *See, e.g., Does v. Utah Dep't of Health*, 776 F.2d 253, 255–56 (10th Cir. 1985); *County of St. Charles v. Missouri Family Health Council*, 107 F.3d 682, 685 (8th Cir. 1997); *Parents United for Better Schools, Inc. v. School Dist. of Philadelphia Bd. of Educ.*, 978 F.Supp. 197, 208–09 (E.D.Pa. 1997).

C. Victims' Rights

There are a number of state and federal personally held victims' rights that attach to minors. These rights may be burdened or otherwise implicated in the mandatory reporting/mature-minor intersection. First, the Supreme Court has made it clear that minors have constitutional rights. *See, e.g., Planned Parenthood of Central Missouri v. Danforth*, 428 US 52, 74 (1976) (noting that “[c]onstitutional rights do not mature and come into being magically only when one attains the state-defined age of majority.”)¹⁹ While minors are not afforded the full force of federal constitutional rights²⁰, and the state’s authority over children’s activities is broader than over like actions of adults²¹, in the context of seeking medical treatment the Supreme Court has recognized that a mature-minor’s constitutional right to privacy is implicated. *See, e.g., Bellotti v. Baird*, 443 U.S. 622, 647-48 (1979) (holding that statute requiring parental notice prior to judicial bypass proceeding was unconstitutional); *Carey v. Population Services, International*, 431 U.S. 678, 693 (1977) (opining that “the right to privacy in connection with decisions affecting procreation extends to minors as well as adults.”); *Danforth*, 428 U.S. at 75 (holding unconstitutional a statute that created a parental veto over an unmarried minor’s right to obtain an abortion).

In addition to federal constitutional privacy, the federal Crime Victims’ Rights Act provides that victims have “[t]he right to be treated with fairness and with respect for the victim’s dignity and privacy.”²² Beyond federal law most state statutes define a crime victim in a way that is not limited to adults²³ and “[a] majority of states provide victims with the right to

¹⁹ The Supreme Court has recognized a minor’s constitutional rights in a number of settings. *See, e.g., New Jersey v. T.L.O.*, 469 U.S. 325, 341-42 (1985) (holding that children enjoy freedom from unreasonable searches and seizures); *Carey v. Population Services International*, 431 U.S. 678, 693 (1977) (holding that in connection with decisions affecting procreation, children enjoy the protection of the right of privacy); *Tinker v. Des Moines Independent Community School District*, 393 U.S. 503, 511 (1969) (holding that “[s]tudents in school as well as out of school are ‘persons’ under our Constitution. They are possessed of fundamental rights which the State must respect, just as they themselves must respect their obligations to the State.”); *In re Gault*, 387 U.S. 1, 13 (1967) (recognizing that minors have right to due process and holding that neither the Fourteenth Amendment nor the Bill of Rights is for adults alone); *Kent v. United States*, 383 U.S. 541, 553-54, 557 (1966) (holding that D.C.’s Juvenile Court Act in the context of constitutional principles relating to due process and the assistance of counsel required a hearing, effective assistance of counsel, and a statement of reasons before waiving “critically important” jurisdiction issue).

²⁰ *See, e.g., Troxel v. Granville*, 530 U.S. 57, 68 (2000) (observing that immaturity and inexperience limit legal autonomy for decision-making because adolescents lack the capable judgment “for making life’s difficult decisions.”); *Ginsberg v. State of New York*, 390 U.S. 629, 637 (1968) (upholding as constitutional statute prohibiting sale of obscene material harmful to minors under 17 years of age because freedom of expression is a more restricted right than that assured to adults).

²¹ *See, e.g., Prince v. Massachusetts*, 321 U.S. 158, 168 (1944) (holding that state’s authority over children’s activities is broader than over like actions of adults).

²² 18 U.S.C. § 3771(a)(8).

²³ *See, e.g., Alaska Stat. Ann. § 12.55.185(19)(A)* (defining “victim” to mean “a person against whom an offense has been perpetrated”); *Colo. Rev. Stat. Ann. § 24-4.1-302(1), (5)* (defining “victim” to mean “any natural person against whom any crime has been perpetrated or attempted”); *OR. Rev. Stat. Ann. § 147.430(7)* (defining “victim”

be treated with fairness, dignity, and respect”²⁴ and “a handful of states explicitly provide victims with a constitutional right to privacy.”²⁵

II. RECONCILING MANDATORY REPORTING, MEDICAL EMANCIPATION AND MATURE-MINOR’S RIGHTS.

While the clear demarcation of age eighteen is a convenient and simple rule for mandatory reporters to apply, a bright line age restriction of eighteen is untenable, lacks a rational scientific basis²⁶, and may ultimately undermine minor-victim health.²⁷

Although the state’s interest in protecting children from child-abuse is a sufficiently compelling interest to burden the right to privacy, broad mandatory reporting statutes are likely not sufficiently narrowly tailored to survive constitutional scrutiny. “Stripping survivors of control over the narrative of their victimization constitutes an act of re-victimization.”²⁸

The effect of mandatory policies [] may be to strip the victim of any sense of control and to foster a sense of disempowerment. Excessive use of state power, particularly forcing the victim to participate in the prosecution, can result in the revictimization of the victim for the actions of the abuser. In taking control of the victim’s life, the state substitutes itself for the abuser as a coercive entity in the victim’s life.²⁹

to mean “any person determined by the prosecuting attorney or the court to have suffered direct financial, psychological or physical harm as a result of a crime.”).

²⁴ Nat’l Crime Victim Law Inst., *Fundamentals Of Victims’ Rights: A Summary of 12 Common Victims’ Rights*, NCVLI Victim Law Bulletin (Nat’l Crime Victim Law Inst., Portland, Or.), Nov. 2011, <http://law.lclark.edu/live/files/11823-fundamentals-of-victims-rights-a-summary-of-12>.

²⁵ *Id.*

²⁶ See Rhonda Gay Hartman, *Coming of Age: Devising Legislation for Adolescent Medical Decision-Making*, 28 Am. J.L. & Med. 409, 414 (2002) (“Limited scientific findings related to adolescent vulnerability suggest that adolescents are no less intentional in medical decision-making than young adults, and that adolescents do not demonstrate intimidation when confronted by coercive parental influence attempts or by the gravity of a medical treatment decision.”).

²⁷ See, e.g., AAP Committee On Adolescence, *The Adolescent’s Right to Confidential Care When Considering Abortion*, Pediatrics, Feb. 2017, at 2, <http://pediatrics.aappublications.org/content/139/2/e20163861> (noting consensus of myriad professional health organizations that a minor should not be compelled or required to involve parents in certain medical decisions because current data indicate mandating parental involvement increases the risk of harm to the adolescent by delaying access to appropriate medical care).

²⁸ See, e.g., Alan N. Young, *The Role of the Victim in the Criminal Process: A Literature Review—1989 to 1999*, at 11, Ottawa, Canada: Department of Justice, Research and Statistics Division, http://www.justice.gc.ca/eng/pi/rs/rep-rap/2000/rr00_vic20/rr00_vic20.pdf; see generally Nat’l Crime Victim Law Inst., *Protecting the Rights of Survivors When They Are Called to Participate in Jury Service*, NCVLI Victim Law Position Paper (Nat’l Crime Victim Law Inst., Portland, Or.), Nov. 2014 (“The importance of victim agency is rooted in the inherently out-of-control nature of a crime; when a person becomes a ‘victim’ he or she often feels robbed of control.”), <https://law.lclark.edu/live/files/18364-victim-law-position-paperoregon-victims-maintain>.

²⁹ Christine O’Connor, *Domestic Violence No-Contact Orders and the Autonomy Rights of Victims*, 40 B.C. L. REV.

“Re-victimization, which is often referred to as secondary victimization, can occur when victims incur additional trauma or harm as a result of their involvement with the criminal justice system.”³⁰ A narrowly tailored solution that integrates the mature-minor-victim’s rights with the state’s competing interest in protecting children through investigation and prosecution of child-abuse is possible; specifically, excepting from mandatory reporting laws mature-minor-victims who seek confidential and private access to healthcare. Asking the health care practitioner to gauge a minor’s level of maturity (*i.e.*, assess whether the minor understands the consequences and implications of not reporting) is not without precedent.³¹

In fact, Oregon’s mandatory reporting statute exempts communications to a psychiatrist or a psychologist, if the communication is otherwise privileged.³² Therefore, in Oregon a minor can obtain confidential, privileged mental health treatment due to victimization that falls within the mandatory reporting statute without triggering the duty to report. Similarly, in Wisconsin in the context of certain types of sexual assault, the wellbeing of the minor and the minor’s access to health care services is the paramount concern, and therefore minors can access health care without triggering reporting.³³

CONCLUSION

Mandatory reporting requirements for medical or mental health professionals undermine mature-minor agency, burden victims’ rights, and, because they present a barrier to access to healthcare, they lack a rational relationship to the compelling objectives of the state to preserve the wellbeing of the minor. A narrowly tailored exception to mandatory reporting requirements could reduce the tension: health care providers who treat minor-victims pursuant to medical emancipation statutes, who are otherwise obligated to report, are exempted when it is determined the patient is a mature-minor.

937, 961 (1999).

³⁰ See generally Nat’l Crime Victim Law Inst., *Protecting the Rights of Survivors When They Are Called to Participate in Jury Service*, NCVLI Victim Law Position Paper (Nat’l Crime Victim Law Inst., Portland, Or.), Nov. 2014, <https://law.lclark.edu/live/files/18364-victim-law-position-paperoregon-victims-maintain>.

³¹ The physician’s inquiry would be analogous to the inquiry the court engages in when deciding if a person is a mature-minor. See *In re E.G.*, 549 N.E.2d 322, 327-28 (Ill. 1989) (“If the evidence is clear and convincing that the minor is mature enough to appreciate the consequences of her actions, and that the minor is mature enough to exercise the judgment of an adult, then the mature-minor doctrine affords her the common law right to consent to or refuse medical treatment.”). “Whether a minor has the capacity to consent to medical treatment depends upon the age, ability, experience, education, training, and degree of maturity or judgment obtained by the minor, as well as upon the conduct and demeanor of the minor at the time of the incident involved.” *Cardwell v. Bechtol*, 724 S.W.2d 739, 748 (Tenn. 1987); see also *Belcher v. Charleston Area Medical Center*, 422 S.E.2d 827, 836, 838 (Va. 1992) (citing *Cardwell’s* factors and setting out a similar list and noting “[w]here there is a conflict between the intentions of one or both parents and the minor, the physician’s good faith assessment of the minor’s maturity level would immunize him or her from liability for the failure to obtain parental consent.”)

³² Or. Rev. Stat. Ann. § 419B.010(1).

³³ Wis. Stat. Ann. § 48.981(2m).