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Confidentiality and Juvenile Mental Health Records In Dependency Proceedings

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CONFIDENTIALITY AND JUVENILE MENTAL HEALTH RECORDS IN DEPENDENCY PROCEEDINGS

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Providing children's disclosures to their mental health therapists greater protection in juvenile dependency cases recognizes the importance of privacy in therapeutic communications. Numerous children are required by juvenile courts to divulge the most intimate details of their lives to mental health experts only to have those disclosures revealed in court proceedings. Reversing the presumption that children's mental health records may be discussed openly in dependency litigation and requiring courts to perform in camera reviews affords children the dignity and respect adults take for granted. Ensuring greater confidentiality for children's mental health records is one step the legal system should take to protect these fragile victims of abuse and neglect.

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> *No one will deny that the law should in some way effectively use expert knowledge wherever it will aid in settling disputes. The only question is as to how it can do so best.*
>
> Learned Hand[1]

INTRODUCTION

Children rarely participate in deciding whether and how much of their mental health records gets disclosed in dependency proceedings in juvenile courts.[2] As these children are often separated from their parents and families, they rarely have concerned adults involved in their daily lives advocating their privacy interests when they have been involved in mental health evaluations, assessments, treatment, or therapy. Learning that the information supplied to a mental health professional may find its way into a court record, or may become the subject of discussion in a

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[1] *Historical and Practical Considerations Regarding Expert Testimony*, 15 HARV. L. REV. 40, 40 (1901).

[2] For a discussion about increasing the participation and involvement of children in state care in the decisions which impact their lives, see Judy Cashmore, *Promoting the Participation of Children and Young People in Care*, 26 CHILD ABUSE & NEGLECT 838 (2002).

court proceeding, is more than a little overwhelming. For a child in a dependency case, such disclosures are not simply embarrassing.[3] Such disclosures may easily cause the child to forego any further communications with an otherwise trusted mental health professional. Thus, children at risk for mental, emotional, or behavioral disorders may not receive necessary mental health services while in state custody.[4] Balancing the needs of dependency courts seeking to provide a safe haven for children while protecting the confidentiality of children's mental health records is a challenging but worthwhile objective. Rather than assuming that children's mental health records should routinely be available and disclosed in dependency proceedings, there are compelling reasons to create procedural safeguards to restrict access to these records whenever possible. Preserving the confidentiality of therapeutic interventions with children should be a fundamental objective of dependency courts.

As a society, we continue to struggle with the ways in which we treat minors differently from adults in the legal system. Much of the underlying tension in the representation of child clients stems from the lack of certainty of the legal rights of children.[5] This tension is epitomized by legislatures adopting paternalistic juvenile

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[3] *See* Dorothy E. Roberts, *Is There Justice in Children's Rights?: The Critique of Federal Family Preservation Policy*, 2 U. PA. J. CONST. L. 112, 112 (1999) (noting that federal child welfare policy in dependency cases has shifted emphasis from the reunification of children in foster care with their biological families under the Adoption Assistance and Child Welfare Act of 1980, Pub. L. No. 96-272, 94 Stat. 500, to support for adoption of these children to new families by adopting swifter timetables for terminating the rights of abusive or neglectful biological parents under the Adoption and Safe Families Act (ASFA) of 1997, Pub. L. No. 105-89, 111 Stat. 2115 (codified in sections of 42 U.S.C.)).

[4] The 2001 Report of the American Bar Association's Steering Committee on the Unmet Legal Needs of Children indicated that:

> An estimated one in five children in the United States has a mental, emotional or behavioral disorder, and many suffer from disorders that substantially diminish their ability to function. Four million children suffer from a "major mental illness that results in significant impairments at home, at school, and with peers . . . ."
>
> A substantial number of children at risk for mental illness and substance abuse do not receive necessary mental health services.

ABA STEERING COMM. ON THE UNMET LEGAL NEEDS OF CHILDREN, AMERICA'S CHILDREN STILL AT RISK 75 (2001) (quoting U.S. DEP'T. OF HEALTH AND HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 124 (1999)) (citation omitted).

[5] For a general discussion of the inconsistencies of the court system's handling of the rights of children in different contexts — within their families, in the social service system, in health care, in education, in juvenile justice, and in employment — and a proposal for the development of a national policy based upon the 1989 United Nations Convention on the Rights of the Child, see NANCY E. WALKER, CATHERINE M. BROOKS, & LAWRENCE S. WRIGHTSMAN, CHILDREN'S RIGHTS IN THE UNITED STATES, IN SEARCH OF A NATIONAL POLICY (1999). For a discussion of the U.S. Supreme Court's rulings in children's rights cases over the past four decades, see generally Susan Gluck Mezey, *Constitutional*

curfew laws[6] while simultaneously lowering the age at which children may be tried in adult criminal courts and exposed to the harshest of penal sanctions, the death penalty.[7] States restrict the ability of children to vote, operate motor vehicles[8] or purchase alcohol,[9] but adopt judicial bypass provisions allowing minors to obtain abortions without parental knowledge or consent.[10] The concept of confidentiality of mental health records[11] — taken for granted by adult patients — is often ignored or minimized when patients are minors. Given the inherent limitations the law imposes on the rights of minors,[12] it is not difficult to understand why children's

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Adjudication of Children's Rights Claims in the United States Supreme Court, 1953-92, 27 FAM. L.Q. 307 (1993).

[6] *See* 1 LEGAL RIGHTS OF CHILDREN, § 14.07, at 605 (Donald T. Kramer ed., 2d ed. 1994) (noting that while a state has more power to regulate and restrict the activity of minors than adults, it is unclear whether curfew laws are constitutionally valid); Brian Privor, *Dusk 'Til Dawn: Children's Rights and the Effectiveness of Juvenile Curfew Ordinances*, 79 B.U. L. REV. 415 (1999); Tona Trollinger, *The Juvenile Curfew: Unconstitutional Imprisonment*, 4 WM. & MARY BILL RTS. J. 949 (1996); Patryk J. Chudy, Note, *Doctrinal Reconstruction: Reconciling Conflicting Standards in Adjudicating Juvenile Curfew Challenges*, 85 CORNELL L. REV. 518 (2000).

[7] *See* Stanford v. Kentucky, 492 U.S. 361, 380 (1989) (upholding death penalty sentences for sixteen- and seventeen- year-olds); Thompson v. Oklahoma, 487 U.S. 815, 838 (1988) (overturning a death penalty sentence of a person under sixteen years of age on Eighth and Fourteenth Amendment grounds).

[8] *See* LEGAL RIGHTS OF CHILDREN, *supra* note 6, *at* § 14.06.

[9] *See id. at* § 14.09, at 621 (noting that the purpose of prohibiting the sale of alcohol to minors is to "protect them").

[10] *See id.* at § 14.16, at 653–54 (discussing the balancing to be done when evaluating these systems); *see also* J. Shoshanna Ehrlich, *Minors as Medical Decision Makers: The Pretextual Reasoning of the Court in the Abortion Cases*, 7 MICH. J. GENDER & L. 65, 69 (2000).

> By examining the Court's failure to consider the allocation of authority between parents and children in the critical realm of medical decision making, this article exposes the irrationality of the Court's acceptance of limitations on the abortion rights of minors and reveals the pronatalist thrust of the parental involvement decisions.

Id.

[11] *See* Joel Glover & Erin Toll, *The Right to Privacy of Medical Records*, 79 DEN. U. L. REV. 540, 549 (2002) (noting that the "right to privacy of medical records is seldom contested").

[12] The Supreme Court's refusal to recognize affirmative duties in the Constitution is often traced to its narrow reading of the Fourteenth Amendment in the *Slaughter-House Cases*. *See* Michael J. Gerhardt, *The Ripple Effects of Slaughter-House: A Critique of a Negative Rights View of the Constitution*, 43 VAND. L. REV. 409, 410–12 (1990) (challenging the Supreme Court's refusal to embrace the full meaning of the Fourteenth Amendment and not imposing affirmative rights). This restrictive rights approach is perhaps epitomized by the analysis of the Due Process Clause and its application to children in the foster care system in *DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 193 (1989) (denying that the state had a duty under the Due Process Clause to intervene and protect a child from abuse).

right to confidentiality of mental health records has received relatively little attention.[13] Nevertheless, the widespread reliance on mental health experts and records in juvenile law[14] involving dependency cases suggests that fundamental protections should be examined and provided to children whose lack of privacy would simply not be tolerated by adult patients involved in litigation.

Along with the increased public awareness of child sexual and physical abuse and neglect as a recurring social problem,[15] juvenile courts have increased their reliance on mental health experts, far beyond anything foreseen when the first juvenile court was established in Chicago in 1899.[16] Historically, juvenile court proceedings have been shrouded in secrecy in order to prevent children from becoming stigmatized[17] and to allow for their treatment and possible rehabilitation,

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[13] *But see* JOY PRITTS ET AL., THE STATE OF HEALTH PRIVACY: AN UNEVEN TERRAIN (A COMPREHENSIVE SURVEY OF STATE HEALTH PRIVACY STATUTES) 607 (1999).

[14] In addition to social workers, psychiatric social workers, physicians, nurses, and psychiatrists:

> [W]ith increasing frequency, psychologists are being called on to provide expert testimony in legal situations involving allegations of child sexual abuse. Some of these experts are clinical psychologists, functioning as forensic evaluators, treating clinicians, or researchers studying sexual abuse and related topics. Others are developmental and cognitive psychologists who focus on relating children's memory and suggestibility to their abilities to provide accurate testimony. As is the case with other professionals who serve as expert witnesses, the involvement of psychologists is based on the assumption that their expertise can facilitate the interpretation of evidence that is presented to the court.

Peter A. Ornstein & Betty N. Gordon, *The Psychologist as Expert Witness: A Comment*, *in* EXPERT WITNESSES IN CHILD ABUSE CASES: WHAT CAN AND SHOULD BE SAID IN COURT 237 (Stephen J. Ceci & Helene Hembrooke eds., 1998).

[15] Professor John E.B. Myers argues that the phenomenon and public recognition of child sexual abuse as a widespread social problem emerged from secrecy at four times in recent history. *See* 1 JOHN E.B. MYERS, EVIDENCE IN CHILD ABUSE AND NEGLECT CASES 163–65 (3d ed. 1997). The earliest emergence dates back to French physician Ambrose Tardieu's 1857 book, *A MedicoLegal Study of Assaults on Decency*, and the most recent emergence is credited to the 1962 publication of C. Henry Kempe and colleagues' *The Battered Child Syndrome*, 181 JAMA 17 (1962). *Id.*

[16] Sanford J. Fox, *Juvenile Justice Reform: An Historical Perspective*, 22 STAN. L. REV. 1187, 1191 (1970). *See generally* Barry C. Feld, *The Transformation of the Juvenile Court*, 75 MINN. L. REV. 691 (1991) (noting that the juvenile court has changed from what the Progressives imagined would be "an informal court whose dispositions reflected the 'best interests of the child'").

[17] This was especially true with juvenile delinquency cases. For a discussion of the policy reasons supporting closure of delinquency courts, and an argument supporting the opening of such hearings, see Stephan E. Oestreicher, Jr., Note, *Toward Fundamental Fairness in the Kangaroo Courtroom: The Due Process Case Against Statutes Presumptively Closing Juvenile Proceedings*, 54 VAND. L. REV. 1751 (2001).

whenever appropriate.[18] The enactment of the 1974 Child Abuse Prevention and Treatment Act created congressionally-approved guidelines for the states to follow in protecting the confidentiality of dependency proceedings.[19] Today, courts depend upon mental health professionals to both evaluate and treat the children and families who become parties in abuse and neglect cases, but the strict confidentiality of these proceedings is being challenged as states revise their policies of banning the public and the press from dependency cases.[20]

States approach the closing of dependency hearings in a number of different ways. Many jurisdictions continue to exclude the general public from all juvenile court proceedings.[21] However, approximately sixteen states have a statute or judicial rule that juvenile abuse and neglect proceedings must be open to the public, barring exceptional circumstances.[22] Some of these jurisdictions place no restrictions on the opening of dependency hearings.[23] Other jurisdictions allow the public and media access to juvenile proceedings based upon the nature of the

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[18] *See* Kent v. United States, 383 U.S. 541, 556 (1966) (stating that being "shielded from publicity" is one of the distinct features of the juvenile court system).

[19] Child Abuse Prevention and Treatment Act, Pub. L. No. 93-247, 88 Stat. 4 (1974) (codified and amended in 42 U.S.C. § 5101 *et seq.* (1966)).

[20] *See* Susan S. Greenebaum, Note, *Conditional Access to Juvenile Court Proceedings: A Prior Restraint or a Viable Solution?*, 44 WASH. U. J. URB. & CONTEMP. L. 135, 138–40 (1993); *see also* Emily Bazelon, Note, *Public Access to Juvenile and Family Court: Should the Courtroom Doors be Opened or Closed?* 18 YALE L. & POL'Y REV. 155, 156–59 (1999).

[21] *See, e.g.*, ALA. CODE § 12-15-65(a) (1975) (stating that the "general public shall be excluded from delinquency, in need of supervision, or dependency hearings"); HAW. REV. STAT. ANN. § 571-41(b) (Michie 2003) (stating that the "general public shall be excluded"); MASS. GEN. LAWS ANN. ch. 119, § 38 (West 2003) (stating that "all hearings . . . shall be closed to the general public"); N.H. REV. STAT. ANN. § 169-C:14 (Lexis Nexis 2001) (stating that the "general public shall be excluded from any hearing under this chapter"); WYO. STAT. ANN. § 14-3-424(b) (Michie 2003) (stating that members of the "general public are excluded from hearings under this act").

[22] Margaret Graham Tebo, *Opening Kid-Abuse Hearings: Minnesota Joining States That Allow Public Access to Juvenile Proceedings*, 2 A.B.A. J. E-Report 6 (Jan. 18, 2002). *See generally* Susan Harris, *Open Hearings: A Questionable Solution*, 26 WM. MITCHELL L. REV. 673 (2000) (providing background to the debate in Minnesota and arguing against opening of hearings).

[23] The following jurisdictions follow a presumption that juvenile hearings are open to the general public: FLA. STAT. ANN. § 39.507(2) (West 2002) (stating that "[a]ll hearings . . . shall be open to the public"); MONT. CODE ANN. § 41-5-1502(7) (2003) (stating that the "general public may not be excluded"); N.Y. CT. RULES § 205.4 (West 2000) (stating that "[t]he Family Court is open to the public"); 42 PA. CONS. STAT. ANN. § 6336 (West 2003) (stating that "general public shall not be excluded from any hearings"); TEX. FAMILY CODE ANN. § 54.08 (Vernon 2002) (stating that "the court shall open hearings under the title to the public").

hearings.[24] Finally, some jurisdictions grant the court much discretion[25] to either open or close proceedings based upon what appears to be in the child's best interest.[26] These variations in state policies have gradually shifted dependency hearings away from the total exclusion of the public and press during the litigation of abuse and neglect cases.[27] As a result, when a mental health professional testifies in a dependency proceeding, the testimony may be disclosed before people who are not connected to the child's case in any way.

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[24] The following jurisdictions usually treat dependency and delinquency adjudications differently. *Compare* ALASKA STAT. § 47.12.110(a) (Michie 2002) (stating that the "public shall be excluded from the hearing"), *with* ALASKA STAT. § 47.12.110(d) (Michie 2002) (stating that "a court hearing on a petition seeking the adjudication of a minor as delinquent shall be open to the public if the alleged act is a felony or other crime or behavior defined by this section"). *Compare* CAL. WELF. & INST. CODE § 346 (West 1998) (stating that the "public shall not be admitted to a juvenile court hearing"), *with* CAL. WELF. & INST. CODE § 676 (West 1998) (stating that "members of the public shall be admitted . . . to hearings concerning petitions filed pursuant to Section 602" which contains a list of felony offenses). *Compare* MINN. STAT. ANN. § 260C.163(1)(c) (West 2003) (stating that "the court shall exclude the general public from hearings under this chapter") *with* MINN. STAT. ANN. § 260B.163(1)(c) (West 2003) (stating that "[t]he court shall open the hearings to the public in delinquency . . . proceedings" where the offense would be a felony and the accused is at least 16 years of age). *Compare* N.M. STAT. ANN. § 32A-4-20(B) (Michie 1978) (stating that "[a]ll abuse and neglect hearings shall be closed to the general public"), *with* N.M. STAT. ANN. § 32A-2-16(B) (Michie 1978) (stating that "all hearings on petitions pursuant to the provisions of the Delinquency Act [this article] shall be open to the general public").

[25] For a brief discussion of the constitutionality of the Federal Juvenile Delinquency Act, 18 U.S.C. § 5031–5042 (2000), which authorizes closure of hearings at the discretion of the judge, see Cheri Panzer, *Access to Juvenile Court Proceedings*, 18 J. JUV. L. 209, 214 (1997) (arguing that "the Act does not violate First Amendment nor common law rights of public access to juvenile court proceedings because it does not mandate the closure of juvenile court proceedings"); Lauren A. Stagnone, *Allowing Judicial Discretion in Determining Closure of Juvenile Proceedings* — United States v. Three Juveniles, 61 F.3d 86 (1st Cir. 1995), 30 SUFFOLK U. L. REV. 999, 999 (1997) (discussing the constitutional issues raised by the First Circuit's holding that the Federal Juvenile Delinquency Act gave judges discretion to decide whether or not to close juvenile court proceedings to the public).

[26] *See, e.g.*, N.J. STAT. ANN. § 2A:4A-60(g) (West 1987) (stating that "the court may . . . permit public attendance during any court proceeding at a delinquency case, where it determines that a substantial likelihood that specific harm to the juvenile would not result"); N.C. GEN. STAT. § 7B-801(a) (2001) (stating that "the court in its discretion shall determine whether the hearing or any part of the hearing shall be closed to the public"); OHIO REV. CODE ANN. § 2151.35 (West Supp. 2003) (stating that "the court still may admit to a particular hearing . . . those persons who have a direct interest in the case and those who demonstrate that their need for access outweighs the interest in keeping the hearing closed").

[27] *See* William Wesley Patton, *Pandora's Box: Opening Child Protection Cases to the Press and Public*, 27 W. ST. U. L. REV. 181, 182 (2000) (noting that "[e]ven though the press and public do not possess a constitutional right of access to child protection proceedings and records, several legislatures and members of the public have recently begun to move toward opening those hearings and records").

Even when states bar the public and press from dependency hearings, mental health professionals are called upon to divulge children's disclosures frequently made under the assumption that the statements would be held in confidence. In many cases, mental health professionals play a pivotal role in litigation, and their professional opinions[28] are often the persuasive testimony that allows a court to adjudicate children dependent in child abuse and neglect cases.[29] In many cases involving sexual misconduct, the testimony of mental health experts may be most compelling where no physical or medical evidence corroborates the dependency allegations.[30] The American Academy of Pediatrics Committee on Child Abuse and

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[28] It is important to recognize that the professional opinions of these mental health experts are just that, opinions. Although the juvenile dependency system is very dependent upon the diagnoses and treatment regimens offered by mental health professionals, these determinations and recommendations are subject to error — perhaps yet another reason to maintain the confidentiality of the mental health reports and evaluations. Some researchers have acknowledged that:

> Unfortunately, clinical judgments can be surprisingly inaccurate. Studies have shown that mental health professionals often assign diagnoses when behavior does not meet published criteria (Morey & Ochoa, 1989); fail to discriminate the test results of actual clients from subjects who are asked to fake disability (Faust, Hart, & Guilmette, 1988; Faust, Hart, Guilmette, and Arkes, 1988); and overlook pathology in clients who are not typical examples, or good "prototypes," of a disorder (Garb, 1996). In fact, some researchers have shown that trained professionals often do no better than simple formulas at diagnosing or predicting clients' behavior, and no better than lay persons in treating behavior disorders (see Dawes, 1994b, and Grove and Meehl, 1996, for reviews, and Garb, 1989, 1992, for exceptions).
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> *There is no reason to believe that the judgments made in child abuse evaluations deviate from these general trends.*

DEBRA A. POOLE & MICHAEL E. LAMB, INVESTIGATIVE INTERVIEWS OF CHILDREN: A GUIDE FOR HELPING PROFESSIONALS 212 (1998) (emphasis added).

[29] Ceci and Bruck suggest that:

> When a child comes to court to testify, it is often because she is the sole witness to a crime. This is particularly likely to be the situation in sexual abuse cases, where not only is the child the sole witness, but there may be no medical signs of abuse, or circumstantial physical evidence. The difficulty posed by uncorroborated reports of sexual abuse is compounded by the fact that the testimony of young children may at times seem to lack credibility.

STEPHEN J. CECI & MAGGIE BRUCK, JEOPARDY IN THE COURTROOM: A SCIENTIFIC ANALYSIS OF CHILDREN'S TESTIMONY 269 (1995).

[30] Myers counsels that:

> Child sexual abuse is often difficult to prove. The child is usually the only eyewitness. In *Pennsylvania v. Ritchie*, the Supreme Court noted that "[c]hild abuse is one of the most difficult crimes to detect and prosecute, in large part because there often are no witnesses except the victim." [480 U.S. 39, 60 (1987)] [A]lthough most children are competent witnesses, some cannot take the stand. Many children find the courtroom a forbidding place, and, when a child is asked

Neglect has recognized that properly diagnosing child sexual abuse can often occur based on the child's history alone, that physical findings are often absent, and that many types of abuse leave no physical evidence.[31] Because of the lack of physical evidence in many of these cases, the opinions and findings of mental health professionals often serve as the foundation for a court's decision to adjudicate a child in need of care or dependent. Following mental health professionals' crucial involvement in the adjudication stage of dependency cases,[32] these professionals often continue their involvement by providing additional evaluations and treatment or therapy for children and their families throughout the disposition and sometimes post-disposition phases of dependency cases.[33]

Some of the children involved in abuse and neglect cases are fortunate enough to find placements in safe and secure environments — including being returned to their own families[34] — in a relatively short period of time,[35] or they may spend months, or sometimes even years,[36] of their childhood in group placements or foster

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to testify against a familiar person, especially a loved one, the experience can be overwhelming. Consequently, children's testimony is sometimes ineffective. The problems of ineffective testimony and lack of eyewitnesses are compounded by the paucity of physical evidence in many child sexual abuse cases. (*Citing* Mark D. Everson & Barbara W. Boat, *False Allegations of Sexual Abuse by Children and Adolescents*, 28 J. AM. ACADEMY OF CHILD & ADOL. PSHY. 230–35, at 230 (1989) ("physical evidence is found in only 15% of confirmed cases")).

1 JOHN E.B. MYERS, EVIDENCE IN CHILD ABUSE AND NEGLECT CASES 411–12 (3d ed. 1997).

[31] *See* American Academy of Pediatrics, Committee on Child Abuse and Neglect, *Guidelines for the Evaluation of Sexual Abuse of Children: Subject Review*, 103 PEDIATRICS 186, 188 (1999).

[32] The adjudication is crucial because unless the state (or the petitioning party) is able to sufficiently prove allegations of abuse or neglect, the child may be returned to a harmful — in some cases, life threatening — environment. Mental health professionals, however, often are involved in providing services to families prior to the filing of legal petitions. They may provide therapy or treatment through community mental health clinics or hospitals; however, the focus of this Article is on the testimony and record keeping of mental health professionals in the context of the litigation process.

[33] *See* George J. Alexander, *Big Mother: The State's Use of Mental Health Experts in Dependency Cases*, 24 PAC. L.J. 1465 (1993).

[34] For a critique of the ASFA's failure to adequately promote more adoptions of children in state foster care systems, see Robert M. Gordon, *Drifting Through Byzantium: The Promise and Failure of the Adoption and Safe Families Act of 1997*, 83 MINN. L. REV. 637 (1999).

[35] Note, however, that the amount of time from validation of abuse or neglect allegations until the child is returned home, placed in foster care, or adopted continues to be longer for African American children. *See* Stephen A. Kapp et al., *The Path to Adoption for Children of Color*, 25 CHILD ABUSE & NEGLECT 216 (2001).

[36] Dyer reports that:

According to the CWLA [Child Welfare League of America], there was a 21% increase in children in out-of-home care from 1990 to 1995, with a total of

homes.[37] Some estimate a 60% increase in the number of children in the United States foster care system from 1982 to 1995, when the number climbed to nearly 480,000.[38] Current estimates place more than 500,000 children in foster care systems throughout the nation.[39] In addition to having been abused or neglected[40] by their families, many of the children with cases in the juvenile court system suffer from prenatal exposure to drugs[41] or alcohol,[42] — with estimates of well over one

> 483,629 children in such placements in 1995. Of the children who left care in 1995, the median number of months spent in foster care was 11. Of the children who remained in care in 1995, the median number of months spent in foster care was 22.1.

FRANK J. DYER, PSYCHOLOGICAL CONSULTATION IN PARENTAL RIGHTS CASES 17 (1999).

[37] According to Goldstein:

> Following the permanency planning reforms of the Adoption Assistance and Child Welfare Act of 1980, it appears that the average length of stay in out-of-home placements dropped — an apparent success. But it appears that some children (15% in one study) who were returned home after briefer foster care placements soon reentered foster care because of reabuse.

ROBERT D. GOLDSTEIN, CHILD ABUSE AND NEGLECT 765 (1999).

[38] Laurel K. Leslie et al., *Children in Foster Care: Factors Influencing Outpatient Mental Health Service Use*, 24 CHILD ABUSE & NEGLECT 465, 466 (2000).

[39] *Id.*

[40] Despite the large numbers of children in foster care, the numbers of children who are *reported* to child protection services are even more staggering. Legal definitions of abuse and neglect differ from state to state, court required proof that children *have been harmed*, as opposed to simply a showing of potential future harm, and evidentiary problems in proving neglect or abuse contribute to the numbers of cases which are closed and never result in litigation:

> In 1984, 1,727,000 [children] were reported to CPS [child protective service agencies] (American Association for the Protection of Children, 1986); by 1994, 2.9 million children were reported to CPS nationwide, and 1 million of these cases were substantiated. Data from the 1994 National Child Abuse and Neglect Data System indicate that child neglect is reported at twice the rate of physical abuse and nearly four times the rate of sexual abuse. . . . Official estimates based on reported cases are clearly low; the Third National Incidence Study indicates that professionals do not report as much as 40% of the maltreatment that they identify (Sedlak & Broadhurst, 1996).

Diana J. English, *Evaluation and Risk Assessment of Child Neglect in Public Child Protection Services*, *in* NEGLECTED CHILDREN, RESEARCH, PRACTICE, AND POLICY 195–96 (Howard Dubowitz ed., 1999).

[41] *See* COCAINE, EFFECTS ON THE DEVELOPING BRAIN 846 (John A. Harvey & Barry E. Kosofsky eds., 1998); JAMES A. INCIARDI ET AL., COCAINE-EXPOSED INFANTS: SOCIAL, LEGAL, AND PUBLIC HEALTH ISSUES 5 (1997).

[42] *See* Sonja C. Davig, *Crack-Cocaine Babies: Protecting Society's Innocent Victims*, 15 HAMLINE J. PUB. L. & POL'Y 281, 281 (1994). Davig points out that:

> As many as 11% of pregnant women are using illegal drugs during pregnancy. The choice of drug for two-thirds of these mothers is crack cocaine. The cost to the state for these babies exposed to drugs throughout their mother's pregnancy

million "infants born each year prenatally exposed to alcohol and illicit drugs"[43] — mental retardation, attention-deficit or attention-deficit/hyperactivity disorder,[44] post-traumatic stress disorder,[45] nonorganic failure to thrive,[46] developmental delays,[47] and a number of other infirmities,[48] sometimes manifesting in different

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ranges from $6,000 to $250,000 per infant, varying on the severity of the drug-related problems.

Id. Judith Larsen et al., *Medical Evidence in Cases of Intrauterine Drug and Alcohol Exposure,* 18 PEPP. L. REV. 279 (1991) (discussing the kinds of evidence in hospitals and clinics which reveal, or disprove, infant drug and alcohol exposure); LaShanda D. Taylor, *Creating a Causal Connection from Prenatal Drug Use to Imminent Harm,* 25 N.Y.U. REV. L. & SOC. CHANGE 383 (1999). "Studies indicate that three-fourths of child neglect cases involve parental problems with drugs or alcohol." *Id.* at 384; *see also* Kenneth A. DeVille & Loretta M. Kopelman, *Fetal Protection in Wisconsin's Revised Child Abuse Law: Right Goal Wrong Remedy,* 27 J. L. MED. & ETHICS 332 (1999).

[43] Ira J. Chasnoff & Lee Ann Lowder, *Prenatal Alcohol and Drug Use and Risk for Child Maltreatment, A Timely Approach to Intervention, in* NEGLECTED CHILDREN, RESEARCH, PRACTICE, AND POLICY 132, 133 (Howard Dubowitz ed., 1999).

[44] *See* STEVEN R. PLISZKA ET AL., ADHD WITH COMORBID DISORDERS, CLINICAL ASSESSMENT AND MANAGEMENT (1999).

[45] *See* Peggy T. Ackerman et al., *Prevalence of Post Traumatic Stress Disorder and Other Psychiatric Diagnoses in Three Groups of Abused Children (Sexual, Physical, and Both),* 22 Child Abuse & Neglect 759 (1998); Kristin K. Schaaf & Thomas R. McCanne, *Relationship of Childhood Sexual, Physical, and Combined Sexual and Physical Abuse to Adult Victimization and Posttraumatic Stress Disorder,* 22 CHILD ABUSE & NEGLECT 1119 (1998).

[46] Nonorganic failure to thrive is the result of the failure of parents to provide basic nutritional and psychological nurturing needs of children which may impede physical growth. James M. Gaudin, Jr., *Child Neglect, Short Term and Long Term Outcomes,* in NEGLECTED CHILDREN, RESEARCH, PRACTICE, AND POLICY 89, 98 (Howard Dubowitz ed., 1999). In comparison, Gaudin notes that "organic failure to thrive results from a medical problem that impairs growth. The usual criteria are weight or height (or both) below the fifth percentile and weight or height below the 10th percentile for children of the same age." *Id.*

[47] *Id.* at 92.

[48] According to Patricia Sullivan, children with disabilities are at increased risk to be victims of child maltreatment:

> A comprehensive study of children taken into foster care completed by the University of Chicago School of Medicine found an overwhelming majority in need of medical and psychological intervention (Hochstadt et al., 1987). Physical evaluations found only 13% (out of 200) of the children to be normal. Physical problems included growth problems (height, weight, and head circumference); dermatologic, opthalmologic, neuromuscular, cardiovascular, dental, and pulmonary abnormalities; fetal alcohol syndrome (FAS); congenital anomalies; ear infections; and pregnancy. Psychological evaluations found 56% of the children over 3 years of age in need of psychological treatment, 52% of the children under 3 years of age in need of infant stimulation due to developmental delays, and 2% in need of psychiatric residential treatment. These findings are consistent with previous research indicating that abused and

degrees of comorbidity,[49] which require special attention while the cases are litigated or mediated.[50] Comorbidity appears to be relatively common in young people with mental retardation, anxiety disorders, learning disorders, and disorders of conduct and attentiveness.[51]

Other children are at risk for maltreatment or further abuse while they reside in foster care facilities,[52] for which the state may be legally liable.[53] Many of the children placed in out-of-home foster care facilities also suffer from isolation from friends, families, and schools, and the trauma of frequent changes in foster care placements, especially common among older foster children.[54] All of these children and their families frequently require mental health evaluations, and in many

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> neglected children have significant cognitive, developmental, and emotional deficits. (Elmer & Gregg, 1967; Fitch et al., 1976; Appelbaum, 1977; Kline, 1977; Koski & Ingram, 1977).

Patricia M. Sullivan, *Developmental Aspects of the Young Child in Maltreatment Cases*, *in* CHILD MALTREATMENT, A CLINICAL GUIDE AND REFERENCE 213, 236 (J.A. Monteleone & A.E. Brodeur eds., 2d ed. 1998).

[49] "Comorbidity" is the condition whenever two different disease processes are present in an individual patient. PLISZKA ET AL., *supra* note 44, at 4. *See also* Richard Famularo et al., *Psychiatric Comorbidity in Post Traumatic Stress Disorder*, 20 CHILD ABUSE & NEGLECT 953 (1996).

[50] *See* Inger Sagatun-Edwards & Coleen Saylor, *Drug-Exposed Infant Cases in Juvenile Court: Risk Factors and Court Outcomes*, 24 CHILD ABUSE & NEGLECT 925 (2000) (stating that the mother's behavior appears to be more important to outcomes of cases in juvenile court than ethnicity, past referrals, and criminal records).

[51] JAMES MORRISON & THOMAS F. ANDERS, INTERVIEWING CHILDREN AND ADOLESCENTS: SKILLS AND STRATEGIES FOR EFFECTIVE DSM-IV DIAGNOSIS 11 (2001).

[52] *See* Georgina F. Hobbs et al., *Abuse of Children in Foster and Residential Care*, 23 CHILD ABUSE & NEGLECT 1239 (1999).

[53] *See* Christina Chi-Young Chou, *Renewing the Good Intention of Foster Care: Enforcement of the Adoption Assistance and Child Welfare Act of 1980 and the Substantive Due Process Right to Safety*, 46 VAND. L. REV. 683 (1993); Christine M. Dine, Comment, *Protecting Those Who Cannot Protect Themselves: State Liability for Violation of Foster Children's Right to Safety*, 38 CAL. W. L. REV. 507 (2002); Brendan P. Kearse, *Abused Again: Competing Constitutional Standards for the State's Duty to Protect Foster Children*, 29 COLUM. J.L. & SOC. PROBS. 385 (1996).

[54] Heather N. Taussig, *Risk Behaviors in Maltreated Youth Placed in Foster Care: A Longitudinal Study of Protective and Vulnerability Factors*, 26 CHILD ABUSE & NEGLECT 1179 (2002).

> The long-term research on foster children grown up suggests that they are at risk of experiencing continued difficulties in adulthood. A recent study found that 12–18 months after leaving foster care (due to emancipation), 27% of the males and 10% of the females had been incarcerated, 37% had not finished high school, and 50% were unemployed. (Courtney & Piliavin, 1998).

Id. at 1180 (citations omitted).

instances mental health treatment or psychotherapy.[55] One group of researchers asserts that thirty-five percent to eighty-five percent of children entering foster care have significant mental health problems ranging from relational and coping difficulties and school failure, to emotional and behavioral disturbances causing moderate to severe impairment, with conduct disorder, attention disorders, aggressive behavior, and depression being the most common disorders.[56] The impact of abuse or neglect is not limited to the victim's childhood years. One scholar has noted that:

> Studies of adults with a known history of child maltreatment document that the adult years may exhibit a range of negative outcomes, including personality and mood disorders, substance abuse disorders, poor social adjustment, vulnerability to further victimization, and chronic physical health problems. While such disorders are not the *inevitable* outcome of early abuse or neglect, research documents that these outcomes occur significantly more often in adults who were abused as children than in adults with no history of abuse .... While many may appear to function adequately as adults, many of these adults pay a significant psychological cost that is reflected in chronic medical, mental health, and relationship difficulties, as well as occupational underachievement.[57]

Juvenile courts rely upon three groups of mental health professionals to evaluate and treat children and their families: psychiatrists (including psychoanalysts), psychologists, and social workers. The recent shift in the role of these three groups combined with the impact of managed health care systems[58] has resulted in non-medically trained professionals (psychologists and social workers) providing most psychotherapy ordered by courts or provided by state child protection agencies.[59] The difference in the fees charged by these mental health

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[55] *See* Candace A. Gross et al., *Extrafamilial Sexual Abuse: Treatment for Child Victims and Their Families*, 24 CHILD ABUSE & NEGLECT 9 (2000).

[56] Leslie et al., *supra* note 38, at 466–67.

[57] Barbara Whitman, *Psychological and Psychiatric Issues*, *in* ANGELO P. GIARDINO & EILEEN R. GIARDINO, RECOGNITION OF CHILD ABUSE FOR THE MANDATED REPORTER 137, 138 (3d ed. 2002) (internal citations omitted).

[58] *See* John Petrila, *Ethics, Money, and the Problem of Coercion in Managed Behavioral Health Care*, 40 ST. LOUIS U. L.J. 359 (1996).

[59] *See* MENTAL HEALTH, UNITED STATES, 1996 (Ronald W. Manderscheid & Mary Anne Sonnerschein eds., Center for Mental Health Services, 1996) (According to the American Psychological Association, practicing psychiatrists (with medical degrees) "numbered 34,500 in comparison to more than 70,000 clinical psychologists with a Ph.D. or Psy.D."); *see also* RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 58–59 (3d ed. 1999) (noting the numerical balance in favor of clinical psychologists is even greater if clinical psychologists who hold only a Master's degree are included).

professionals has contributed to the juvenile court system's increased reliance on the least expensive of the three groups of professionals[60] — usually social workers — as mental health evaluators and therapists for children and their families.[61] Nevertheless, psychiatrists and psychologists continue to play major roles as providers of mental health evaluations and treatment for children in the system.[62]

Startling numbers of children are either evaluated[63] or treated each year, with the Surgeon General estimating that 21% of children age nine and up have mental disorders, including depression, attention deficit hyperactivity disorder, and bipolar disorder.[64] Additionally, children with organic problems, ranging from mental retardation[65] to fetal alcohol syndrome,[66] must be evaluated and often require

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Additionally, the National Association of Social Workers reported 25,000 offering psychotherapy in the mid-1970's, while there were 60,000 by 1985. *See id.* at 54 (citing D. Gorman, *Social Workers Vault Into a Leading Role in Psychotherapy*, N.Y. TIMES, Apr. 30, 1985, at C1).

[60] For a discussion of the successful and unsuccessful legal attacks upon cost containment mechanisms used by managed health care organizations, see Allison Faber Walsh, Comment, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207 (1997).

[61] Jean Koh Peters has warned that court-appointed experts tend to have ongoing relationships with the court, rather than with the child, the child's family, or the child's attorney, and that:

> Unfortunately, rates of payment for these court-appointed experts remain relatively low. Until the rate of payment is raised to compensate fully the amount of time a complete evaluation should take, many court-appointed experts will be forced to seek a high volume of evaluations in order to be able to devote a substantial amount of their practice to (and to be able to make a living by) doing this difficult work.

JEAN KOH PETERS, REPRESENTING CHILDREN IN CHILD PROTECTIVE PROCEEDINGS: ETHICAL AND PRACTICAL DIMENSIONS 139 (1997).

[62] *Id.* at 138.

[63] One psychologist/attorney author has noted that:

> There is no paucity of tests available to assess, measure, and evaluate all sorts of human attributes. The most definitive source, *Tests in Print*, lists more than 3000 entries that cover, inter alia, achievement tests (91 tests), educational tests (128), intelligence tests/scholastic aptitude measures (233), personality tests (669), and assessments of vocational interests and skills (568). . . . Lawyers are most likely to see reports written on child and adolescent functioning that assess intelligence, infant development, academic achievement, visual-motor perception, auditory skills, motor proficiency, and personality.

Michael L. Lindsey, *Ethical Issues in Interviewing, Counseling, and the Use of Psychological Data with Child and Adolescent Clients*, 64 FORDHAM L. REV. 2035, 2042 (1996) (footnotes omitted).

[64] *See* Nancy Shute et al., *The Perils of Pills: The Psychiatric Medication of Children is Dangerously Haphazard*, U.S. NEWS & WORLD REP., Mar. 6, 2000, at 44.

[65] The use of the term "mentally retarded" can be especially problematic for a child:

> Labeling people as mentally retarded imposes a "shattering stigma," impairing

treatment. Even children with no diagnosable problems may be evaluated and exposed to mental health professionals in order to assist the children in coping with the separation from their families, or to aid them in the process of reuniting with often dysfunctional[67] families.[68]

Before identifying ways of protecting children's confidential communications with their mental health therapists, several observations are in order. First, a distinction should be made between ordinary medical records and mental health records. Second, a distinction may be made between confidentiality, privilege, and the privacy rights of children who disclose information to professionals. Third, it is important to recognize that the indiscriminate disclosure of children's mental health records may have harmful — at times, even catastrophic — effects on the lives of minor patients involved in juvenile proceedings. Fourth, mental health professionals who treat and attorneys who represent children are urged to take reasonable precautions to ensure the confidentiality of these mental health records. At the very least, professionals who work with children should attempt to limit the extent to which children's mental health issues and records are disclosed in court, absent some compelling reason for the disclosure.

I. MENTAL HEALTH RECORDS VERSUS OTHER MEDICAL RECORDS

A strong argument may be made that mental health records are uniquely different from ordinary medical records. Although many medical procedures give

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> their educational and occupational opportunities and dominating every aspect of their lives. The severe social disadvantages of labeling people as mentally ill or mentally retarded are augmented when the individual also is labeled *incompetent*, thereby confirming general stereotypes about mental disability and providing a further rationalization for the deprivation of social, occupational, and educational opportunities.

Bruce J. Winick, *The Side Effects of Incompetency Labeling and the Implications for Mental Health Law*, 1 PSYCHOL. PUB. POL'Y & L. 6, 12 (1995) (footnote omitted).

[66] *See* Larsen, Horowitz, & Chasnoff, *supra* note 42.

[67] *See* Maxia Dong et al., *The Relationship of Exposure to Childhood Sexual Abuse to Other Forms of Abuse, Neglect, and Household Dysfunction During Childhood*, 27 CHILD ABUSE & NEGLECT 625 (2003) (noting that childhood sexual abuse is frequently accompanied or strongly associated with multiple other forms of adverse childhood experiences and household dysfunction).

[68] Of course, not all families are good candidates for reunification:

> Not all parents involved in abusive behavior toward their children can be successfully treated. A few parents are too emotionally disturbed, either psychotic, mentally retarded or severely sociopathic, to be able to resume the tasks of caring for their children within a reasonable length of time before the children are grown.

HELPING THE BATTERED CHILD AND HIS FAMILY 14–18 (C. Henry Kempe & Ray E. Helfer eds., 1972).

rise to privacy concerns,[69] the simple act of consulting a mental health specialist, in itself, often creates such a stigma either in the minds of the public,[70] or from the perspective of the patient, that special treatment of mental health records should be considered.[71] Unlike most medical problems, the social stigma of mental health problems creates a barrier against patients seeking out treatment. Perhaps as developments in neurology and pharmacology become more widespread and accepted,[72] this social stigma will lessen or disappear, but at present it creates compelling problems for those who need mental health treatment and sometimes for those who provide the treatment. Perlin asserts that the discrimination against persons with mental disabilities has continued for years:

> Surveys show that mental disabilities are the most negatively perceived of all disabilities. Individuals with mental disabilities have been denied jobs, refused access to apartments in public housing or entry to places in public accommodation, and turned down for participation in publicly funded programs because they appear "strange" or "different." A series of behavioral myths has emerged suggesting that persons with mental disabilities are deviant, worth less than "normal" individuals, disproportionately dangerous, and presumptively incompetent.[73]

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[69] *See generally* JONATHAN P. TOMES, HEALTHCARE PRIVACY & CONFIDENTIALITY: THE COMPLETE LEGAL GUIDE (1994).

[70] A recent survey found that seventy-one percent of the general population thought that mental illness resulted from an emotional weakness; sixty-five percent thought bad parenting caused mental illness; and forty-five percent thought victims of mental illness could will it away. Only ten percent of the general public thought that mental illness "had a biological basis or involved the brain."

Maria A. Morrison, *Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. REV. 8, 9 (2000) (citing STEPHEN M. STAHL, ESSENTIAL PSYCHOPHARMACOLOGY: NEUROSCIENTIFIC BASIS AND CLINICAL APPLICATIONS 100 (1996)); *see also* Alison Bass, *Stigma Against Mental Illness Persists Despite New Research*, HOUS. CHRON., Feb. 16, 1992, at 3.

[71] *See generally* Wayne Edward Ramage, *The Pariah Patient: The Lack of Funding for Mental Health Care*, 45 VAND. L. REV. 951, 973 (1992).

[72] Medications are increasingly used in the treatment of emotional and behavioral disorders among adolescents (Greenhill and Setterberg, 1993; Simeon et al., 1995). The demonstrated efficacy and economy of pharmacotherapy suggests that medicine should and will be a vital element of a comprehensive treatment plan for many adolescents with psychiatric diagnoses.

R. Alan Williams et al., *Attitudes Toward Psychiatric Medications Among Incarcerated Female Adolescents*, 37 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 1301, 1302 (1998) (footnotes omitted).

[73] Michael L. Perlin, *The ADA and Persons with Mental Disabilities: Can Sanist Attitudes be Undone?*, 8 J.L. & HEALTH 15, 26–27 (1993–94).

Even health care professionals fail to seek out mental health care because of their fears of stigmatization and the potential consequences for their medical licensure.[74] Whether or not these fears are reasonable, they certainly exist and they have tremendous consequences.[75]

The impact of this stigmatization associated with mental health problems may be even greater on children: "'Twenty percent or less of kids with major depression get treatment,' says Neal Ryan, a professor of child psychiatry at the University of Pittsburgh. Many of the children who are diagnosed are massively undertreated, Ryan says, in part because of parents' fears of stigmatizing their children."[76]

Parental concerns about the stigma of a child's mental problems and the impact on either the child or the child's family members creates a compelling reason to safeguard this issue from public disclosure. While a parent might not hesitate to take a child with a broken arm to the hospital for treatment, the same parent might be reluctant to take the child to a mental health professional for treatment of depression. Although older adolescents might be able to seek out professional help on their own, perhaps from school counselors or publicly-funded mental health clinics, younger children are completely dependent upon their parents or guardians for such care. Thus, a parent's perception or fear might limit a child's access to mental health treatment.[77]

Because such a large segment of the population involved in juvenile court proceedings[78] are indigent,[79] their family mobility is limited in comparison to

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[74] *See* Steven H. Miles, *A Challenge to Licensing Boards: The Stigma of Mental Illness*, 280 JAMA 865 (1998).

[75] *See generally* Winick, *supra* note 65 (discussing the impact of labeling of mentally ill individuals as "incompetent" in the application of the law).

[76] Shute et al., *supra* note 64, at 44.

[77] Parental fears of stigmatization are not limited, of course, to exposing themselves to the possible label of mental illness. Parental fears may also dictate whether or not physically-injured children are brought to a hospital, or a health clinic. Parental fears over public disclosure that a family member suffers from an addiction might also preclude a child from receiving assistance. The potential stigmatization impact is not limited to issues of mental health, but it certainly is a major issue in many instances where mental health problems exist.

[78] Federle argues that:

> In many ways, the modern juvenile court continues to be an institutional response to the problems created by poverty. The dependency and foster care systems have retained certain practices that make poor children more likely to be the subject of a petition and less likely to escape foster care. For example, some critics argue that removals are attributable to a general disdain for the rights of poor parents; this may explain, in part, why poor parents are far more likely to be charged with child abuse or neglect. Moreover, the need to rescue children may signal a reluctance to return poor children to their parents; consequently, poor children comprise a disproportionate number of all children in the dependency and foster care systems. The Adoption and Safe Families Act of 1997, with its renewed emphasis on permanency planning leading to adoption

middle class and upper middle income families.[80] Disclosing compromising information about a family member in the community where a family lacks the resources to move makes it very difficult for the child — or the child's family — to avoid the consequences of the disclosure. Whereas people of means might consider moving to a community where they are not known, such an option may not be readily available to indigent families.[81] Additionally, even if a child's family were in a position to consider such a course of action, the child herself is essentially powerless in this situation,[82] that is, she cannot elect to move on her own in order

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> rather than reunification, signifies a return to child-rescue practices that disregard the rights of poor parents.

Katherine Hunt Federle, *Child Welfare and the Juvenile Court*, 60 OHIO ST. L.J. 1225, 1235 (1999) (footnotes omitted).

[79] The indigency of children involved in juvenile dependency proceedings makes them especially vulnerable. One observer has noted that "[a] critical challenge facing managed health care programs today is the creation of subsidized, workable health delivery programs for disenfranchised and medically fragile groups, especially poor, developmentally disabled children." Stephanie Rifkinson-Mann, M.D., Note, *The Impact of Managed Care Payer Contracts on the Subspecialty Medical Provider: Policy Implications That Impact on the Care of Disabled Children*, 27 FORDHAM URB. L.J. 1943, 1945 (2000) (footnote omitted).

[80] *See generally* WILLIAM JULIUS WILSON, THE TRULY DISADVANTAGED, THE INNER CITY, THE UNDERCLASS, AND PUBLIC POLICY (1987).

[81] Defining poverty in the U.S. has become somewhat complicated:

> The federal Office of Management and Budget defines poverty by setting money income thresholds for various family sizes. The federal Census Bureau in turn surveys the population to estimate the number of families who live below these threshold income levels. It counts the family's pre-tax money income, including wages, salaries, and Social Security and cash welfare benefits. It does not include capital gains or noncash benefits such as food stamps, health insurance payments, or medical benefits. The poverty line is adjusted annually to account for changes in the Consumer Price Index . . . . For example, a family of two lived below the official poverty threshold in 1995 if it had an annual income less than $9,933. The figure for a family of four was $12,158.

JULIE A. NICE & LOUISE G. TRUBEK, CASES AND MATERIALS ON POVERTY LAW: THEORY AND PRACTICE 6 (1997).

[82] According to Nice and Trubek:

> Children constitute only 26% of the general population, but 40% of all poor people. The Census Bureau reported that the poverty rate for children has been at or above 20% since the early 1980s.
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> According to a summary by the American Sociological Association, one-third of all children in the United States experience at least a year of poverty during their childhood. A 1998 report by the Children's Defense Fund and the National Coalition for the Homeless found that the number of children in extreme poverty (below half of the poverty line) increased by 400,000 between 1995 and 1997, coincidentally a period of economic growth.
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> In its in-depth study, *Dynamics of Economic Well-Being: Poverty 1993–1994*, the Census Bureau reported that children had the highest average monthly poverty rate (24.5%), episodic poverty rate (32.4%), chronic poverty rate

to achieve some degree of anonymity concerning her mental health problems.[83]

In contrast to mental health problems, treatment by a physician for physical ailments can often proceed successfully on the basis of a physical examination, objective information supplied by the patient, and the results of diagnostic tests. Public disclosure of such treatments rarely creates the type of stigma more commonly associated with mental illness. Rather obvious exceptions to this distinction include medical conditions which themselves carry stigmas, such as sexually-transmitted diseases and the AIDS-causing virus.[84] Additionally, other medical conditions and diseases — such as drug addiction[85] and alcoholism[86] — may require treatment jointly by physicians and mental health professionals, thus exposing the patient to potential stigmatization.

Effective psychotherapy, unlike most conventional medical treatment, requires an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears.[87] Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause potential embarrassment or humiliation. For this reason, the possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.[88] Sometimes the mere disclosure that a person is being treated for a mental health problem — regardless of the mental condition — creates a problem for the patient. The same phenomenon does not occur with most conventional — that is, non-mental health — medical treatments.

(9.4%), and entry rate (4.4%).
JULIE A. NICE & LOUISE G. TRUBECK, CASES AND MATERIALS ON POVERTY LAW: THEORY AND PRACTICE 5 (Supp. 1999).

[83] *See generally* LEROY H. PELTON, FOR REASONS OF POVERTY: A CRITICAL ANALYSIS OF THE PUBLIC CHILD WELFARE SYSTEM IN THE UNITED STATES (1989).

[84] *See* Grace Kathleen Hogan & Nicole Wertz, *Privacy, Privilege and the Right to Know: Disclosure of AIDS/HIV Status in the Physician-Patient Relationship*, 11 ST. JOHN'S J. LEGAL COMMENT. 805 (1996); Richard C. Turkington, *Confidentiality Policy for HIV-Related Information: An Analytic Framework for Sorting Out Hard and Easy Cases*, 34 VILL. L. REV. 871 (1989); Gary Williams, *California's Constitutional Right to Privacy: Can It Protect Private Figures From the Unauthorized Publication of Confidential Medical Information?*, 18 LOY. L.A. ENT. L. REV. 1 (1997).

[85] *See generally* PHILIP P. MUISENER, UNDERSTANDING AND TREATING ADOLESCENT SUBSTANCE ABUSE (1994).

[86] *See generally* BRYAN E. ROBINSON & J. LYN RHODEN, WORKING WITH CHILDREN OF ALCOHOLICS, THE PRACTITIONER'S HANDBOOK (2d ed. 1998).

[87] *See generally* Carolyn Peddy Courville, Comment, *Rationales for the Confidentiality of Psychotherapist-Patient Communications: Testimonial Privilege and the Constitution*, 35 HOUS. L. REV. 187 (1998).

[88] *See id.*

II. CONFIDENTIALITY, PRIVILEGE, AND PRIVACY

Although the terms confidentiality, privilege and privacy are often used interchangeably, their sources of origin and proper application are very different. The notion of confidentiality springs from the obligations professionals owe their patients or clients based upon ethical codes and licensing statutes.[89] Confidentiality may be viewed as an ethical duty owed by the professional to the patient or client. The patient ordinarily has the power to waive confidentiality either in writing or orally, whereas the professional does not ordinarily have the power to waive this duty.[90] In discussing the need to protect confidential records, Myers observes that:

> The ethical principles of medicine, nursing, and other professions require professionals to safeguard confidential information revealed by patients. The principles of medical ethics of the American Medical Association require physicians to "safeguard patient confidences within the constraints of the law." The Hippocratic oath states that "whatsoever I shall see or hear in the course of my profession . . . if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets." The Code of Nurses of the American Nurses Association states that nurses safeguard the patient's right to privacy by carefully protecting information of a confidential nature.[91]

Both the American Medical Association and the American Psychiatric Association have authority to enforce the Principles of Medical Ethics against their members,[92] while the National Association of Social Workers has its own Code of Ethics enforceable only against its members.[93] Similarly, the American Psychological Association has a Code of Conduct enforceable only against APA

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[89] *See generally* Gerard F. Glynn, *Multidisciplinary Representation of Children: Conflicts Over Disclosures of Client Communications*, 27 J. MARSHALL L. REV. 617, 621–22 (1994).

[90] *See* Audrey Rogers, *New Insights on Waiver and the Inadvertent Disclosure of Privileged Materials: Attorney Responsibility as the Governing Precept*, 47 FLA. L. REV. 159, 164 (1995) (discussing the authority to waive confidentiality).

[91] John E.B. Myers, *Medicolegal Aspects of Child Abuse*, *in* TREATMENT OF CHILD ABUSE: COMMON GROUND FOR MENTAL HEALTH, MEDICAL, AND LEGAL PRACTITIONERS 313, 319 (Robert M. Reece ed., 2000) (citing American Medical Assoc., Principles of Medical Ethics, Chicago: American Medical Assoc. 1989; and American Nurses Assoc., Code for Nurses, Wash. D.C.: American Nurses Assoc., 1985).

[92] *See* American Medical Assoc., Code of Medical Ethics (2001); American Psychiatric Assoc., The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (2001).

[93] *See* National Association of Social Workers, Code of Ethics, pmbl. (1999), and National Assoc. of Social Workers, Ethical Review Procedures, Rule 2 (2001).

members.[94] Each mental health profession is guided by its own separate ethical code, and the codes may also vary from state to state.[95]

A. Privilege

The notion of privilege is derived from evidentiary rules which prohibit disclosure of certain communications between a professional and the client or patient during pretrial proceedings such as depositions, during trials and during other judicial hearings.[96] There are three requirements which ordinarily attach to privileges: first, the communication must be between a patient and a professional with whom privileged communication is recognized under law; second, the patient must seek professional services; and third, only those communications that the patient intended to be confidential are considered privileged.[97]

The types of communications that are considered priveleged are ordinarily restricted to the professional services which are being provided, and the list of professionals who owe patients and clients this protection is also limited by statute. These are provisions which have been enacted by legislative bodies: in the case of proceedings in federal courts, Congress enacts the rules of evidence; in the case of state court proceedings, state legislatures enact the state rules of evidence. Although most states recognize in their evidence codes a physician-patient privilege, increasing numbers recognize psychotherapist-patient, psychologist-patient, and social worker-patient privileges as well.[98] Wigmore identified four conditions which must be satisfied before a privilege would be recognized in the law:

> (1) The communications must originate in a *confidence* that they will not be disclosed.
> (2) The element of *confidentiality must be essential* to the full and satisfactory maintenance of the relationship between the parties.
> (3) The *relation* must be one which in the opinion of the community ought to be sedulously *fostered.*

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[94] *See* American Psychological Assoc., Ethical Principles of Psychologists and Code of Conduct, Introduction (2003).

[95] LELAND C. SWENSON, PSYCHOLOGY AND LAW FOR THE HELPING PROFESSIONS 59 (2d ed. 1997).

[96] *See* Scott R. White, Comment, *Discovery of Non-Parties' Medical Records in the Face of the Physician-Patient Privilege,* 36 CAL. W. L. REV. 523 (2000).

[97] Myers, *supra* note 91.

[98] *See* GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS 660 (2d ed. 1997).

(4) The *injury* that would inure to the relation by disclosure of the communications must be *greater than the benefit* thereby gained for the correct disposal of litigation.[99]

Although Congress apparently failed to adopt a privilege for communications between psychotherapists and patients when it enacted the Federal Rules of Evidence, the United States Supreme Court was willing to create a new common-law based privilege in the landmark decision of *Jaffee v. Redmond*.[100] The Supreme Court recognized a federal privilege which applies to psychiatrists, psychologists, and licensed social workers engaged in psychotherapy.[101] The Court focused on the therapist's total dependence upon the willingness and ability of the patient to talk freely, reasoning that effective psychotherapy requires an "atmosphere of confidence and trust."[102]

B. Exceptions to Privilege

Because privileges are derived from rules of evidence which apply to pre-litigation (that is, depositions) and litigation contexts only, courts recognize exceptions to privileges. These exceptions suspend the application of the privilege in narrowly-defined contexts.[103] The application of evidentiary privileges, however, may be modified by decisions such as the California Supreme Court's ruling in

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[99] 8 JOHN HENRY WIGMORE, EVIDENCE 527 (John T. McNaughton rev. 1961).

[100] 518 U.S. 1 (1996).

[101] *Id.* at 15.

[102] *Id.* at 10. For a discussion of the effects of *Jaffe*, see generally Christopher B. Mueller, *The Federal Psychotherapist-Patient Privilege After* Jaffee*: Truth and Other Values in a Therapeutic Age*, 49 HASTINGS L.J. 945 (1998); Melissa L. Nelken, *The Limits of Privilege: The Developing Scope of Federal Psychotherapist-Patient Privilege Law*, 20 REV. LITIG. 1 (2000); Anne Bowen Poulin, *The Psychotherapist-Patient Privilege After* Jaffee v. Redmond*: Where Do We Go From Here?*, 76 WASH. U. L. Q. 1341 (1998); Lynda Womack Kenney, Note, *Role of* Jaffee v. Redmond's *"Course of Diagnosis or Treatment" Condition in Preventing Abuse of the Psychotherapist-Patient Privilege*, 35 GA. L. REV. 345 (2000).

[103] Although this notion of limiting the application of exceptions to evidentiary privileges is generally true, many commentators have suggested recently that exceptions to evidentiary privileges should be increased or broadened, or that courts should clearly define and adopt standards for waiver of the privilege. *See generally Evidence—Evidentiary Privilege—First Circuit Recognizes Crime-Fraud Exception to Psychotherapist-Patient Privilege* — In Re Grand Jury Proceedings (Gregory P. Violette), *183 F.3d 71 (1st Cir. 1999)*, 113 HARV. L. REV. 1539 (2000); Jack Achiezer Guggenheim & Aaron D. Werbel, *Confidentially Speaking: Why the Psychotherapist-Patient Privilege Should Include Employee Assistance Program ("EAP") Counselors*, 68 U. OF MO. KAN. CITY L. REV. 29 (1999); Alexandra P. West, Comment, *Implying Plaintiffs' Waivers of the Psychotherapist-Patient Privilege After* Jaffee v. Redmond, 59 U. PITT. L. REV. 901 (1998).

Tarasoff v. Regents of University of California,[104] where the court created a duty for therapists to warn third parties of dangers posed by therapists' patients. Thus, in limited circumstances, a therapist may feel compelled to disclose that the patient poses a danger to the public,[105] but this duty may *not* apply to forensic evaluators. Several commentators have observed that although:

> [M]ost jurisdictions now recognize a *Tarasoff*-type duty, the vast majority that do limit it to situations in which . . . "the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims." Moreover, application of the duty to therapists does not necessarily mean it also applies to evaluators, even in those situations where the attorney-client privilege would permit disclosure. A person does not normally have a legal obligation to help another unless he or she stands in a "special relationship" to that person. *Tarasoff* found that the therapist does have such a relationship with potential victims of patients, in part because the therapist's involvement with and control over the party's potential assailant is "significant," and in part because . . . the therapist possesses expertise in predicting who may be violent. But the *evaluator* may not have as much contact with the subject of an evaluation as a therapist does with a patient; moreover, malpractice law has traditionally made a distinction between "treating" and "examining" doctors and placed less of a duty on the latter.[106]

Perhaps most importantly, the enactment of mandatory child abuse reporting laws[107] has created a mechanism which overrides both the ethical duties of professionals to protect confidential communications and the legal privilege applicable in legal proceedings,[108] which shield from disclosure communications between professionals and their patients and/or clients.[109]

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[104] 551 P.2d 334 (Cal. 1976).

[105] *See* Fay Anne Freedman, *The Psychiatrist's Dilemma: Protect the Public or Safeguard Individual Liberty?*, 11 U. PUGET SOUND L. REV. 255 (1988); Vanessa Merton, *Confidentiality and the "Dangerous" Patient: Implications of* Tarasoff *for Psychiatrists and Lawyers*, 31 EMORY L. J. 263 (1982); D.L. Rosenhan et al., *Warning Third Parties: The Ripple Effects of* Tarasoff, 24 PAC. L. J. 1165 (1993).

[106] MELTON ET AL., *supra* note 98, at 76–77.

[107] *See* Brian G. Fraser, *A Glance at the Past, A Gaze at the Present, A Glimpse at the Future: A Critical Analysis of the Development of Child Abuse Reporting Statutes*, 54 CHI.-KENT L. REV. 641 (1977).

[108] *See* Elizabeth Anderson et al., *Consequences and Dilemmas in Therapeutic Relationships with Families Resulting from Mandatory Reporting Legislation*, 14 LAW & POL'Y 241 (1992).

[109] Myers, *supra* note 91, at 324.

C. Privacy Rights

The legal notion of privacy rights has evolved from statutory, common law, and constitutional rights.[110] The right to privacy has been described as "a sweeping concept, encompassing (among other things) freedom of thought, control over one's body, solitude in one's home, control over information about oneself, freedom from surveillance, protection of one's reputation, and protection from searches and interrogations."[111] The constitutional basis for privacy rights in non-criminal matters has been recognized in cases such as *Griswold v. Connecticut*,[112] *Eisenstadt v. Baird*,[113] and *Roe v. Wade*,[114] involving reproductive freedom, then expanded into a right to informational privacy in *Whalen v. Roe*.[115] Although the Supreme Court in *Whalen* expressly refused to hold that there was a constitutional right to privacy in medical records, many subsequent lower court decisions appear to rely upon the case as though it had recognized such a constitutionally based privacy right.[116] Of course, such a privacy interest has been recognized for adults, while it remains unclear whether minors will be successful in asserting such a privacy right.

Privacy rights have also evolved from cases involving challenges to unlawful searches and seizures in criminal matters.[117] The often used "reasonable expectation of privacy" standard, applied in the context of the Fourth Amendment, dates to Justice Harlan's 1967 concurring opinion in *Katz v. United States*.[118] The Supreme Court has rarely explored the application of children's privacy interests based on the Constitution.[119] Children's privacy interests and their reasonable

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[110] *See* Tom Gerety, *Redefining Privacy*, 12 HARV. C.R.-C.L. L. REV. 233 (1977); Ken Gormley, *One Hundred Years of Privacy*, 1992 WIS. L. REV. 1335 (1992); Robert C. Post, *Three Concepts of Privacy*, 89 GEO. L.J. 2087 (2001).

[111] Daniel J. Solove, *Conceptualizing Privacy*, 90 CAL. L. REV. 1087, 1088 (2002).

[112] 381 U.S. 479 (1965). Justice Douglas stated in his opinion that "specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance." *Id.* at 484. This created a substantive due process right to privacy while invalidating a state law prohibiting the use of contraceptive drugs or devices and counseling or aiding and abetting the use of contraceptives. *Id.*

[113] 405 U.S. 438 (1972) (invalidating a law prohibiting the distribution of contraceptives to unmarried persons under the Equal Protection Clause of the Constitution).

[114] 410 U.S. 113 (1973) (invalidating a Texas law prohibiting abortions, and holding that, although a woman's rights were not absolute, her right to elect an abortion does have real and substantial protection as an exercise of her liberty under the Due Process Clause of the Fourteenth Amendment).

[115] 429 U.S. 589 (1977).

[116] *See* Glover & Toll, *supra* note 11, at 540.

[117] *See generally* Sherry F. Colb, *What is a Search? Two Conceptual Flaws in Fourth Amendment Doctrine and Some Hints of a Remedy*, 55 STAN. L. REV. 119 (2002).

[118] 389 U.S. 347, 360–61 (1967) (Harlan, J., concurring).

[119] *See* Barbara Bennett Woodhouse, *The Constitutionalization of Children's Rights:*

expectations of privacy, however, in the context of searches performed on school premises and involving school drug testing programs[120] have been limited by the Supreme Court's decisions in *New Jersey v. TLO*,[121] *Vernonia School District 47J v. Acton*,[122] and *Board of Education v. Earls*.[123] These decisions have not recognized any prevailing right to privacy enjoyed by minors when allegations of Fourth Amendment rights violations have been raised.[124]

Incorporating Emerging Human Rights Into Constitutional Doctrine, 2 U. PA. J. CONST. L. 1 (1999). Woodhouse argues that:

> Children have few clearly articulated or firmly established constitutional rights in the United States of America. Children enjoy few independent rights outside the context of criminal or administrative proceedings, because children's rights (generally called "interests") are conceptualized as subsumed within the rights of parents. Children's interests are defined by parents, who exercise their constitutionally protected rights to physical custody and control of children's upbringing. Children have succeeded in asserting rights in various narrow areas, which are confined primarily to criminal procedure and equal protection law and based entirely in decisional doctrines rather than text. . . . They enjoy no federal constitutional rights to education or to programs of protection from abuse and exploitation, and no rights to the basic nutrition, income supports, shelter, and health care on which the right to life obviously depends.

Id. at 8–9.

[120] *See* Jason E. Yearout, Note, *Individualized School Searches and the Fourth Amendment: What's a School District to Do?*, 10 WM. & MARY BILL RTS. J. 489 (2002).

[121] 469 U.S. 325 (1985). In *T.L.O.*, the Court allowed a warrantless search in a school setting of a 14-year-old student's purse following a teacher's observation of the minor smoking in a restroom. The Court ruled that probable cause for the search was unnecessary. *Id.* at 341. Thus, the expectation of privacy for adults and juveniles is clearly different. *See* Sunil H. Mansukhani, *School Searches After* New Jersey v. T.L.O.*: Are There Any Limits?*, 34 U. LOUISVILLE J. FAM. L. 345 (1995–96); Robert E. Shepard, Jr., *School Searches After* T.L.O. *and* Veronia School District, 13 CRIM. JUST. 45, 45 (1998) ("[A] standard lower than probable cause — articulated as reasonable grounds or reasonable suspicion — governs school searches, and a violation of school rules as well as violations of the law may provide the impetus for the search. This is obviously a looser predicate than would apply with adults . . . .").

[122] 515 U.S. 646 (1995) (upholding a warrantless, suspicionless drug-testing program for high school students participating in interscholastic sports). The Court ruled that the minors had diminished expectations of privacy because of their status as custodians of the state acting in loco parentis, and because of the unemancipated minors' lack of the fundamental rights of self determination, not to mention their voluntary participation in sports programs. *Id.* at 655–57. "Traditionally at common law, and still today, unemancipated minors lack some of the most fundamental rights of self-determination — including even the right to liberty in its narrow sense . . . . They are subject, even as to their physical freedom, to the control of their parents or guardians." *Id.* at 654.

[123] 536 U.S. 822 (2002) (validating school policy of testing all students who participate in extra-curricular activities for drug use).

[124] *See* George M. Dery, III, *The Coarsening of Our National Manners: The Supreme Court's Failure to Protect Privacy Interests of Schoolchildren* — Vernonia School District

Although the United States Constitution does not expressly codify a right to privacy, approximately ten states and the District of Columbia have enacted explicit rights of privacy provisions in their constitutions.[125] It is difficult to predict how these specific enactments will be applied to protect minors. The application of a state-constitutionally-based right to privacy seems unlikely to expand to protect juvenile mental health records in dependency proceedings.[126] Because the patients are minors, the right to privacy is far more restricted than the right of adult patients, and guardians likely will have the right to waive such privacy rights of their minor wards or children.[127] Additionally, in the case of juveniles' therapy or mental health records which result from court-ordered interventions, the application of any privacy right theory would be balanced against the needs of the State to provide protection for children in dependency cases, or against the need to comply with a direct court order which seeks information about a party to pending litigation.

If the juvenile court has legitimate jurisdiction over the lives of children in dependency proceedings, the court must be free to evaluate and order necessary services for those children and to monitor the effectiveness of those services. If juveniles had an unqualified right of privacy[128] that effectively barred courts from ordering mental evaluations or reports from therapists, dependency courts would be marginalized in their ability to assess and order mental health treatment for children in their custody.

Rather than turning to the Constitution as a basis to assert some type of privacy protection over mental health records,[129] it seems more likely that statutory

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47J v. Acton, 29 SUFFOLK U. L. REV. 693 (1995); Meg Penrose, *Shedding Rights, Shredding Rights: A Critical Examination of Students' Privacy Rights and the "Special Needs" Doctrine After* Earls, 3 NEV. L. J. 411 (2003); Rosemary Spellman, Comment, *Strip Search of Juveniles and the Fourth Amendment: A Delicate Balance of Protection and Privacy*, 22 J. Juv. L. 159, 162 (2001–02); Stuart C. Berman, Note, *Student Fourth Amendment Rights: Defining the Scope of the* T.L.O. *School-Search Exception*, 66 N.Y.U. L. REV. 1077 (1991).

[125] *See* ALASKA CONST. art. I, § 22; ARIZ. CONST. art. II, § 8; CAL. CONST. art. I, § 1 (amended 1972); D.C. CONST. art. I, § 4; FLA. CONST. art. I, § 23; HAW. CONST. art. I, § 6; ILL. CONST. art. I, §§ 6, 12; LA. CONST. art. I, § 5 (amended 1972); MONT. CONST. art. II, § 10; S.C. CONST. art. I, § 10; WASH. CONST. art. I, § 7.

[126] At least one federal circuit has rejected the recognition of juveniles having informational privacy rights based on the Constitution in a class action suit against a juvenile court for its practice of compiling and disclosing social histories about juvenile offenders. *See* J.P. v. DeSanti, 653 F.2d 1080, 1090 (6th Cir. 1981) (holding that, absent some clear indication from the Supreme Court, "the Constitution does not encompass a general right to nondisclosure of private information").

[127] *See generally* JEFFREY ROSEN, THE UNWANTED GAZE: THE DESTRUCTION OF PRIVACY IN AMERICA (2000) (discussing the law of data protection and computer security).

[128] *See* Robert Post, *The Social Foundations of Privacy: Community and Self in the Common Law Tort*, 77 CAL. L. REV. 957 (1989) (discussing the necessity of limitations on the right of privacy).

[129] *But see* Ferguson v. City of Charleston, 532 U.S. 67, 78 (2001) (holding that regardless

enactments have greater potential to shield juvenile mental health records from disclosure. The federal regulations enacted under the Health Insurance Portability and Accountability Act ("HIPAA")[130] are based on the presumption that medical records are entitled to protection because of patients' privacy rights.[131] It is too soon to know whether this enactment will restrict disclosure of court-ordered mental health evaluations, or whether it even applies to the records of minors.[132] Other statutory enactments might be viewed as creating privacy protections for patients' medical records,[133] but such protections would likely not extend to mental health records made in compliance with court orders. Absent the passage of statutory provisions at the state or federal level which grant explicit recognition to the privacy rights of juvenile mental health records, children's advocates have little hope of advancing an argument that their clients have identifiable privacy rights[134] — separate and apart from the recognition given to the rights of adults — in this area.

III. THE IMPACT OF DISCLOSING CHILDREN'S MENTAL HEALTH RECORDS IN THE COURSE OF LITIGATION

As the director of a law school affiliated clinical program which represents children, the author has litigated a number of cases where children's mental health records have become the focus of litigation. Often, with no prior notice to the child

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of whether the right to privacy is protected by the Constitution, the "reasonable expectation of privacy enjoyed by the typical patient undergoing diagnostic tests in a hospital is that the results of those tests will not be shared with nonmedical personnel without her consent").

[130] *See generally* Health Insurance Portability & Accountability Act of 1996, Pub. L. No. 104–91, § 110 Stat. 1936 (1996). The Privacy Rule is codified in 45 C.F.R. § 164.

[131] *See* Glover & Toll, *supra* note 11.

[132] *See* Jack A. Rovner et al., *Managing the Privacy Challenge: Compliance with the Amended HIPAA Privacy Rule*, 15 HEALTH LAW. 18 (2002); Nick Littlefield & Colin Zick, *HIPAA: New Federal Privacy Rules and Their Implications*, 46 B. B.J. 14 (2002).

[133] For instance, medical records constitute "records" accorded protection under the Privacy Act, 5 U.S.C. § 552a (2000), where they include a patient's medical history, clinical findings and recommended therapeutic interventions. Williams v. Dep't of Veterans Affairs, 104 F.3d 670, 673 (4th Cir. 1997), *cert. denied*, 526 U.S. 1150 (1999) (holding that for purposes of the Privacy Act, one descriptive item about an individual constitutes a "record").

[134] *See, e.g.*, Benjamin F. Sidbury, Gonzaga University v. Doe *and Its Implications: No Right To Enforce Student Privacy Rights Under FERPA*, 29 J.C. & U.L. 655 (2003) (discussing the Supreme Court's decision which foreclosed private enforcement by a person whose educational records were improperly disclosed in violation of the Family Education Rights & Privacy Act of 1974, 20 U.S.C. § 1232g (2000)). *See generally* Lynn M. Daggett, *Bucking Up Buckley I: Making the Federal Student Records Statute Work*, 46 CATH. U. L. REV. 617 (1997); Lynn M. Daggett, *Bucking Up Buckley II: Using Civil Rights Claims to Enforce the Federal Student Records Statute*, 21 SEATTLE U. L. REV. 29 (1997) (discussing the difficulty of enforcing FERPA to protect student records).

or the child's counsel, the mental health professional has been called to testify about ongoing evaluations or therapy,[135] often in the patient's presence. Frequently, witnesses other than the mental health professional have been questioned about the child's treatment or diagnosis, the impressions of the mental health expert, or the recommended regimen of therapy.

Despite state evidence codes which ordinarily preclude the introduction of hearsay testimony at trial, the numerous hearsay exceptions recognized by the law[136] create myriad opportunities for a child's mental health records or statements made to a therapist or evaluator to be admitted in a juvenile proceeding.[137] Additionally, after a child has been adjudicated dependent, many jurisdictions relax the application of evidentiary rules which might otherwise restrict the admissibility of children's mental health records.[138] This is not uncommon in a legal system which is so dependent on the testimony of social workers charged with the responsibility of providing for the needs of children in state custody.

Because the system tends to be underfinanced, it often relies on social workers to report the findings, conclusions and recommendations of mental health professionals.[139] This is not to suggest that social workers are inadequate therapists, or that they are insensitive to the need for confidentiality of information learned when children enter the legal system. To the contrary, social workers often spend far more time providing therapeutic services to children than other licensed therapists. However, the primary reliance upon social workers in juvenile litigation is the result of concentrating resources on the payment of mental health professionals to provide mental health services, not to testify in court. It is also permitted because most courts relax their evidentiary code prohibitions against

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[135] For a discussion about the limitations of psychiatric and psychological evaluations and suggestions of strategies for challenging the "final product" of these mental evaluations, see generally, 1 JAY ZISKIN, *Challenging the Results & Conclusions of Psychiatric & Psychological Evaluations*, *in* COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 380 (5th ed. 1995).

[136] *See generally* 2 JOHN E.B. MYERS, EVIDENCE IN CHILD ABUSE AND NEGLECT CASES, § 7.1 (3d ed. 1997) (discussing the importance of hearsay in child abuse litigation).

[137] This author is not condoning the relaxation of all evidentiary rules in juvenile proceedings. There are serious questions about the actual reliability of details in some statements children make to professionals during interviews because of the limitations of interviewers' abilities to recall specific information. *See* Amye R. Warren & Cara E. Woodall, *The Reliability of Hearsay Testimony: How Well Do Interviewers Recall Their Interviews With Children?*, 5 PSYCHOL. PUB. POL'Y & L. 355 (1999).

[138] *See* Krista MacNevin Jee, Comment, *Hearsay Exceptions in Child Abuse Cases: Have the Courts and Legislatures Really Considered the Child?*, 19 WHITTIER L. REV. 559 (1998) (addressing the issues a court considers when balancing a defendant's constitutional rights and the court's interest in protecting evidence).

[139] *See* Lucy S. McGough, *Hearing and Believing Hearsay*, 5 PSYCHOL. PUB. POL'Y & L. 485 (1999) (discussing the admission of social workers' hearsay testimony).

hearsay testimony[140] in the post adjudication stage of dependency proceedings. Thus, there may be a social worker who provides mental health services in the case, but even if another licensed professional actually treated the child, a different social worker may actually testify in court about the status of the mental health treatment, because that social worker is likely to be the caseworker assigned to the case. Additionally, many jurisdictions allow such testimony to be admitted as exceptions to traditional hearsay rules under the diagnosis or treatment hearsay exception,[141] or because the rules of evidence may be relaxed in post-adjudicatory stages of the juvenile proceeding.[142]

Even in jurisdictions where such juvenile proceedings are closed to the public — and there is an increasing amount of pressure to open up juvenile proceedings up to the general public[143] — such disclosures may be — at the very least — sources of great embarrassment for the child patient. In one case where the Tulane Law Clinic represented an adolescent client, the client attempted suicide following disclosure by the client's therapist that the client had been diagnosed with HIV. The client had been diagnosed a year earlier, but seemed to adjust to her medical status. She maintained control and discretion over who was told about her status.

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[140] Federal Rule of Evidence 801(c) defines hearsay as "a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted." FED. R. EVID. 801(C).

[141] *See* John J. Capowski, *An Interdisciplinary Analysis of Statements to Mental Health Professionals Under the Diagnosis or Treatment Hearsay Exception*, 33 GA L. REV. 353, 361–62 (1999) (discussing the diagnosis hearsay exception); Robert R. Rugani, Jr., Comment, *The Gradual Decline of a Hearsay Exception: The Misapplication of Federal Rule of Evidence 803(4), The Medical Diagnosis Hearsay Exception*, 39 SANTA CLARA L. REV. 867 (1999) (discussing the federal courts' application of the diagnosis hearsay exception).

[142] Relaxing the evidentiary hearsay prohibitions in child abuse cases has taken on a life of its own in criminal prosecutions. *See* Lynne Celander DeSarbo, *The Danger of Value-Laden Investigation in Child Sexual Abuse Cases: Are Defendants' Constitutional Rights Violated When Mental Health Professionals Offer Testimony Based On Children's Hearsay Statements and Behaviors?*, 2 U. PA. J. CONST. L. 276 (1999); Jean Montoya, *Child Hearsay Statutes: At Once Over-Inclusive and Under-Inclusive*, 5 PSYCHOL. PUB. POL'Y & L. 304 (1999); William Wesley Patton, *Evolution in Child Abuse Litigation: The Theoretical Void Where Evidentiary and Procedural Worlds Collide*, 25 LOY. L.A. L. REV. 1009 (1992).

[143] *See* Joshua M. Dalton, *At the Crossroads of* Richmond *and* Gault*: Addressing Media Access to Juvenile Delinquency Proceedings Through a Functional Analysis*, 28 SETON HALL L. REV. 1155 (1998); Gordon A. Martin, Jr., *Open the Doors: A Judicial Call to End Confidentiality in Delinquency Proceedings*, 21 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 393 (1995); Shannon F. Mclatchey, *Media Access to Juvenile Records: In Search of a Solution*, 16 GA. ST. U. L. REV. 337 (1999); Susan S. Greenebaum, Note, *Conditional Access to Juvenile Court Proceedings: A Prior Restraint or a Viable Solution?*, 44 WASH. U. J. URB. & CONTEMP. L. 135 (1993); Danielle R. Oddo, Note, *Removing Confidentiality Protections and the "Get Tough" Rhetoric: What Has Gone Wrong With the Juvenile Justice System?*, 18 B.C. THIRD WORLD L.J. 105 (1998).

This information was somehow disseminated to the client's teacher, and then apparently to the client's classmates. The client's suicidal ideation did not appear to develop until she lost control and power over disclosure of her medical status.

Suicidal ideation is a major concern for mental health professionals who work with children and adolescents. Each year more than 2,000 American teenagers commit suicide, a rate that has more than doubled since the 1960s.[144] Although suicide is the eighth leading cause of death for all Americans, it is the third leading cause of death for young people aged fifteen to twenty-four.[145] Suicidal ideation is not only more common among severely physically abused and sexually abused children, but the pathology continues well past childhood.[146]

If the child has disclosed information under the assumption that the disclosure will remain in confidence, the very foundation necessary for therapeutic trust has been eroded. Compelling the therapist to disclose the child's communications in the child's presence may preclude any future effective therapy with the testifying therapist. The Supreme Court's *Jaffee v. Redmond* decision recognized that issues discussed in mental health therapy are so sensitive that "the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment."[147] Indeed, the child who perceives such disclosure as an act of betrayal on the part of the therapist may thereafter maintain suspicion of any other therapist as well. The consequences may eliminate the potential benefits of therapeutic intervention for that particular child. Although attitudinal barriers against communicating with therapists may not appear to create a major problem in the eyes of some, it may actually contribute to the ongoing social problem of intergenerational child abuse.[148]

Additionally, the impact of the disclosure may create a barrier when the child discusses the case with other professionals. The child patient whose "confidential" communications with his therapist have been disclosed may well be justified in deciding that no communications with professionals are truly confidential. Such a

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[144] *See* Andrea Sachs, *Catching Teens in Time*, TIME, May 15, 2000, *available at* http://www.time.com/time/archive/preview.

[145] CDC unpublished mortality data from the National Center for Health Statistics (NCHS) Mortality Data Tapes, *at* http://www.cdc.gov/ncicp/factsheets/suifacts.htm (last modified Jan. 28, 2000).

[146] *See* Susan L. Bryant & Lillian M. Range, *Type And Severity of Child Abuse and College Students' Lifetime Suicidality*, 21 CHILD ABUSE & NEGLECT 1169–70 (1997) (Physical and/or sexual abuse victims are four to seven times more likely to have suicidal thoughts and attempts than nonabused teens).

[147] Jaffee v. Redmond, 518 U.S. 1, 10 (1996).

[148] *See* Christine M. Kreklewetz & Caroline C. Piotrowski, *Incest Survivor Mothers: Protecting the Next Generation*, 22 CHILD ABUSE & NEGLECT 1305 (1998) ("Paradoxically, the children of incest survivor mothers are at high risk for sexual abuse, yet mothers are rarely perpetrators themselves. Therefore, an important issue for both mothers and clinicians alike is the protection and prevention of sexual victimization of the next generation.").

child may be inhibited from communicating with legal counsel, physicians, nurses and, social workers, in addition to the child's therapist. Once the child's trust is compromised, attempting to provide effective mental health treatment may be futile. It may be incumbent on the therapist to recognize the potential harm to the patient and to request direction from the court.

Of course, if the child is represented by counsel, the child's attorney should be the party to make such a request. Unfortunately, the child's counsel may be the party responsible for calling the therapist to the stand and posing the questions in the first place.[149] Limitations on statutory discovery in post-adjudication proceedings may impede counsel's opportunities to access information in advance of court hearings. As a result, the child's counsel may be in the difficult position of questioning the mental health expert with limited or no prior information about the status of the child's treatment. Of course, an attorney for any party may call the therapist to the stand and question the mental health professional about the patient's evaluation or therapy, thus leaving the door open to compromising the child's confidential communications, at least within the context of the court hearing.

It may be worthwhile to require a preliminary hearing before allowing children's mental health professionals to testify about the child's disclosures or condition. The court may not find it necessary for the child's therapist to disclose in detail what is occurring in the professional relationship. Further, if in the therapist's professional opinion it would be detrimental to the patient's recovery or treatment to disclose otherwise confidential information, such testimony should be offered in to the record before allowing the therapist to testify. Restricting the scope of the therapist's testimony may preserve the therapeutic relationship.[150] The difficulty with implementing such a process, however, is that it might be time consuming. Courts might be reluctant to add yet another layer of litigation to their already clogged dockets. Additionally, requiring therapists to appear for some type of preliminary hearing and the scheduled hearing takes time and probably increases

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[149] Much has been written about the poor quality of representation children receive in the nation's juvenile court system. *See generally A Report of the American Bar Association Presidential Working Group on the Unmet Legal Needs of Children and Their Families*, America's Children at Risk, A National Agenda for Legal Action (1993); Patricia Puritz et al., *Due Process Advocacy Project Report: Seeking Better Representation for Young Offenders*, 10 CRIM. JUST. 14 (1996); Janet Weinstein, *And Never the Twain Shall Meet: The Best Interests of Children and the Adversary System*, 52 U. MIAMI L. REV. 79 (1997).

[150] One group of experts notes that reports of forensic mental health evaluations are quite different from reports prepared for use in traditional clinical settings, in part because:

> [T]he substance of the report is more likely to become public knowledge, as part of a court record, through word-of-mouth statements of courtroom spectators or through media coverage of court proceedings. Thus, special care must be taken to minimize any infringement on the privacy rights of persons mentioned in the report.

MELTON ET AL., *supra* note 98, at 523.

the professional fees charged. This might ultimately reduce the availability of therapists willing to participate in such court proceedings, if they view each court hearing as a potentially time consuming process which reduces their available time for their other patients. However, such a process might also help ensure that the therapist is able to balance the demands of the court system with the therapist's duties and obligations to the juvenile patient without compromising either role.

If the court is unwilling for whatever reason to restrict the scope of the therapist's testimony, the consequences to the child should be balanced against the prospect of having the child present in the courtroom when the disclosure is made. If the child has disclosed suicidal or homicidal ideation in the course of therapy,[151] having such information openly disclosed in the child's presence in court may greatly exacerbate the child's already difficult plight.[152] Of course, if such information is withheld altogether from the court, the opportunity to ensure appropriate therapeutic response, or to ensure the protection of third parties or even the child herself, may have been lost. In any event, should it be necessary to disclose such information during a juvenile court proceeding, shielding the child from a public disclosure should be of paramount importance to the child's legal representative and the child's therapist.

IV. AMBIGUITIES IN LEGAL DECISION MAKING FOR CHILD CLIENTS IN DEPENDENCY CASES

One of the recurring issues attorneys face when representing minors is the legal concept of autonomy. Who ultimately has the authority and legal capacity to make decisions on behalf of children involved in legal proceedings?[153] Although this

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[151] *See* George C. Harris, *The Dangerous Patient Exception to the Psychotherapist-Patient Privilege: The* Tarasoff *Duty and the* Jaffee *Footnote*, 74 WASH. L. REV. 33 (1999).

[152] This focuses on the consequences of disclosure alone, not on the possible consequences of the suicidal or homicidal ideation. Obviously, a juvenile making such serious disclosures should be closely monitored. But some children make such statements seeking attention, and not intending to act upon their threats. The difficulty, of course, is knowing when to take such statements seriously and to respond appropriately.

[153] The changing legal definition of childhood has contributed to the issue. Commentators have observed that:

> The belief that adolescents are as capable as adults of making decisions about their lives also contributed to the attack on laws governing hospitalization for children. Little concerted attention was given to whether twenty-one was the most appropriate age for assumption of adult privileges and responsibilities until the Vietnam War, when the voting age was reduced from twenty-one to eighteen. Consideration of this issue evidently stimulated a reassessment of age requirements for other "adult" rights: the vast majority of states adopted eighteen as the maximum age of minority for almost all purposes shortly after the twenty-sixth amendment was ratified.

appears to be a fairly straightforward question which can be resolved by turning to the minor's parent or guardian,[154] the issue has become more complicated over time.[155] In one jurisdiction, children under the age of ten are incompetent to testify in court — unless they are victims of specific sexual abuse crimes — but they are eligible to be transferred to courts of general jurisdiction to be tried as adults.[156] In other words, they cannot give reliable testimony in court, but they can form the requisite *mens rea* to commit murder.

As children are increasingly the subjects of dependency legal proceedings, the parent's or legal guardian's relationship with the child may be radically altered. If the parent or guardian is accused of neglecting or abusing the child, then the parent's ability to make decisions about the child's life may be called into question. Legally, one might assume that even after a parent has been accused of neglecting or abusing the child, that an accusation alone would not be sufficient reason to deprive a parent's authority over his or her own child. However, some jurisdictions call for the immediate appointment of guardians *ad litem* to function in much the same legal capacity as a parent, thus relieving the natural parent of decision-making autonomy over the child.[157]

In many traditional legal settings, a lawyer who represents a minor as a client might turn to the minor's parents for direction about the objectives of the legal representation. However, in most dependency proceedings, the state has intervened in the family's life under the doctrine of parens patriae,[158] and the underlying reason

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Elyce H. Zenoff & Alan B. Zients, *If Civil Commitment is the Answer for Children, What Are the Questions?*, 51 GEO. WASH. L. REV. 171, 182 (1983) (footnotes omitted).

[154] In *Stanley v. Illinois*, the Supreme Court recognized that "'[i]t is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.'" 405 U.S. 645, 651 (1972) (citing Prince v. Massachusetts, 321 U.S. 158, 166 (1944)).

[155] *See generally* Robert Bennett, *Allocation of Child Medical Care Decision-Making Authority: A Suggested Interest Analysis*, 62 VA. L. REV. 285 (1976) (describing the allocation of legal responsibility for a child's medical care decisions among parents, the child, medical practitioners, and the state).

[156] Jacqueline Cuncannan, Note, *Only When They're Bad: The Rights and Responsibilities of Our Children*, 51 WASH. U. J. URB. & CONTEMP. L. 273, 290 n.82 (1997) (citing MO. REV. STAT. §§ 491.060(2), 211.071.1 (1996)).

[157] *See generally* Roy T. Stuckey, *Guardians* Ad Litem *As Surrogate Parents: Implications for Role Definition and Confidentiality*, 64 FORDHAM L. REV. 1785 (1996) (describing the role and responsibilities of guardians *ad litem*).

[158] The term "parens patriae" literally means "parent of the country," and:

> [It] refers traditionally to the role of the state as sovereign and guardian of persons under legal disability, such as juveniles or the insane, . . . and in child custody determinations, when acting on behalf of the state to protect the interests of the child. It is the principle that the state must care for those who cannot take care of themselves, such as minors who lack proper care and custody from their parents.

for the intervention is that the child has been neglected or abused. It would be anomalous for the child's attorney to turn to the parents for direction about the objectives of representation in such a scenario.[159] Haralambie addresses the issue by identifying the party with authority to waive the child's rights:

> It is not clear in most jurisdictions who has the authority to waive confidentiality for children. Parents usually have authority to waive the psychologist-patient or physician-patient privilege. In cases involving appointed counsel for the child, it is likely that the child and parents are at least procedurally adverse. In child abuse and neglect cases, the interests may be factually adverse also. A number of courts have held therefore that, in such cases, parents may lose their rights to waive professional privileges on behalf of their children; the child's attorney or guardian *ad litem* may then have the authority to assert or waive privileges on behalf of the child. Where the custodial parent and child's attorney have the same substantive position in the case (for example, when only one parent has abused the child, and the other parent is protecting the child), the custodial parent should sign an authorization, even if it is duplicative or unnecessary.[160]

If the parent directed the attorney to make every effort to defeat the legal proceedings, then the purpose behind the appointment of independent counsel for a child in a dependency proceeding would surely be defeated.[161] Nonetheless, many jurisdictions ignore this issue until after the child has been adjudicated dependent. That is, the parents' legal rights are somehow suspended until there is a judicial determination that the child has been neglected or abused. If the child is immediately placed in the custody of the state at the time of the filing of the

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BLACK'S LAW DICTIONARY 1114 (6th ed. 1990) (citations omitted).

[159] *See* Judith G. McMullen, *Privacy, Family Autonomy, and the Maltreated Child*, 75 MARQ. L. REV. 569, 592–99 (1992) (calling into question the "presumption that parents will consistently act in the best interests of their children").

[160] ANN M. HARALAMBIE, THE CHILD'S ATTORNEY, A GUIDE TO REPRESENTING CHILDREN IN CUSTODY, ADOPTION, AND PROTECTION CASES 58 (1993) (footnotes omitted).

[161] *See* Catherine J. Ross, *From Vulnerability to Voice: Appointing Counsel for Children in Civil Litigation*, 64 FORDHAM L. REV. 1571 (1996). Ross argued, "[F]irst, . . . that the interests of children and their parents do not necessarily coincide." *Id.* at 1582. "Second, that parents may not be motivated by their children's needs and interests." *Id.* at 1584. And "[t]hird, parents and state guardians do not and cannot always speak for their children, even if they are well-motivated and believe that their interests coincide with the child's." *Id.* at 1585; *see also* George H. Russ, *Through the Eyes of a Child, "Gregory K.": A Child's Right to be Heard*, 27 FAM. L.Q. 365 (1993) (discussion by the adoptive father of an 11-year-old boy who sued in his own name to terminate the rights of his biological parents, and to allow his foster parents to adopt him).

dependency petition, then the parents' rights over the child may be suspended and a legal guardian would be vested with the type of authority normally enjoyed by the parent. If the jurisdiction fails to provide for a temporary award of guardianship over the child, however, the child's attorney might actually be bound by the decisions made by the very parents[162] accused of neglecting or abusing the child in the first place.

V. THE ATTORNEY'S ETHICAL DUTIES

Yet another factor which adds to the complication is the ethical duty and obligation of the child's counsel. Because the ethics codes governing the conduct of lawyers were drafted with adult clients in mind, few specific provisions currently exist which regulate the ethical representation of child clients.[163] Despite the efforts of the American Bar Association to draft a specific ethics code applicable to child dependency litigation (the Standards of Practice for Lawyers Who Represent Children in Abuse and Neglect Cases),[164] no state supreme court has yet adopted the ABA-proposed ethics code. Nevertheless, the ABA Standards "express a clear preference for the appointment" of a lawyer who takes the role of the child's attorney, which is defined as "a lawyer who provides legal services for a child and who owes the same duties of undivided loyalty, *confidentiality*, and competent representation to the child as [are] due an adult client."[165]

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[162] *See* Stanley v. Illinois, 405 U.S. 645 (1972) (holding that the fundamental right to family integrity is guaranteed by the Due Process Clause of the Fourteenth Amendment, the Equal Protection Clause of the Fourteenth Amendment, and the Ninth Amendment); Pierce v. Soc'y of Sisters, 268 U.S. 510 (1925) (holding that a parent has a fundamental constitutional right to direct the upbringing and education of a child); Meyer v. Nebraska, 262 U.S. 390 (1923) (holding that a parent has a fundamental constitutional right in directing the upbringing and education of his/her child).

[163] *See generally* Robert E. Shepherd, Jr. & Sharon S. England, *"I Know the Child is My Client, But Who Am I?"*, 64 FORDHAM L. REV. 1917, 1951 (1996) ("Although attorney activities are regulated by the ABA Model Code of Professional Responsibility and the Model Rules of Professional Responsibility, commentators have observed that neither the Code nor the Rules adequately address the special problems of child advocates.").

[164] *Proposed American Bar Association Standards of Practice for Lawyers Who Represent Children in Abuse and Neglect Cases*, 29 FAM. L.Q. 375 (1995). These Standards were approved by the ABA Family Law Section in August, 1995, and then by the ABA House of Delegates in February, 1996. Linda D. Elrod, *An Analysis of the Proposed Standards of Practice for Lawyers Representing Children in Abuse and Neglect Cases*, 64 FORDHAM L. REV. 1999, 2002 (1996).

[165] The American Bar Association's Standards of Practice for Lawyers Who Represent Children in Abuse and Neglect Cases (1996), at §§ A-1, A-2, *available at* http://www.abanet.org/child/childrep.html.

Because of the failure of jurisdictions to adopt the ABA Standards of Practice, one might reasonably assume that a child's counsel should continue to turn to the child's parent or legal guardian for direction in making decisions about the child's legal problems.[166] The ABA Model Code of Professional Responsibility Ethical Consideration 7.12 provided that "[i]f a client under disability has no legal representative, his lawyer may be compelled in court proceedings to make decisions on behalf of the client."[167] The more recently enacted Model Rules of Professional Conduct offer not much more clarity in Rule 1.14(b) which provides that "[a] lawyer may seek the appointment of a guardian or take other protective action . . . only when the lawyer reasonably believes that the client cannot adequately act in the client's own interest."[168] Clearly, states need to adopt provisions which sever the legal autonomy of parents who are accused of neglecting or abusing their own children, at least until a legal determination has been made that the child may be safely returned to the family, or that the child should remain in the protective custody of the state.

Similarly, states should consider amending current legal ethics codes to provide for those situations in which an attorney must provide representation for a child in a dependency proceeding, but where the parental rights have not been terminated.[169] If a child has been removed from her family under suspicion that she was subject to abuse or neglect, that child's attorney should not be faced with any ambiguity as to who makes decisions immediately on behalf of the child. Moreover, the attorney should not have to unravel his or her ethical duties to the child because of the ambiguities of the current ethics codes.

Additionally, at least twenty-two jurisdictions have enacted laws which require attorneys to report child abuse,[170] thus creating a potential conflict for the lawyer who attempts to honor attorney-client privileged information on this issue. An additional pressure for counsel to comply with the mandatory reporting statutes[171]

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[166] *See generally Report of the Working Group on the Allocation of Decision Making*, 64 FORDHAM L. REV. 1325 (1996) (discussing who should make a child-client's decision in legal proceedings).

[167] MODEL CODE OF PROF'L RESPONSIBILITY EC 7-12 (1980).

[168] MODEL RULES OF PROF'L CONDUCT R. 1.14 (2003).

[169] On the issue of legal proceedings to terminate parental rights, see generally Donald C. Bross, *Terminating the Parent-Child Legal Relationship As A Response to Child Sexual Abuse*, 26 LOY. U. CHI. L.J. 287 (1995).

[170] *See* Robert P. Mosteller, *Child Abuse Reporting Laws and Attorney-Client Confidences: The Reality and the Specter of Lawyer as Informant*, 42 DUKE L.J. 203, 208 (1992) (noting that although the statutes typically apply to the general public, including lawyers, only a few statutes require lawyers in particular to report child abuse).

[171] *See* Ellen Marrus, *Please Keep My Secret: Child Abuse Reporting Statutes, Confidentiality, and Juvenile Delinquency*, 11 GEO. J. LEGAL ETHICS 509 (1998) (describing the tension between child abuse reporting statutes and attorney-client privilege).

is the prospect of criminal sanctions as well as civil liability for failing to report suspected child abuse cases.[172] However, as one author has noted:

> Even in states where lawyers are not mandated reporters, the significance of the confidentiality duty is undermined by the fact that, lawyer aside, the child is not in control of his own private information. In most cases, parents, even those whose children have been removed from their care, have a right to access a child's mental health records, school reports, and child welfare records (which may include information about a child's fear of his parents, his desire to be adopted, or other private information only indirectly related to the court procedure, such as his drug use and sexual activity). Moreover, no confidentiality rule confines disclosure by the parents, so they are free to share this information, as well as any secrets told to them by their children, with anyone they please.[173]

While an abuse/neglect complaint is under investigation, or at least before the court has entered a judgment that the child is dependent or neglected or abused, the child's attorney must be able to consult with an adult who has legal authority to make decisions on behalf of the child, pending the court's determination.[174] Although most jurisdictions appoint lawyers or guardians *ad litem* for children in dependency proceedings,[175] many jurisdictions have failed to address the issue of who has legal autonomy and decision-making capability for the child prior to the adjudication. If the evidence sustains an adjudication, then the guardian or the state's representative will be cloaked with such legal autonomy. Whereas, if the evidence is not sufficient and the court does not adjudicate the child dependent, then the legal autonomy presumptively returns to the minor's parents or legal guardians.

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[172] *See* Steven J. Singley, Comment, *Failure to Report Suspected Child Abuse: Civil Liability of Mandated Reporters*, 19 J. JUV. L. 236 (1998) (arguing that the imposition of civil liability on mandated reporters is counterproductive to protecting children, and that existing criminal sanctions provide adequate protection for children at risk).

[173] Emily Buss, *"You're My What?" The Problem of Children's Misperceptions of Their Lawyers' Roles*, 64 FORDHAM L. REV. 1699, 1729–30 (1996) (footnotes omitted).

[174] *See* JOSEPH GOLDSTEIN ET AL., BEFORE THE BEST INTERESTS OF THE CHILD 111–12 (1979) (suggesting that parents must be presumed to act in the best interest of their children, unless and until they are disqualified by a court of law, and this presumption is necessary to preserve both family integrity and parental autonomy).

[175] For a discussion of the differences in the roles and ethical duties of attorneys and guardians *ad litem* for children, see Buss, *supra* note 173.

VI. MENTAL HEALTH PROFESSIONALS' NEED TO OBTAIN PATIENT, PARENTAL, OR GUARDIAN CONSENT TO DISCLOSE

Given the difficulties and complications faced by the child's counsel, consider now the added problems which confront mental health professionals who provide services for children involved in dependency proceedings. In general, judges tend to give tremendous deference to the testimony and recommendations of mental health experts,[176] and these experts play a major role in the daily operations of the nation's juvenile dependency systems. Lawyers may turn to mental health experts for science-based precision in their opinions, an unrealistic expectation at best. One critic indicates:

> Diagnosis of psychopathology in children and adolescents is imprecise and unreliable. As a result, formal criteria for the admission of juveniles into inpatient psychiatric facilities have not yet been developed by either the American Psychiatric Association or the American Psychological Association. Although various professional and accrediting organizations have promulgated their own standards, the lack of scientific guidance has resulted in variegated admissions criteria among inpatient facilities.[177]

Assuming that the mental health professional satisfies the court's scrutiny as an expert witness under *Daubert v. Merrell Dow Pharmaceuticals, Inc.*,[178] the court may request evaluations, therapy, recommendations and opinions as to what is in the child's best interests in dependency proceedings.[179] Some of these professionals have treated their child patients before the legal dependency proceedings were initiated; thus, they have pre-existing relationships with their patients.[180] Other

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[176] *See* Donald N. Bersoff, *Judicial Deference to Nonlegal Decisionmakers: Imposing Simplistic Solutions on Problems of Cognitive Complexity in Mental Disability Law*, 46 SMU L. REV. 329 (1992).

[177] Dennis E. Cichon, *Developing a Mental Health Code for Minors*, 13 T.M. COOLEY L. REV. 529, 533 (1996) (footnotes omitted).

[178] 509 U.S. 579 (1993) (holding that the "general acceptance" standard for expert testimony was superseded by FED. R. EVID. 402). *See generally* Jane Goodman-Delahunty, *Forensic Psychological Expertise in the Wake of* Daubert, 21 LAW & HUM. BEHAV. 121 (1997).

[179] *See* Daniel W. Shuman, *What Should We Permit Mental Health Professionals to Say About "The Best Interests of the Child"?: An Essay on Common Sense,* Daubert, *and the Rules of Evidence*, 31 FAM. L.Q. 551 (1997).

[180] These pre-existing therapist-patient relationships may open the door to circumstances in which the patient's right to privacy has been limited, such as where the therapist is

mental health professionals are ordered by courts of law to provide evaluations[181] and/or treatment to child patients; thus they have no pre-existing relationship with the patient. Some of the mental health professionals are privately retained by the child's family (not necessarily the parents), guardians or foster family, while others are drawn to the case by virtue of providing services at public institutions such as adolescent mental health hospitals or mental health clinics. Thus, the mental health professionals are brought to the legal arena through a number of different entry points, and they may or may not have pre-existing professional relationships with the minors whom they evaluate and treat. The role of the mental health expert — doing investigative interviews, conducting evaluations, providing appropriate treatment plans, or providing actual therapy — should substantially alter the type of record and the information the expert compiles.[182]

In situations where the mental health professional has treated or evaluated the child patient prior to the state's involvement in a dependency action, the professional has probably disclosed the duties and obligations, as well as the limitations of those duties and obligations with the patient and the patient's parent or guardian. However, this prior relationship in and of itself provides no guarantee that the patient has been advised of the details and the limitations of confidentiality and the privacy of the patient's records. These duties of disclosure owed to patients are often found in the various professional codes of ethics.[183]

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obligated to disclose some medical records to the patient's employer or to the patient's insurance company. *See* David G. Scalise & Kevin P. Farmer, *Disclosure of a Patient's Medical Information to Third Parties: How Much Is Too Much?*, 22 LAW & PSYCHOL. REV. 199 (1998).

[181] *See generally* JONATHAN W. GOULD, CONDUCTING SCIENTIFICALLY CRAFTED CHILD CUSTODY EVALUATIONS (1998).

[182] In reviewing the theory and assessment techniques used to validate allegations of child sexual abuse for forensic purposes, Fisher and Whiting observe:

> In recent years, psychologists have been called on to assist the courts in drawing conclusions about the probability that an alleged child victim has been sexually abused. This has necessitated a shift in focus from clinical interviews primarily designed to provide a foundation for appropriate treatment plans, to investigatory interviews designed to substantiate whether a child has been abused. In contrast to interviews conducted to determine appropriate therapeutic procedures for identified victims of abuse, data collected for judicial evidentiary purposes must rigorously avoid interview bias (e.g., a priori assumptions that the abuse occurred) and contamination of the child's recollections. This is often difficult because in many situations a complaint has already been filed and the child has been questioned by one or several other investigators prior to seeing the psychologist.

Celia B. Fisher & Katherine A. Whiting, *How Valid are Child Sexual Abuse Validations?*, *in* EXPERT WITNESSES IN CHILD ABUSE CASES: WHAT CAN AND SHOULD BE SAID IN COURT 159, 161 (Stephen J. Ceci & Helene Hembrooke eds., 1998) (internal citations omitted).

[183] *See, e.g.*, Am. Med. Ass'n Principles of Medical Ethics, Op. E-5.05 (1994).

Voluntary membership professional organizations, such as the American Psychological Association, have adopted professional ethics codes with specific sections on forensic activities,[184] such as Standard 5.03, Minimizing Intrusions on Privacy, which requires psychologists to provide "only information germane to the purpose for which the communication is made" in oral and written reports.[185] The American Psychological Association added a section on forensic activities to its 1992 revision of the *Ethical Principles of Psychologists and Code of Conduct*, including Section 7.05 on prior relationships:

> A prior professional relationship with a party does not preclude psychologists from testifying as fact witnesses or from testifying to their services to the extent permitted by applicable law. Psychologists appropriately take into account ways in which the prior relationship might affect their professional objectivity or opinions and disclose the potential conflict to the relevant parties.[186]

Similarly, the American Academy of Psychiatry and Law has its own ethical guidelines which require psychiatrists to protect confidentiality and to notify clients about the limitations of confidentiality, as well as to obtain clients' informed consent whenever possible.[187] One group of experts has suggested that the "minimum standards for notice about the limits of confidentiality in a forensic context"[188] should include the following:

> (1) The name or role of the person(s) or agencies for whom the clinician is conducting the evaluation and to whom the clinician will submit a report.
> (2) The legal issues that will be addressed in the evaluation . . .

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[184] *See* Committee on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 LAW & HUM. BEHAV. 655 (1991).

> The *Specialty Guidelines for Forensic Psychologists* represent a joint statement of the American Psychology-Law Society and Division 41 of the American Psychological Association and are endorsed by the American Academy of Forensic Psychology. . . . The *Guidelines* provide an aspirational model of desirable professional practice by psychologists . . . in an activity primarily intended to provide professional psychological expertise to the judicial system.

Id. at 655–56.

[185] *See* RICHARD ROGERS & DANIEL SHUMAN, CONDUCTING INSANITY EVALUATIONS 41 (2d ed. 2000). Rogers and Shuman argue that in order to minimize privacy intrusions in insanity evaluations, "potentially prejudicial information regarding family history of criminality, substance abuse, or mental disorders are irrelevant to the issue of insanity and should not be included in court reports." *Id.* (footnote omitted).

[186] *See* American Psychological Association, *Ethical Principles of Psychologists and Code of Conduct*, 47 AM. PSYCHOLOGIST 1597–1611 (Dec. 1992b).

[187] ROGERS & SHUMAN, *supra* note 185, at 43 (*citing* AAPL Ethical Standards II, on confidentiality, and III, on informed consent).

[188] MELTON ET AL., *supra* note 98, at 88.

(3) The kinds of information most likely to be material to the evaluation and the proposed techniques (interview, testing, etc.) To be used to gather that information.
(4) The legal proceeding(s) (e.g., hearing; trial; posttrial sentencing hearing) at which testimony is anticipated.
(5) The kinds of information that may require special disclosure to third parties (e.g., an admission that one has abused a child) and the potential consequences for the individual.
(6) Whether there is a legal right to decline/limit participation in the evaluation and any known sanctions for declining.[189]

Even if the patient has been advised about the limitations of confidentiality, that confidentiality may be breached when the mental health professional is requested or compelled to disclose information[190] obtained during the prior or current treatment.[191] In those situations where the mental health professional has no prior relationship with the patient, however, it is important for the therapist/evaluator to disclose to the patient and/or to the patient's parent or guardian the limitations of confidentiality and privacy rights which the patient may enjoy. Obtaining the patient's voluntary and informed written consent[192] to disclose mental health records in certain specified situations — such as when the mental health professional is ordered to produce such information pursuant to a court order — provides clarity for the patient, and provides a measure of protection for the mental health

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[189] *Id.*

[190] *See* JAMES A. MONTELEONE, RECOGNITION OF CHILD ABUSE FOR THE MANDATED REPORTER (3d ed. 2002).

[191] Jean Koh Peters discusses many of the conflicts these professionals face, especially when requested to offer their opinion on what is in the client's best interests:

> First, if a professional is currently treating the client, writing a report to a court or attorney about the client's best interest could easily run afoul of the confidentiality which the professional promised to the client. Second, even if the confidentiality problems are resolved, through waiver, for instance, the professional may still conclude that stating an opinion and laying forth the evidence for that opinion at this juncture in the professional-child client relationship would compromise the relationship. . . . Similarly, testifying in court on a delicate matter like a child's removal from the home may forever taint the professional's relationship with the family. . . . [Additionally], because these professionals are already enmeshed in the client's life, they may not always have unbiased information to offer.

Jean Koh Peters, *The Roles and Content of Best Interests in Client-Directed Lawyering for Children in Child Protective Proceedings*, 64 FORDHAM L. REV. 1505, 1531 (1996).

[192] For a general discussion of the informed consent doctrine, see Alan Meisel et al., *Toward a Model of the Legal Doctrine of Informed Consent*, 134 AM. J. PSYCHIATRY 285 (1977).

professional.[193] The patient then has the right to determine what — if any — information he or she is comfortable in disclosing.[194] The mental health professional, on the other hand, has disclosed the circumstances and situations in which confidentiality may be breached. Although the informed consent doctrine for adult patients may be justified to protect an adult's right of self-determination and to protect against authoritarian medical treatment, these justifications are difficult to apply to child patients:

> Because it was thought that children lacked the capacity to provide consent for purposes of avoiding a battery, courts at common law held that until children reached majority, only a parent or legal guardian could give effective consent to medical treatment. What policies does this rule serve? It protects the child from the responsibility of deciding for himself. For infants and children who lack the maturity to evaluate alternatives and to make an informed choice, someone must decide on the child's behalf. But why parents? The general rule of paternal consent is in accordance with broad notions of family privacy, parental autonomy, and the importance of familial bonds. But at the root of the common law rule was the narrower notion that parents are legally responsible for the care and support of their children. Among other things, the parental consent requirement protects parents from having to pay for unwanted or unnecessary medical care and from the possible financial consequences of supporting the child if unwanted treatment is unsuccessful.[195]

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[193] The American Professional Society on the Abuse of Children's Guidelines for Evaluating Psychological Maltreatment recommend that:

> Professionals conducting forensic assessments should be aware of legal and ethical principles governing informed consent. Informed consent should be obtained unless such consent is unnecessary because of the forensic nature of the assessment. Whether or not informed consent is obtained, the professional should advise persons being assessed of the purposes of the assessment and the intended uses of any report or testimony resulting form the assessment.
>
> In forensic situations where informed consent is required but the person being assessed is incapable of giving such consent, the professional should consult with the legal counsel or the judge regarding the appropriate way to proceed.

Myers, *supra* note 15, at § 4.40.

[194] This may be a more commonplace problem in criminal/delinquency cases where the patient's admissions might jeopardize constitutional protections, especially if the patient has not been advised of his rights in advance of the forensic evaluation. *See* Kenneth E. Meister, Miranda *on the Couch: An Approach to Problems of Self-Incrimination, Right to Counsel and* Miranda *Warnings in Pre-Trial Psychiatric Examinations of Criminal Defendants*, 11 COLUM. J.L. & SOC. PROBS. 403 (1975); Christopher Slobogin, Estelle v. Smith: *The Constitutional Contours of the Forensic Evaluation*, 31 EMORY L.J. 71 (1982).

[195] ROBERT H. MNOOKIN & D. KELLY WEISBERG, CHILD, FAMILY, AND STATE: PROBLEMS AND MATERIALS ON CHILDREN AND THE LAW 601–02 (4th ed. 2000) (footnotes omitted).

Nevertheless, unlike situations where the mental health professional is providing therapy, the informed consent doctrine may not apply to forensic evaluations because "the evaluation is court-ordered and will proceed whether the subject wants it or not; in fact, . . . in criminal cases the defendant may risk sanctions upon a refusal to cooperate."[196]

Although the process of obtaining informed patient consent[197] to disclose mental health records may create some problems when the mental health professional is in the embryonic stages of the therapeutic relationship with the patient,[198] it may also be seen as empowering the patient and defining the terms of confidentiality and privacy rights. In addition, seeking informed consent, even from young patients helps the professional to ward off future malpractice actions.[199] Because mental health professionals are mandatory reporters of child abuse, patient disclosure documents should include the legal or statutory requirements of the jurisdiction in which the patient receives treatment. In addition to the jurisdiction's child abuse disclosure requirements, the mental health professional's ethical disclosure duties should also be incorporated in the patient disclosure document. Mandatory child abuse disclosure laws are not uniform, and the precise language of these statutes alters the legal duties of the affected professionals and their patients.

Actions for breach of confidentiality against therapists have been based upon contract law and tort law.[200] Although, at least one author has argued that there has been an increase in the number of reported cases against psychotherapists for breach of patient confidentiality, a number of reasons contributes to the relatively small number of cases actually reported: "the standard of care for psychotherapists is not as clearly defined as in other fields of medicine";[201] "negligence in this area tends usually only to exacerbate pre-existing emotional disorders";[202] "patients are reluctant to expose their mental health problems to the world";[203] patients and their

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[196] MELTON ET AL., *supra* note 98, at 79.

[197] *See generally* RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT (1986).

[198] One study found that roughly half (only 54.9%) of the mental health professionals surveyed in New York informed their clients about the limits of confidentiality and of their status as mandated reporters early in therapy, before the client revealed anything that aroused suspicion of child abuse or maltreatment. *See* Barbara Weinstein et al., *Mental Health Professionals' Experiences Reporting Suspected Child Abuse and Maltreatment*, 24 CHILD ABUSE & NEGLECT 1317, 1321 (2000).

[199] *See* Andrew Popper, *Averting Malpractice by Information: Informed Consent in the Pediatric Treatment Environment*, 47 DEPAUL L. REV. 819 (1998).

[200] *See* Ellen W. Grabois, *The Liability of Psychotherapists for Breach of Confidentiality*, 12 J.L. & HEALTH 39 (1998).

[201] *Id.* at 43.

[202] *Id.* at 44.

[203] *Id.*

psychotherapists usually enjoy healthy rapport;[204] and many patients simply fail to recognize the role the therapist might have played in the patient's situation.[205]

The very nature of the mental health services being provided to minors requires that some initial inquiry be made as to the capacity or competence of the child[206] to provide informed consent,[207] either to the treatment itself[208] or to the disclosure of mental health records. In the context of representing children in class action litigation, one commentator summed up the problem of children's incapacity by acknowledging that:

> Young children often cannot state their own needs and desires. Older children may be able to articulate their desires, but their desires may not be accepted as authoritative in dictating the actions of their counsel. Moreover, most structural reform cases on behalf of children involve poor and minority children, where parents and communities may also be unable to serve as a check on attorney power. At the same time, children usually cannot participate directly in the political process by voting, lobbying, organizing, or influencing the administrators of public agencies.[209]

Although legal capacity and competency are two different issues, they have much in common. In the case of pre-adolescent children, the parent, caretaker or guardian will have the legal capacity to consent to treatment and/or disclosure of mental health records.[210] However, empowering parents to make decisions about their children's mental health needs may be in part based upon a flawed assumption.[211] As one commentator has noted:

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[204] *Id.*

[205] *Id.*

[206] *See* Paul S. Applebaum & Thomas Grisso, *Assessing Patients' Capacities to Consent to Treatment*, 319 NEW ENG. J. MED. 1635 (1988); Lois A. Weithorn, *Children's Capacities for Participation in Treatment Decision Making*, *in* EMERGING ISSUES IN CHILD PSYCHIATRY AND THE LAW 28 (Diane H. Schetky & Elissa P. Benedek eds., 1985).

[207] *See generally* Thomas Grisso & Paul S. Appelbaum, *Mentally Ill and Non-Mentally Ill Patients' Abilities to Understand Informed Consent Disclosures for Medication*, 15 LAW & HUM. BEHAV. 377 (1991) (discussing informed consent and its relation to mental health).

[208] *See* Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 744–48 (1993).

[209] Martha Matthews, *Ten Thousand Tiny Clients: The Ethical Duty of Representation in Children's Class-Action Cases*, 64 FORDHAM L. REV. 1435, 1442 (1996) (footnotes omitted).

[210] *See* Jennifer L. Rosato, *Using Bioethics Discourse to Determine When Parents Should Make Health Care Decisions for Their Children: Is Deference Justified?*, 73 TEMP. L. REV. 1 (2000); Popper, *supra* note 199, at 330–32.

[211] *See generally* Dennis E. Cichon, *Developing a Mental Health Code for Minors*, 13 T.M. COOLEY L. REV. 529 (1996) (asserting that parents often institutionalize their children in psychiatric hospitals for inappropriate or harmful reasons).

> The assumption that parents act in their child's best interest is intuitively sensible and inherently appealing. It undoubtedly holds true in most families under normal circumstances. However, the legal system has extended this generally valid assumption to one area where it may not be tenable: the mental health context. The mental health literature is filled with anecdotal, case-study, and empirical data indicating that parents often act contrary to the best interests of their child in the area of mental health treatment.[212]

This assumption notwithstanding, parents are recognized as having the capacity to determine the mental health treatment needs of their children, especially pre-adolescent children.[213]

If the child in question is a party to a dependency proceeding, however, the parent's capacity to make mental health decisions may be suspended.[214] The child's legal guardian, guardian *ad litem*,[215] or perhaps even the child's counsel may be called upon to make decisions concerning mental health issues on behalf of the child in state custody. If this responsibility falls on the shoulders of the child's attorney, this creates ethical problems for the child's counsel to resolve.[216] During the 1996 Fordham Conference on Ethical Issues in the Representation of Children, one of the ten major themes highlighted was recognition that the lawyer's responsibilities with respect to the child whom he represents will vary depending on whether the child has capacity to direct the representation.[217] This issue is likely to be a constant concern in the field of child representation, and it should be determined on a client by client basis.

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[212] Redding, *supra* note 208, at 697–98.

[213] *See generally* Parham v. J.R., 442 U.S. 584 (1979) (holding that laws permitting parents to voluntarily commit their minor children to state mental hospitals do not violate the Due Process Clause of the Fourteenth Amendment).

[214] *See* Kelli Schmidt, Note, *"Who Are You to Say What My Best Interest Is?" Minors' Due Process Rights When Admitted by Parents for Inpatient Mental Health Treatment*, 71 WASH. L. REV. 1187, 1206–08 (1996).

[215] *See generally* Rebecca H. Heartz, *Guardians* Ad Litem *in Child Abuse and Neglect Proceedings: Clarifying the Roles to Improve Effectiveness*, 27 FAM. L.Q. 327 (1993).

[216] *See* Jesica Matthews Eames, Comment, *Seen But Not Heard: Advocating for the Legal Representation of a Child's Expressed Wish in Protection Proceedings and Recommendations for New Standards in Georgia*, 48 EMORY L.J. 1431 (1999).

[217] *See* Bruce A. Green & Bernardine Dohrn, *Foreword: Children and the Ethical Practice of Law*, 64 FORDHAM L. REV. 1281, 1295 (1996).

There are some exceptions where minors may consent to medical treatment,[218] regardless of their age and without parental consent.[219] These exceptions include providing consent to the diagnosis or treatment of venereal disease, drug addiction, alcoholism, pregnancy,[220] or donating blood.[221] Additionally, parental consent for medical treatment is generally not required in cases of medical emergencies,[222] and, in some instances, in cases where parents are thought to have neglected the child's medical needs,[223] and where the minor seeks an abortion.[224] Legally-emancipated minors — a concept developed as a means to allow parents to escape or relinquish control over their children[225] — and minors in jurisdictions which recognize the "mature minor" rule or doctrine[226] — where children, usually 14 years of age and older, understand the nature of proposed treatment and its risks, and the physician believes the child can provide a similar degree of informed consent as that of an adult, and where treatment does not involve very serious risks — are also capable of giving consent to medical procedures without parental participation.

In the case of adolescent patients, the issue of capacity to consent is perhaps more complicated. Although "[t]raditional common law viewed minors as unable to make sound decisions about medical treatment,"[227] the mature minor doctrine

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[218] *See, e.g.*, Jan C. Costello, *Making Kids Take Their Medicine: The Privacy and Due Process Rights of De Facto Competent Minors*, 31 LOY. L.A. L. REV. 907, 908–09 (1998).

[219] *See* Janine P. Felsman, Note, *Eliminating Parental Consent and Notification for Adolescent HIV Testing: A Legitimate Statutory Response to the AIDS Epidemic*, 5 J.L. & POL'Y 339 (1996) (discussing laws allowing minors to consent to HIV testing without parental consent).

[220] *See* Stephanie Bornstein, *The Undue Burden: Parental Notification Requirements for Publicly Funded Contraception*, 15 BERKELEY WOMEN'S L.J. 40 (2000) (discussing contraception and parental notification); Marilyn G. Hakim, *Privacy Rights of Minors Re: Sexual Intercourse*, 18 J. JUV. L. 316 (1997) (discussing privacy interests of minors who are having consensual sexual intercourse); Pilar S. Ramos, *The Condom Controversy in the Public Schools: Respecting a Minor's Right of Privacy*, 145 U. PA. L. REV. 149 (1996) (discussing minors' access to condoms).

[221] *See* MNOOKIN & WEISBERG, *supra* note 195, at 657–65.

[222] *See* JAMES M. MORRISSEY ET AL., CONSENT AND CONFIDENTIALITY IN THE HEALTH CARE OF CHILDREN AND ADOLESCENTS: A LEGAL GUIDE 50–54 (1986).

[223] *See* J. Shoshanna Ehrlich, *Minors as Medical Decision Makers: The Pretextual Reasoning of the Court in the Abortion Cases*, 7 MICH. J. GENDER & L. 65, 74–75 (2000).

[224] *See* Michael Grimm, Comment, American Academy of Pediatrics v. Lungren: *California's Parental Consent to Abortion Statute and the Right to Privacy*, 25 GOLDEN GATE U. L. REV. 463 (1995).

[225] *See* Sanford N. Katz et al., *Emancipating Our Children — Coming of Legal Age in America*, 7 FAM. L.Q. 211 (1973); Carol Sanger & Eleanor Willemsen, *Minor Changes: Emancipating Children in Modern Times*, 25 U. MICH. J. L. REFORM 239, 240–41 (1992).

[226] *See* Angela R. Holder, *Disclosure and Consent Problems in Pediatrics*, 16 LAW MED. & HEALTH CARE 219, 221 (1988).

[227] *See* Lisa Anne Hawkins, Note, *Living Will Statutes: A Minor Oversight*, 78 VA. L. REV. 1581, 1586 (1992).

evolved and recognized that "if a minor is of sufficient intelligence and maturity to understand and appreciate both the benefits and risks of the proposed medical or surgical treatment, then the minor may consent to that treatment without parental consent . . . ."[228] The three components of the legal definition of informed consent require that decisions be made knowingly, competently, and voluntarily.[229] Psychologists argue that:

> Historically, because adolescents have been deemed "incompetent" by virtue of their age, they have been seen as developmentally incapable of providing informed consent; their decisions by definition fail the second test of the informed consent doctrine. There are, however, at least three problems in the application of the informed consent doctrine to adolescent decision-making in legal situations. First, very little empirical knowledge exists regarding age differences in the capacity to consent either competently or voluntarily, and the few extant investigations of the issue are inconclusive. Second, the courts have never adequately defined *competence*; for example, the Second Restatement of Torts describes competence to consent simply as an appreciation of the "nature, extent, and probable consequences of the conduct consented to." Finally, legal definitions of maturity vary both between legal jurisdictions and between adjudicating individuals within the same jurisdiction.[230]

Application of the informed consent doctrine to adolescent patients, even in consideration of the mature minor doctrine, remains problematic.[231] Nevertheless, establishing a routine where adolescent patients are advised about the limits of confidentiality and where their written consent to disclose pertinent information because of the pending court action serves several purposes.[232] First, it acknowledges the patient's autonomy and control — albeit limited — over their

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[228] *See* MORRISSEY ET AL., *supra* note 222, at 43.

[229] *See* FADEN & BEAUCHAMP, *supra* note 197.

[230] Elizabeth Cauffman & Laurence Steinberg, *The Cognitive and Affective Influences on Adolescent Decision-Making*, 68 TEMP. L. REV. 1763, 1766 (1995).

[231] *See* Jennifer L. Rosato, *The Ultimate Test of Autonomy: Should Minors Have a Right to Make Decisions Regarding Life-Sustaining Treatment?*, 49 RUTGERS L. REV. 1 (1996) (discussing the problematic nature of a minor's right to consent to and refuse medical treatment).

[232] *But see* William Adams, *"But Do You Have to Tell My Parents?" The Dilemma for Minors Seeking HIV-Testing and Treatment*, 27 J. MARSHALL L. REV. 493, 506 (1994) (arguing that disclosure might deter a minor from seeking medical treatment).

personal mental health records.[233] This empowering gesture may be especially beneficial to these particular patients — juveniles who have been adjudicated dependent and who have lost control over the most fundamental aspects of their daily lives. Second, it informs the patient, prior to the court proceeding, about the necessity of release or disclosure of some of the communications made during evaluations or therapy. This helps to eliminate the shock of disclosure some patients may be exposed to during the course of litigation. Third, it provides direction and scope for the therapist who may be uncertain about which information should remain protected by privilege or confidentiality. Fourth, it should help to prevent some of the ambiguities which give rise to malpractice or breach of contract actions based upon privacy issues.[234]

VII. PROTECTING THE JUVENILE'S MENTAL HEALTH RECORDS

A number of preemptive legal mechanisms currently assist in protecting the confidentiality of juvenile mental health records. Evidentiary rules, restraining orders, and discovery statutes might all play useful roles in limiting the disclosure of some juvenile mental health records in dependency proceedings. Although there may be instances in which juveniles might consider suits for breach of privacy for the disclosure of their mental health records, this approach has many limitations and offers little promise of relief.[235] First, the juvenile would have to overcome statutory immunity provisions which shield the various officials engaged in providing court-ordered services to children in state custody.[236] The various lower

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[233] *See generally* Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. 1705 (1992).

[234] *See generally* Ken Gormley, *One Hundred Years of Privacy*, 1992 WIS. L. REV. 1335 (1992) (discussing the ambiguous nature of the right to privacy that results from the many sources of the right).

[235] *See* Eric P. Gifford, Comment, *42 U.S.C. § 1983 and Social Worker Immunity: A Cause of Action Denied*, 26 TEX. TECH L. REV. 1013 (1995) (reviewing social worker's immunity claims when they fail to act on evidence of child abuse or neglect).

[236] The Supreme Court's 1992 decision in *Suter v. Artist M.*, 503 U.S. 347 (1992):

> foreclosed private lawsuits brought by abused and neglected children who were attempting to force states to make reasonable efforts to provide adequate child protection services. As beneficiaries of federal child protection legislation, children brought suit pursuant to the Adoption Assistance and Child Welfare Act of 1980 . . . and 42 U.S.C. § 1983.

Will L. Crossley, *Defining Reasonable Efforts: Demystifying the State's Burden Under Federal Child Protection Legislation*, 12 B.U. PUB. INT. L. J. 259, 259 (2002). The Court in *Suter* held that child plaintiffs did not have a federally enforceable right to reasonable efforts. *Id.*

court decisions[237] following the Supreme Court's 1989 ruling in *DeShaney v. Winnebago County Department of Social Services,*[238] offer little hope that actions under the Fourteenth Amendment's Due Process Clause[239] will guarantee minimal levels of safety and security for children, especially if children are not harmed directly by the State,[240] but by third parties.[241] Because of the limitations of after-the-fact legal remedies (such as suits for damages for breach of privacy),[242] it appears that the more propitious approach to protecting juvenile mental health records would be to preemptively limit their disclosure in court proceedings.

Those jurisdictions which continue to follow the CAPTA-grant-driven statutory enactments,[243] which close dependency proceedings to the public and the press, offer one form of protection from disclosure of a child's mental health records.[244] However, even in so-called closed hearings, many individuals may be present who have no connection with the juvenile's case. Lawyers awaiting other cases, court staff and professionals waiting to testify in unrelated cases may be present in court

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[237] *See* Thomas A. Eaton & Michael Wells, *Governmental Inaction as a Constitutional Tort:* DeShaney *and Its Aftermath*, 66 WASH. L. REV. 107 (1991).

[238] 489 U.S. 189 (1989).

[239] *But see* Laura Oren, DeShaney's *Unfinished Business: The Foster Child's Due Process Right to Safety*, 69 N.C. L. REV. 113 (1990).

[240] *See* Catherine A. Crosby-Currie & N. Dickon Reppucci, *The Missing Child in Child Protection: The Constitutional Context of Child Maltreatment from* Meyer *to* DeShaney, 21 LAW & POL'Y 129 (1999); Mary Kate Kearney, *Breaking the Silence: Tort Liability for Failing to Protect Children from Abuse*, 42 BUFF. L. REV. 405 (1994).

[241] *See* Mary Kate Kearney, DeShaney's *Legacy in Foster Care and Public School Settings*, 41 WASHBURN L.J. 275, 276 (2002) (asserting that "although the State was not liable for harm inflicted on a child by a father because the State's affirmative duty of protection did not reach into the father's home," the issue remains "under what circumstances the State does owe a child an affirmative duty of protection").

[242] These limitations are numerous. Other than those states which have enacted specific provisions in their state constitutions creating rights of privacy, the entire concept of a minor having an enforceable right of privacy is generally limited to violations of those statutory enactments such as educational privacy laws and technology-based privacy laws such as the Family Educational Rights and Privacy Act of 1974, 20 U.S.C. § 1232g (2002) (FERPA), or the Children's Online Privacy Protection Act of 1998, 15 U.S.C. §§ 6501–03 (2002). Locating attorneys willing to initiate suits on behalf of children for privacy breaches would be more than a little challenging as well. Other than in cases where the child is able to document a significant impact from the courtroom disclosure, such suits might generate relatively low damage awards. Thus, the local bar might be less than enthusiastic about filing such actions.

[243] Child Abuse Prevention and Treatment Act of 1972, as amended in 1996, 42 U.S.C. § 5101.

[244] *See* Susan S. Greenebaum, *Conditional Access to Juvenile Court Proceedings: A Prior Restraint or a Viable Solution?*, 44 WASH. U. J. URB. & CONTEMP. L. 135, 140–43 (1993).

while a child's mental health records become the focus of a dependency proceeding.[245]

Evidentiary objections offer yet another legal mechanism to restrict the disclosure of a juvenile's mental health records in a dependency proceeding.[246] The child's counsel may object to the relevance of admitting the child's entire mental health record into evidence, depending upon the nature of the hearing and the reason why the mental health record is being offered.[247] This is not to suggest that mental health records are not relevant to dependency proceedings, for they may well be relevant. However, it may not be necessary to divulge a juvenile's entire mental health record in order for the court to reach whatever conclusion the hearing is designed to facilitate. For instance, if the hearing is a status hearing to determine whether the state has complied with a court order to provide a child in state custody with therapy, then the actual compliance with the court order may be relevant, whereas the findings of the child's therapist might not be relevant. "There are two components to relevant evidence: materiality and probative value."[248] Evidence would be immaterial if it were offered to help prove a proposition that is not a matter in issue.[249] The precise disclosures a juvenile makes to a therapist may have no bearing on whether the state complied with the court's order by arranging the therapy session, and evidentiary objections may serve the purpose of helping to maintain the child's confidential disclosures.[250] Additionally, the jurisdiction may recognize a "psychotherapist/patient" privilege as part of the state evidence code,[251] and counsel might raise objections to disclosure of the minor's mental health records on this basis.

Several measures can help to ensure that a minor's mental health records are not unnecessarily publicized or disclosed. A crucial issue concerns the concept of

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[245] *See* Emily Bazelon, Note, *Public Access to Juvenile and Family Court: Should the Courtroom Doors Be Open or Closed?*, 18 YALE L. & POL'Y REV. 155 (1999) (discussing the debate over whether juvenile and family court proceedings should be open to the public).

[246] *See generally* Craig Lee Montz, *Trial Objections from Beginning to End: The Handbook for Civil and Criminal Trials*, 29 PEPP. L. REV. 243 (2002) (discussing the range of evidentiary objections available to a trial lawyer).

[247] Federal Rule of Evidence 401 defines "relevant evidence" as "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." FED. R. EVID. 401.

[248] MCCORMICK ON EVIDENCE § 185 (John W. Strong et al. eds., 5th ed. 1999).

[249] *Id.*

[250] *See* Montz, *supra* note 246, at 246 (stating that "[objections] attempt[] to prevent the admission of inadmissible evidence").

[251] *See* People v. Tauer, 847 P.2d 259, 260–61 (Colo. App. 1993) (protecting teenage victim's mental health records under Colorado privilege); Attorney ad Litem for D.K. v. Parents of D.K., 780 So. 2d 301, 304–08 (Fla. Dist. Ct. App. 2001) (describing and applying the statutory privilege to minors).

"unnecessary" disclosure. The fact that a child is involved in juvenile court dependency proceedings suggests that the child has been abused or neglected, and that a thorough evaluation of the child's condition is essential for an adjudication hearing. It would be self-defeating to restrict the free flow of mental health testimony and mental health records under the guise of protecting the child's right to privacy, or honoring the child's privileged communications with mental health professionals. Given the very high rates of child abuse victimization by adult inpatients at psychiatric hospitals,[252] a prohibition against the use of children's mental health records in juvenile proceedings might well exacerbate a major social problem and aid in its continuation into the next generation.[253] The objective is not to ban the use of mental health records in dependency proceedings, but to restrict the disclosures made so as to allow the court to accomplish the goal of providing juveniles with the services of mental health professionals while avoiding destroying or undermining the confidentiality of the therapist-patient relationship.

The concern that professionals should embrace is the degree to which otherwise private or confidential mental health information needs to be disclosed in court proceedings. It may be unnecessary, for example, to disclose a child's actual comments about her parents in a court proceeding where the comments may not be relevant to the issue before the court.[254] It may not be necessary to disclose a child's newly discovered sexual orientation,[255] unless that is an issue that merits the

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[252] *See* John Read, *Child Abuse and Severity of Disturbance Among Adult Psychiatric Inpatients*, 22 CHILD ABUSE & NEGLECT 359 (1998).

> In the last decade it has been repeatedly demonstrated that psychiatric inpatients frequently have histories of abuse as children. A recent review of 15 studies from 1984 to 1996 (Read, 1997a) has calculated that 64% of women inpatients report either physical or sexual childhood abuse . . . . Male inpatients report similar rates of childhood physical abuse but lower rates of childhood sexual abuse than female inpatients (Jacobson & Richardson, 1987).

Id. at 359.

[253] For a discussion of the intergenerational cycle of violence and child abuse, see James J. Williams, *The Cycle of Abuse*, *in* CHILD MALTREATMENT, A CLINICAL GUIDE AND REFERENCE 397 (J.A. Monteleone ed., 2d ed. 1998). It should be noted, however, that intergenerational transmission is not nearly as prevalent in cases involving neglect. *See* Gaudin, *supra* note 46, at 103–04 (the evidence suggests that intergenerational repetition applies only to a minority of chronically neglectful families, with one study reporting only 15% of neglectful mothers having a clear history of neglect in their own childhoods); *see also* Katherine C. Pears & Deborah M. Capaldi, *Intergenerational Transmission of Abuse: A Two-Generational Prospective Study of an At-Risk Sample*, 25 CHILD ABUSE & NEGLECT 1439 (2001) (discussing the results of a data model showing that the children of abuse victims may, in turn, become abusers themselves).

[254] *See* FED. R. EVID. 401.

[255] *See* Ingrid Schupbach Martin, *The Right to Stay in the Closet: Informational Disclosures by Government Officials*, 32 SETON HALL L. REV. 407 (2002) (examining the "tensions" between privacy and government interests in obtaining personal information and concluding that more rights protection is needed).

court's attention because it requires services which may not be included in the child's caseplan. The intimate details of therapy sessions may generate great interest in an otherwise mundane court hearing, but such disclosures may contribute very little towards reunifying families, or moving towards long term foster care, or termination of parental rights and subsequent adoption. Similarly, after an adjudication is granted, it may not be necessary to divulge what occurs in the course of the child's therapy, or in the course of family therapy. This type of information may be routinely incorporated in mental health reports to the juvenile court simply because the reporter has not been told or ordered to do otherwise.

Although discerning between "necessary" and "unnecessary" disclosures ultimately requires a judgment call on the part of the mental health provider,[256] such a determination might be better made where the court identifies specific issues germane to the court's review process prior to the creation of mental health reports, or before mental health professionals' testimony is offered into the record. A number of procedures might help preserve the child's sense of privacy and confidentiality, despite the court's involvement in the child's daily life pending termination of parental rights, long term foster care placement, or reunification with the family.[257]

First, the child's attorney[258] might routinely provide written notification and copies of pertinent statutes, case decisions, and rules of court to all mental health professionals involved in the case.[259] This step should be taken well in advance of the preparation of any written evaluations or reports in connection with the matter in dispute. Such written notice should include any statutory provisions governing informed patient consent, and any cases, statutes, or laws establishing a mature minor doctrine, and any material pertinent to the limitations of discovery. If the

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[256] A similar issue arises when a mental health care provider decides what is "medically necessary" for Medicaid mental health care. *See* John A. Flippen, Note, *The Early and Periodic Screening, Diagnostic, and Treatment Program and Managed Medicaid Mental Health Care: The Need to Reevaluate the EPSDT in the Managed Care Era*, 50 VAND. L. REV. 683, 698–99 (1997) (stating that "a physician . . . determines which treatments are medically necessary for a particular diagnosis [in determining eligibility]").

[257] *See generally* Gary B. Melton, *Minors and Privacy: Are Legal and Psychological Concepts Compatible?*, 62 NEB. L. REV. 455, 456 (1983) (arguing that "an examination of the significance of privacy for minors . . . would result in a more . . . humane policy of respect for children's personhood").

[258] The National Council of Juvenile and Family Court Judges' 1998 survey found that only 40 states require the appointment of lawyers for children in abuse and neglect cases. *See* SHIRLEY A. DOBBIN ET AL., CHILD ABUSE AND NEGLECT CASES: REPRESENTATION AS A CRITICAL COMPONENT OF EFFECTIVE PRACTICE 43–44 (1998).

[259] Although a qualified forensic expert would be expected to be familiar with the laws and regulations applicable to her field, most mental health professionals are not forensic experts. For a discussion of how to thoroughly prepare an expert in this field of litigation, see PAUL STERN, PREPARING AND PRESENTING EXPERT TESTIMONY IN CHILD ABUSE LITIGATION: A GUIDE FOR EXPERT WITNESSES AND ATTORNEYS (1997).

same group of professionals regularly engage in evaluation and treatment in juvenile proceedings, the necessity of sending out repeated written notices diminishes. By providing such information to the evaluator or therapist, the mental health expert is better prepared to defend whatever limitations she may deem to be appropriate when testifying or providing written reports for the court. Although the juvenile court system routinely enrolls the services of mental health experts, it does not always defer to their expertise when determining what is therapeutically recommended or what is in the best interest of their patients.[260]

Second, if the evaluation or written reports pertains to the represented child, counsel for the child might request that the evaluator not initially distribute any written reports to all counsel of record or all parties involved. Counsel might file a motion requesting the court to conduct an *in camera* inspection of the evaluation or report,[261] or to at least allow counsel an opportunity to have a hearing to consider limiting the scope of the information which is disclosed in open court.[262] Similarly, if the mental health professional believes that some of the contents of the written report should not be disclosed, the child's counsel may wish to request the court to redact that information, or to limit the scope of direct and cross examination prior to the hearing.[263]

Disclosure of personal information which is not germane to questions before the court serve little purpose other than to potentially embarrass the child. If the child has disclosed to a therapist that he hates his parents, yet such information is not relevant to the issue before the court, then disclosing such a remark in the presence of the child's parents may be counterproductive, regardless of the goals of the system. Once the child has reached the age of majority, many courts relinquish

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[260] *See, e.g.*, Daniel B. Lord, Note, *Determining Reliability Factors in Child Hearsay Statements:* Wright *and Its Progeny Confront the Psychological Research,* 79 IOWA L. REV. 1149, 1177–78 (1994) (arguing that courts "rely[] principally on precedent" rather than research when determining the reliability of child witnesses).

[261] This *in camera* review process was adopted by the Supreme Court of Appeals of West Virginia in *Nelson v. Ferguson*, 399 S.E. 2d 909 (1990):

> [If] the mental health records [of a minor] are sought for the purpose of seeking to impeach the witness' credibility, the circuit court should first examine the records *ex parte* to determine if the request is frivolous. If the court finds probable cause to believe that the mental health records contain material relevant to the credibility issue, counsel should be allowed to examine the records, after which an *in camera* hearing should be held [to allow both sides to present arguments on relevance about designated parts of the record].

Id. at 910.

[262] *See generally* 2 RANDY HERTZ ET AL., TRIAL MANUAL FOR DEFENSE ATTORNEYS IN JUVENILE COURT, § 46.02 (1991) (advising motion *in limine*).

[263] Yet another approach might be for the court to order production of the child's mental health records following an *in camera* hearing, but to also issue a "protective order prohibiting the disclosure of the contents of the [mental health] records." *In re* Saint, 785 N.E.2d 1101, 1101 (Ind. 2003).

personal or subject matter jurisdiction over the case. Although the court system may no longer be a presence in the former child's life, the parents — even abusive parents — may continue to play a major role in the former child's life. Many children continue their contact with biological families, even after legal proceedings have terminated parental rights.[264] Selective disclosure of a child's statements during evaluation or therapy does not simply promote the child's sense of privacy and confidentiality, it also helps to provide an opportunity for the child to expose his thoughts without having to confront the adult subjects of those thoughts.[265] Open and public disclosure of every statement a child makes during evaluation or

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[264] Experts recognize that:

> Although there is a growing body of research on the characteristics of incestuous families, no longitudinal study has examined how these families change, function, and naturally resolve these family relationship tasks over time. In addition, no longitudinal study has investigated the long-term familial and relational effects of interventions commonly used in sexual abuse cases. Consequently, at this point little guidance is available from the empirical research literature. However, it is clear that *these families do not cease to exist when a child abuse case is closed by professionals or a parent offender is sentenced to prison. It is likely that in most cases of parent-child sexual abuse, families will persist in one form or another long after the professionals have exited their lives. Even if the offender is incarcerated, he likely will be released within five years, and most probably will return to the family.*

Benjamin E. Saunders & Mary Meinig, *Immediate Issues Affecting Long-term Family Resolution in Cases of Parent-Child Sexual Abuse*, *in* TREATMENT OF CHILD ABUSE: COMMON GROUND FOR MENTAL HEALTH, MEDICAL, AND LEGAL PRACTITIONERS 36, 38 (Robert M. Reece ed., 2000) (emphasis added).

[265] If a child is safely residing in a foster home, and the parents are involved in therapy attempting to improve their parenting skills, divulging the child's every disclosure to the child's therapist may be counter-productive for the parents, as well. Understanding the opposition of many child-abusing parents, themselves victims of abusive childhoods, may assist in prioritizing the confidentiality of child victims, especially in the early stages of the family members' therapy:

> Among all the kinds of perpetrators of child abuse and across the wide spectrum of maltreatment, it is necessary to know how the perpetrator's child-caring abilities have been directed or hampered by his or her own past experiences. The behavior and caregiving patterns of perpetrators are impossible to "treat" or deeply influence unless we attempt to understand these perpetrators in relation to their own history. Not all perpetrators are cooperative and submissive at the beginning of a therapeutic relationship. Many are angry, rebellious, uncooperative, denying all problems and any need for help, and wish only that all the authorities would get out of their lives and leave them alone to raise their children in the way they please.

Brandt T. Steele, *Further Reflections on the Therapy of Those Who Maltreat Children*, *in* THE BATTERED CHILD 566, 567, 571 (Mary Edna Helfer, Ruth S. Kempe, & Richard Krugman eds., 5th ed. 1997).

therapy may further complicate the process of resolving the problems that caused the child to be involved in the juvenile court process in the first place.[266]

Third, requesting the court to provide specific requests and guidance to mental health professionals might also eliminate or at least restrict the disclosure of patient confidences that are not germane to issues pending before the court. It is not an uncommon practice for juvenile courts to order mental health evaluations on a child without specifying what issues or concerns the court wishes the evaluator to address. For instance, a child may have been traumatized[267] by exposure to sexual abuse,[268] and the petition filed in the court proceedings may assert such facts, and thus the court may wish to have the child evaluated specifically for this in order to

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[266] Additionally, such disclosures might be misleading to the court. The state of the art knowledge of child psychologists is not a constant factor, it changes as scientific research is done and published. What may be assumed about patterns of behavior in abused children today may well be refuted tomorrow:

> Although it was claimed that there is a systematic pattern to the disclosure of child abuse that involves initial denial, subsequent disclosure, recanting, and finally repeated disclosure, research in support of this presumed sequence (*see, e.g.*, Gonzalez, Waterman, Kelly, McCord, & Oliveri, 1993; Sorensen & Snow, 1991) is problematic because of difficulties with the validation of the abuse (vs. nonabuse) status of the children included in the studies. As far as we can tell, without physical or other corroborative evidence, there is no way to know with absolute certainty whether children who initially deny abuse were or were not abused. The situation is complicated further by conflicting reports in the literature (*see, e.g.*, Bradley & Wood, 1996), leaving us in basic agreement with Ceci and Bruck's (1995) assessment that there is no one pattern of disclosure that accounts for the behavior of all (or even most) children suspected of having been sexually abused.

Ornstein & Gordon, *supra* note 14, at 239.

[267] Steele explains "trauma" in neglect and abuse scenarios as follows:

> The deleterious effects of child maltreatment can be generically described as the consequences of trauma. The concept of trauma is borrowed from medicine, where it defines bodily damage such as fractures, lacerations, and burns caused by the impact of some object or substance. In maltreatment, the term has been broadened to include damage to the child's psychological, cognitive, emotional, and social functions caused by the behaviors of caregivers and others.
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> Psychological trauma occurs when there is an imbalance — when a stronger, noxious stimulus overwhelms a weaker coping ability of the child. Consequently, the child's psychic functions are disturbed and disabled.

Brandt F. Steele, *Psychodynamic and Biological Factors in Child Maltreatment, in* THE BATTERED CHILD, *supra* note 265, at 73, 79.

[268] Traumatized sex abuse victims may also create problems by providing different factual information or inconsistent versions of what occurred. *See United States v. Carroll*, 105 F.3d 740, 742 (1st Cir. 1997) (stating that "[s]ome degree of inconsistency is not surprising when a minor testifies about traumatic events instigated by a close relative"), *cert. denied*, 520 U.S. 1258 (1997).

determine whether the child should be removed from an unsafe environment. Including material in the mental health evaluation which does not address the child's possible post-traumatic stress disorder ("PTSD")[269] may be irrelevant for purposes of this particular evaluation. Similarly, many issues may arise in the course of the child's therapy which are unrelated to the issues pending before the court. One commentator has noted that:

> Experience has shown that one of the most common shortcomings of psychological evaluations in child protection matters is that the practitioner uncritically accepts a case from a referring party who couches the reason for referral in general terms — for example, "We want a psychological on this birth parent." In fact, this is a common complaint from casework supervisors, whose supervisees have made this type of amorphous assessment request. When the evaluator accepts the case without clarifying what the agency needs from the testing, casework supervisors, who must decide on appropriate intervention strategies, find such "generic" or "vanilla" psychological reports to be of little value in providing guidance. Before accepting the referral at all, it is important for psychologists to ascertain what specific issues the examination is to address.[270]

If the court narrows the scope of the evaluation or of the written report, then the child's privacy is better protected. It may not be necessary, and, in fact, it may be counterproductive to the child's treatment, for the therapist to include in the written report to the court every aspect of the child's therapy.

Fourth, it may be sufficient to have the mental health evaluator/therapist document that the evaluation/therapy is ongoing, rather than disclosing detailed information in written or oral testimony.[271] For instance, if a child has weekly

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[269] *See* Lisa R. Askowitz & Michael H. Graham, *The Reliability of Expert Psychological Testimony in Child Sexual Abuse Prosecutions*, 15 CARDOZO L. REV. 2027 (1994); Karl Kirkland, *Post-Traumatic Stress Disorder vs. Pseudo Post-Traumatic Stress Disorder*, 56 ALA. LAW 90 (1995).

[270] DYER, *supra* note 36, at 87.

[271] Nondisclosure of information, however, also raises a number of problems. For instance, if the therapist is restricted in the number or frequency of treatment sessions by financial limitations, then the court may have no means of ensuring that the child-patient is receiving necessary services for the child's adjustment, especially if the only information provided by the mental health care provider is limited in scope. The child's counsel might not be in a position to independently assess the client's progress in therapy given the limited disclosures by the therapist. Managed care providers must currently deal with the ethical dilemmas of providing limited information to their patients about non-covered forms of treatment, and whether non-disclosed treatment options satisfy the requirements of the informed consent doctrine. *See* Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care*

scheduled therapy sessions, ensuring the court that the sessions are occurring may be sufficient to keep the court and all litigants aware of compliance with any court orders. This might circumvent the need to disclose any specific information which has been developed in the course of the therapy. In other words, the less detailed information disclosed, the better. Of course, such cryptic reports to the court may not be sufficient, but whenever possible, counsel and the mental health professional should prevent disclosure, if preserving the confidentiality of the therapeutic relationship is a legitimate objective. This approach might not be appropriate when a court has ordered an initial psychiatric or psychological evaluation of a juvenile, but even in those circumstances, it might not be necessary to disclose the contents of the evaluation.

In the post-adjudication review stages of a case, however, it might be easier to protect the child's disclosures made in ongoing therapy sessions. Of course, this is not to suggest that mandatory reporters of abuse or neglect should disregard their legal duties,[272] but they may report such disclosures to state authorities without necessarily divulging the child's information in open court. If the therapist believes the child is in need of special court-ordered services, then the therapist would probably want to make the disclosure in court. However, if the child is already receiving whatever services the community is able to provide, then the court disclosure by the therapist might be counter-productive. The objective here is not to withhold important developments from the court and the various parties, but to maintain the benefits of the therapeutic intervention by attempting to preserve the confidentiality of the patient's disclosures whenever possible.

Fifth, the court might consider allowing the mental health professional to maintain more than one set of written records or to organize a child's records into two separate sections: privileged information and non-privileged information.[273] The type of documentation, currently required by many third parties responsible for payment of the professional services, would be one possible model to follow. Many insurance companies and managed health care providers only receive materials containing numerical codes which designate the type of treatment the patient has

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Cost Containment, 85 IOWA L. REV. 261 (1999) (arguing that physicians have explicit and implicit incentives to withhold treatments not covered by insurance plans).

[272] *See* GIARDINO & GIARDINO, *supra* note 57.

[273] Myers suggests maintaining privileged information separately from non-privileged information, so that when a professional reviews a record before testifying:

> it is sometimes possible to avoid review of privileged communications. This done, if a judge orders the record disclosed, the judge may be willing to limit disclosure to nonprivileged portions of the record. Although this approach entails the burden of separating records into privileged and nonprivileged sections, and may not persuade all judges, the technique is worth considering, especially for professionals who testify regularly.

Myers, *supra* note 91, at 313.

received.[274] It is not necessary to provide the insurer or HMO with actual copies of the therapist's notes or other documents from the patient's file.[275] This process documents the provision of services without jeopardizing the confidential disclosures made by the patient.[276]

If the mental health professional includes her own written mental notes and impressions as part of the patient's file, such information probably should not be subject to open disclosure in a juvenile dependency proceeding. For instance, if a patient has disclosed information and the therapist is skeptical about the veracity of the disclosure, requiring the therapist to make such a revelation in court would likely undermine the therapeutic relationship. This type of record keeping, if permitted, would be subject to disclosure to all counsel of record.[277] It is

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[274] The aggressive cost-saving policies of market-driven managed care organizations will likely create many tensions for patient-physician confidentiality in the future:

> The organization, management, and delivery of health care has become highly information-sensitive, especially so in the case of managed care. Sharing of patient medical and financial information among physicians, hospitals, payors, employers, pharmacies and related health care entities through networked computers and relational databases is a common and permanent feature of all MCOs [managed care organizations]. . . . The abuses of medical confidentiality that could stem from easy access to sensitive medical information on unsecured electronic information systems have been discussed at great length and depth in the popular press, the professional literature, and in a recent report from a blue ribbon panel convened by the National Academy of Sciences/National Research Council (NRC).

Jeroo S. Kotval, *Market-Driven Managed Care and the Confidentiality of Genetic Tests: The Institution as Double Agent*, 9 ALB. L.J. SCI. & TECH. 1, 11–12 (1998).

[275] This is not to suggest that there are no problems with the manner in which insurers provide coverage for clients in need of mental health care. For a discussion of the disparity in insurance coverage for medical versus mental health illness, see Brian D. Shannon, *Paving the Path to Parity in Health Insurance Coverage for Mental Illness: New Law or Merely Good Intentions?*, 68 U. COLO. L. REV. 63, 65–72 (1997).

[276] *See generally* White, *supra* note 96.

[277] It is helpful to note that disclosures of the mental health records might occur in response to a discovery motion filed by a parent's attorney, or they might occur during litigation should the mental health provider reveal during cross-examination that her testimony is based upon a record or file with which the opposing party has not been provided. If the information is being requested while the therapist testifies, then the child's counsel may assert the psychotherapist-patient privilege, and opposing counsel will likely respond that the privilege has been waived (either because the child's mental health has been placed in issue, or because the disclosure was made pursuant to a court-ordered therapeutic intervention). *See* Edward Imwinkelried, *The Rivalry Between Truth and Privilege: The Weakness of the Supreme Court's Instrumental Reasoning in* Jaffee v. Redmond, *518 U.S. 1 (1996)*, 49 HASTINGS L.J. 969 (1998) (arguing that the court should not have implemented a psychotherapist privilege because autonomy and the ability to determine truth in the litigation process outweigh any privacy interest); Poulin, *supra* note 102, at 1385–87; Glen Weissenberger, *The Psychotherapist Privilege and the Supreme Court's Misplaced Reliance*

foreseeable that an unfavorable or critical mental health report, from the perspective of the party subject to the evaluation, could open the door to that party's attempt to obtain all written records in order to prepare to cross examine, or perhaps challenge, the mental health professional.[278]

Sixth, courts may adopt local rules which better coordinate the disclosure of sensitive records from a child's mental health evaluations or therapy sessions.[279] This would be especially helpful in situations where multiple courts are involved in the child's life. Although the mental health records may be prepared in conjunction with an ongoing juvenile proceeding, they may be sought after by other counsel involved in other legal proceedings. If the child's parents or caregivers are subject to criminal prosecution for the behavior which gave rise to the dependency action in juvenile court,[280] the attorney for the accused parents may well seek to discover the child's therapist's notes and reports,[281] only to use them to discredit the child witness should she testify in the criminal case.[282] Many jurisdictions do very little to coordinate concurrent criminal prosecutions for child abuse and neglect with ongoing juvenile dependency cases.[283] One consequence of this lack of coordination may be the untimely delay of therapeutic interventions to provide treatment to the family members. Additionally, because discovery rules vary greatly in civil and criminal proceedings,[284] whenever counsel recognize an

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on State Legislatures, 49 HASTINGS L.J. 999, 1005–06 (1998) (questioning how the "competing autonomy interests" of the patient and litigant will be resolved in light of the therapist patient privilege).

[278] *See generally* JAY ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY (5th ed. 1995).

[279] For an example of a case adopting a rule requiring a threshold showing by the moving party seeking access to the child's mental health records that such disclosure may reasonably be expected to provide information material to the moving party's defense, see *State v. Ruiz*, 34 P.3d 630, 639 (N.M. Ct. App. 2001).

[280] *See* William Wesley Patton, *Child Abuse: The Irreconcilable Differences Between Criminal Prosecution and Informal Dependency Court Mediation*, 31 U. LOUISVILLE J. FAM. L. 37 (1992–93).

[281] This might place the onus on the therapist to resist the third party's attempt to obtain the patient's records. *See* Robert M. Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 N.C. L. REV. 255 (1984) (contending that legislation should guide physicians through ethical issues when confidential records are requested by non-professionals).

[282] And the right of confrontation probably supercedes any privacy interest the child might otherwise assert. *See* Davis v. Alaska, 415 U.S. 308 (1974) (holding that the Sixth Amendment right to confront a witness in a criminal trial was violated when the State refused to allow defense counsel to cross-examine and impeach a key prosecution witness about his confidential juvenile delinquency record).

[283] *See* Marcia Sprague and Mark Hardin, *Coordination of Juvenile and Criminal Court Child Abuse and Neglect Proceedings*, 35 U. LOUISVILLE J. FAM. L. 239 (1996–97).

[284] Unlike the discovery rules in many civil matters, criminal discovery provisions have been broadened, in part, because of the *Brady v. Maryland* decision — and its progeny —

opportunity to take advantage of the more liberal civil discovery rules, they will most certainly do so in order to provide competent representation for their clients.

Whenever criminal cases and dependency cases are handled simultaneously,[285] the potential inconsistencies in the systems frequently work to the disadvantage of children.[286] For example, if a parent voluntarily stipulates that his child should be adjudicated dependent in the civil or juvenile forum, but demands to go to trial in the criminal forum, the parent remains in a potentially adverse position in relationship to the child.[287] The parent's admission in the civil proceeding might not even be introduced in the pending criminal matter[288] in those jurisdictions where such admissions are allowed only where the parent actually takes the witness stand, testifies, and then is subjected to cross-examination.[289] The child may become the

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which held that "the suppression by the prosecution of evidence favorable to an accused upon request violates due process where the evidence is material either to guilt or to punishment." 373 U.S. 83, 87 (1963); *see also* United States v. Bagley, 473 U.S. 667, 676 (1985) (requiring prosecutorial disclosure of impeachment evidence in addition to exculpatory evidence); Kyles v. Whitley, 514 U.S. 419 (1995) (establishing that when failure by the prosecution to disclose material evidence is raised, the standard for materiality allows review of the suppressed evidence collectively, not item by item).

[285] *See* Sprague & Hardin, *supra* note 283.

[286] St. Onge and Elam describe the differences in objectives of criminal and civil system interventions for physically-abused children as follows:

> The purpose of the child protective service agency's civil investigation is to protect the child from further harm. The agency, however, has a further mandate to prevent removal of the child from his or her home if appropriate safeguards can be applied. The purpose of the initial investigation is to gather sufficient information to determine if child maltreatment occurred, if there is a risk of future maltreatment, and the level of that risk. . . .
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> Criminal proceedings differ from civil proceedings in several important ways. First, the goal of a criminal proceeding is primarily to identify the abuser, gather sufficient evidence to successfully prosecute the abuser, and, after conviction, to fashion a sentence that punishes the crime, reflects the particular vulnerability of the child victim, reflects the particular circumstances of the abuser, and provides for rehabilitation of the offender and safety for the child. Additionally, the criminal process is designed to serve as a deterrent to others.

Anita M. St. Onge & Megan L. Elam, *Legal Intervention for the Physically Abused Child*, *in* TREATMENT OF CHILD ABUSE, COMMON GROUND FOR MENTAL HEALTH, MEDICAL, AND LEGAL PRACTITIONERS 107, 108 (Robert M. Reece ed., 2000).

[287] *See generally* Bruce A. Boyer, *Ethical Issues in the Representation of Parents in Child Welfare Cases*, 64 FORDHAM L. REV. 1621 (1996); Ross, *supra* note 161, at 1583–87.

[288] *See* William Wesley Patton, *The World Where Parallel Lines Converge: The Privilege Against Self-Incrimination in Concurrent Civil and Criminal Child Abuse Proceedings*, 24 GA. L. REV. 473, 477–85 (1990).

[289] *See generally* Brian D. Gallagher, *"The Right of the People . . ." The Exclusionary Rule in Child Abuse Litigation*, 4 T.M. COOLEY J. PRAC. & CLINICAL L. 1, 7–10 (2000).

principal witness against the parent in the criminal trial.[290] Even if the child has been removed from the offending parent's custody, the court handling the civil dependency proceeding may still consider reuniting the child with the offending parent. The prospect of referring such a family to therapy would have little or no merit,[291] especially if the therapeutic foundation is based on the parent admitting to misconduct directed at the child.[292] Additionally, counsel for accused sex offenders may encourage their clients to be more resistant to admitting any misconduct if the criminal trial is pending. Such admissions might be used against the parent should the parent elect to waive their Fifth Amendment privilege and testify, and if the admission was made to someone other than a law enforcement official, then the statement might be admitted without any Fourth Amendment challenges.[293] Lastly, as more states enact sexual predator laws,[294] which increase sentences for first time sex offenders and authorize civil commitment for sex offenders following the completion of their prison terms,[295] defense counsel for accused sex offenders must

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[290] Although four states — Idaho, Minnesota, Connecticut, and Massachusetts — have created parent-child testimonial privileges by statute, and the courts of one state — New York — have expressly recognized a qualified parent-child privilege, the privilege apparently "is not applicable where the offense at issue was committed against the child or against another family member." *See* Catherine J. Ross, *Implementing Constitutional Rights for Juveniles: The Parent-Child Privilege in Context*, 14 STAN. L. & POL'Y REV. 85, 97–99 (2003).

[291] *See* Jonathan Kaden, Comment, *Therapy for Convicted Sex Offenders: Pursuing Rehabilitation Without Incrimination*, 89 J. CRIM. L. & CRIMINOLOGY 347, 349–50 (1998).

> [O]ffenders who have refused to admit guilt in court may not be inclined to admit guilt in therapy either; thus their participation in therapy may be terminated, leaving them untreated and more dangerous than if they had been meaningfully involved in therapies that did not require an admission of guilt.

Id. at 349.

[292] *See* Brendan J. Shevlin, Note, *"[B]etween the Devil and the Deep Blue Sea": A Look at the Fifth Amendment Implications of Probation Programs for Sex Offenders Requiring Mandatory Admissions of Guilt*, 88 KY. L.J. 485, 492 (2000) (arguing that rehabilitation will be "more fully served by encouraging sex offenders to make the admissions of guilt that states assert are vital to successful treatment").

[293] *See* Jillian Grossman, Note, *The Fourth Amendment: Relaxing the Rule in Child Abuse Investigations*, 27 FORDHAM URB. L.J. 1303 (2000).

[294] *See* John Q. LaFond, *Can Therapeutic Jurisprudence Be Normatively Neutral? Sexual Predator Laws: Their Impact on Participants and Policy*, 41 ARIZ. L. REV. 375 (1999); John Q. LaFond, *The Costs of Enacting a Sexual Predator Law*, 4 PSYCHOL. PUB. POL'Y & L. 468 (1998) [hereinafter LaFond, *The Costs of Enacting*].

[295] With the Supreme Court's determination that such statutory schemes pass constitutional muster in the five-to-four opinion of *Kansas v. Hendricks*, 521 U.S 346 (1997), it would not be surprising to see additional states enacting such civil commitment provisions for dangerous sex offenders. *See* LaFond, *The Costs of Enacting*, *supra* note 294, *at* 468. Washington was the first state to enact a modern sexual predator law in 1990, and at least six

advise their clients of the potential consequences of making any admissions during the therapy sessions, thus creating more pressure for resisting involvement in therapy.[296]

If the child alone submits to therapy, while the parent asserts a Fifth Amendment privilege against self-incrimination[297] and refuses therapy while awaiting the criminal trial,[298] or if the parent enrolls in therapy but denies any misconduct,[299] the parent's attorney would presumably seek access to the child's therapist's notes and records.[300] Given the sense of guilt and personal responsibility that many abused children exhibit in therapy, it would not be surprising if the child's disclosures to the therapist — including delays in disclosing and recanting claims of abuse — open the door to access to these notes and records by the parent-defendant in the context of the criminal case.[301]

For instance, a child victim of sexual abuse recants his accusation against a parent abuser during the course of the child's therapy.[302] In preparation for the criminal trial, the therapist discloses to the prosecutor that the child has recanted his original testimony. The prosecutor is now obligated[303] to disclose to the defense the nature or content of the child's admissions, assuming that the prosecution intends to rely on the child's testimony at the criminal trial.[304] Although an experienced

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other states, including California, have enacted some form of sexual predator law since then. *Id.* For further discussion of *Hendricks*, see John Kip Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment Before and After* Hendricks, 4 PSYCHOL. PUB. POL'Y & L. 377 (1998); Robert F. Schopp, *Civil Commitment and Sexual Predators: Competence and Condemnation*, 4 PSYCHOL. PUB. POL'Y & L. 323 (1998).

[296] *See* Kaden, *supra* note 291; Jessica Wilen Berg, Note, *Give Me Liberty or Give Me Silence: Taking a Stand on Fifth Amendment Implications for Court-Ordered Therapy Programs*, 79 CORNELL L. REV. 700, 711–12 (1994).

[297] *See* Patton, *supra* note 288, at 481–82.

[298] *See* HERTZ et al., *supra* note 262, at § 42.05(a).

[299] *See* Berg, *supra* note 296, at 703.

[300] *See generally* Murray Levine & Eric Doherty, *Professional Issues: The Fifth Amendment and Therapeutic Requirements to Admit Abuse*, 18 CRIM. JUST. & BEHAV. 98 (1991).

[301] *See* Lisa M. Kurcias, Note, *Prosecutor's Duty to Disclose Exculpatory Evidence*, 69 FORDHAM L. REV. 1205 (2000).

[302] "Retractions of accusations by children, particularly in cases of sexual abuse, are quite common and present difficult questions for any trial court or jury since great weight is commonly ascribed to the constancy and persistency of any complaint." LUCY S. MCGOUGH, CHILD WITNESSES: FRAGILE VOICES IN THE AMERICAN LEGAL SYSTEM 178 (1994).

[303] *See* Roland C. Summit et al., *The Child Sexual Abuse Accommodation Syndrome: Clinical Issues and Forensic Implications*, *in* CHILDREN OF TRAUMA: STRESSFUL LIFE EVENTS AND THEIR EFFECTS ON CHILDREN AND ADOLESCENTS 43 (Thomas W. Miller ed., 1998).

[304] *See* Kurcias, *supra* note 301.

mental health professional may be able to explain to the fact finder that the child's recantation is not inconsistent with the behavior of other sex abuse victims,[305] the damaging admissions are nevertheless made available to the defense.

The child's most intimate and confidential revelations to the therapist might constitute evidence which the accused parent would seek to obtain, perhaps as part of a legal strategy to discredit the child during the criminal trial.[306] Additionally, if the state prosecutors are aware or in possession of such mental health reports or records, they may well have affirmative duties to disclose such information to the parent's counsel.[307] The duties of the prosecutor to disclose material evidence to the defense include statutory discovery provisions,[308] constitutionally-based obligations,[309] and ethical obligations[310] included in state legal ethics codes.[311]

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[305] *See* Simona Ghetti et al., *Consistency in Children's Reports of Sexual and Physical Abuse*, 26 CHILD ABUSE & NEGLECT 977 (2002).

[306] One commentator notes that:

> Research has identified that many of the cross-examination tactics lawyers use to question children are suggestive and evidentially unsafe (Brennan & Brennan, 1988; Dent & Flin, 1992; Goodman & Bottoms, 1993; Kranat & Westcott, 1994). The average cross-examination of a child is a virtual "how not to" guide to investigative interviewing: The characteristics of a typical interview conducted during cross-examination appear to violate all the principles of best practice, with the predicted outcome of maximizing the risk of contaminating the evidence (Spencer & Flin, 1993).

Emily Henderson, *Persuading and Controlling: The Theory of Cross-examination in Relation to Children*, *in* CHILDREN'S TESTIMONY: A HANDBOOK OF PSYCHOLOGICAL RESEARCH AND FORENSIC PRACTICE 279 (Helen L. Westcott et al. eds., 2002) (citations omitted).

[307] *See* Joseph R. Weeks, *No Wrong Without a Remedy: The Effective Enforcement of the Duty of Prosecutors to Disclose Exculpatory Evidence*, 22 OKLA. CITY U. L. REV. 833 (1997); Stephen P. Jones, Note, *The Prosecutor's Constitutional Duty to Disclose Exculpatory Evidence*, 25 U. MEM. L. REV. 735 (1994).

[308] Many state-enacted statutes are based upon the Federal Rules of Criminal Procedure. FED. R. CRIM. P. 16, 26.2, & 12.1 all require disclosure of information upon request by the defendant. For example, Rule 16 requires disclosure of five types of information prior to trial: (1) the defendant's statements; (2) the defendant's prior criminal record; (3) certain documents and objects; (4) certain examination and test reports; and (5) the content and bases of expert testimony upon which the government intends to rely. *See* Grossman, *supra* note 293.

[309] The duty to disclose exculpatory evidence should be traced to *Brady v. Maryland*, 373 U.S. 83, 87 (1963); *see also* Jones, *supra* note 307; Kurcias, *supra* note 301; Weeks, *supra* note 307.

[310] Both ABA Model Rule 3.8(d) and the Model Code of Professional Responsibility (DR 7-103(B)) require that the prosecutor disclose any evidence that "tends to" be exculpatory as to guilt or punishment. *See generally* Stanley Z. Fisher, *The Prosecutor's Ethical Duty to Seek Exculpatory Evidence in Police Hands: Lessons From England*, 68 FORDHAM L. REV. 1379 (2000).

[311] *See generally* Joshua M. Levinson & Brian M. Lambert, *Discovery*, 88 GEO. L.J. 1175 (2000).

Thus, the competing objectives of the juvenile or civil forum (to obtain an adjudication and to protect a child in harm's way) and the objectives of the criminal forum (to enforce the criminal law and prosecute child abusers)[312] make it all the more difficult to ensure confidentiality of children's mental health records.

Although policy makers and criminal prosecutors should weigh the impact of exposing children to further harm when civil and criminal judicial systems are not well coordinated,[313] existing evidentiary rules and constitutional rights of accused parties[314] — including the Sixth Amendment right of confrontation in criminal cases[315] — often preclude ensuring complete confidentiality of children's statements to mental health professionals whether they were made during evaluation or therapy.[316] Crafting a provision which allows for the creation of more than one set of documents by the mental health professional involved in a juvenile adjudication may not ultimately shield the more detailed notes and records from the scrutiny of a potentially adverse party.[317] Alternatively, jurisdictions might consider

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[312] *See* St. Onge & Elam, *supra* note 286.

[313] Myers concludes that in some cases, the harm to the child caused by the adversarial intervention of the criminal justice system outweighs any benefit:

> Involvement in the legal system is hard on children. The trauma of abuse may be compounded by the trauma of the criminal justice system. Several courts and commentators have described the effect of the legal system on abused children as a "second victimization." The child is subjected to multiple interviews in which the details of the abuse must be described repeatedly. The delay, anxiety, and fear associated with litigation and cross-examination are repeated at the grand jury, pretrial and trial stages. If juvenile court proceedings are underway, the child goes through a similar, if less adversarial, gauntlet in that court. There is the embarrassment of appearing in court where the details of an excruciatingly private event or series of events must be recounted in public and, finally, there is the requirement that the child face the defendant.

John E.B. Myers, *The Legal Response to Child Abuse: In The Best Interest of Children?*, 24 J. FAM. L. 149, 182–84 (1985).

[314] *See* John C. Thomure, Jr., Kyles v. Whitley*: An Opportunity Lost?: An Examination of the Rule of Discovery Concerning the Disclosure of Impeachment Material Contained in Personnel Files of Testifying Government Agents in Federal Criminal Cases*, 83 MARQ. L. REV. 547 (2000).

[315] *See* Alfred Hill, *Testimonial Privilege and Fair Trial*, 80 COLUM. L. REV. 1173 (1980); Robert Weisberg, Note, *Defendant v. Witness: Measuring Confrontation and Compulsory Process Rights Against Statutory Communications Privileges*, 30 STAN. L. REV. 935 (1978).

[316] *See generally* Robert F. Schopp, *The Psychotherapist's Duty to Protect the Public: The Appropriate Standard and the Foundation in Legal Theory and Empirical Premises*, 70 NEB. L. REV. 327 (1991).

[317] This is not to suggest that the records should be hidden from other parties. A broad overview of a record might provide sufficient information to allow another party the opportunity to request that the court conduct an *in camera* hearing and review the entire patient file. This type of process would allow the child's counsel to comply with discovery requests without initially jeopardizing the confidentiality of the child's therapy or treatment. This process would also place the court in a position to be aware — prior to an adversarial

developing rules which place the burden on the party seeking to discover the child's therapy records to demonstrate the necessity to obtain the records, or perhaps to request the court to review the documents to determine whether legitimate reason exists to disclose the child's records. Although not a complete ban against disclosure of children's mental health records, such statutes or rules might reduce the opportunities for adverse parties to use such documents to the detriment of children, while complying with the due process discovery rights of the adverse parties.

It may be that the most counsel for the child or the mental health professional can realistically hope to accomplish is to limit the scope of disclosure of the patient's confidential communications.[318] Additionally, if mental health professionals develop routines whereby age-appropriate children involved in dependency proceedings are consulted and informed consent is obtained prior to disclosing any mental health records,[319] the juvenile court system will have established a new priority of recognizing the privacy rights of children.[320] If nothing else, by focusing attention on the impact of unnecessary disclosures and then determining the exact information which must be disclosed in litigation, the mental health professional or the child's counsel might increase the child's sense of privacy and help reduce the potential embarrassment and potential trauma[321] suffered by the child when indiscriminate reporting occurs.[322] By focusing and limiting the scope

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hearing — of the nature of the child's communications to the therapist. If the proceedings are designed to reunite the child with the parent, then the court's evidentiary rulings may take that objective into account. If the proceedings are designed to determine whether the child should be adjudicated dependent, then the court once again may consider the impact of disclosing all of the child's revelations made to the therapist. Thus, the purpose of the hearing and the stage of the case would be important factors for the court to consider before revealing the child's entire mental health record or therapy file to another party. If the party seeking access to the child's otherwise confidential statements to a therapist believes that an adverse ruling precludes adequate trial preparation, then the matter might be subject to appellate review, assuming the material reviewed by the trial court is sealed and made part of the court record.

[318] For a discussion of the psychologist adopting the role of child advocate and modifying current ethical duties of therapists involved in the conflict-laden field of family therapy, see Sonja C. Grover, *The Psychologist as Child Advocate: Ethical and Legal Issues in the Clinical Context*, 71 U. CIN. L. REV. 43 (2002).

[319] One commentator, citing empirical evidence of children involved in psychotherapy, suggests that limited informed consent might be possible with children as young as six years of age. Gerald P. Koocher, *Competence to Consent: Psychotherapy*, in CHILDREN'S COMPETENCE TO CONSENT 121 (Gary S. Melton et al. eds., 1983).

[320] *See* Wesley B. Crenshaw & James W. Lichtenberg, *Child Abuse and the Limits of Confidentiality: Forewarning Practices*, 11 BEHAV. SCI. & L. 181 (1993).

[321] *See* Jim Henry, *System Intervention Trauma to Child Sexual Abuse Victims Following Disclosure*, 12 J. OF INTERPERSONAL VIOLENCE 499 (1997).

[322] One of the founders of therapeutic jurisprudence, has indicated that:

> To succeed, mental health treatment requires a high degree of trust and

of information the court actually requires from mental health professions, and then by restricting the disclosure of therapeutic and evaluative records of children whenever possible, the juvenile court system will move in the direction of respecting the rights of the children[323] it was established to protect.[324]

VIII. CONCLUSION

The juvenile court system continues to rely upon the evaluations and therapeutic interventions of mental health professionals, but much can be done to guard against unnecessary disclosures of children's mental health records and communications. Although the law in most jurisdictions fails to define specific privacy rights for children,[325] the juvenile court system should take a leading role in recognizing the importance of privacy and confidentiality of juvenile mental health and treatment records.[326] Despite the occasional necessity of using children's mental health records in court proceedings, there are many situations in which disclosure may be limited or even prevented. The current practice of admitting written records or oral testimony that reveal the disclosures children make to mental health professionals should be scrutinized. Counsel for children and the various mental health professionals involved have ethical duties to maintain client and patient confidences, and the foundation for successful therapeutic interventions

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> confidence by the patient in the therapist. Establishing this trust and confidence at the outset of the therapeutic relationship may be essential for its ultimate success. It is precisely at this point that a therapist will feel ethically obligated to reveal to the patient that the confidentiality of the patient's communications cannot be fully protected. For at least some patients, the specter of their therapist as a weapon in the hands of an adversary in litigation will prevent formation of the therapeutic alliance. Concern about disclosure of intimate and personal information confided in a therapist thus can have profoundly antitherapeutic effects for the individual, producing a distrust of the therapist that can make the therapeutic process impossible.

Bruce J. Winick, *The Psychotherapist-Patient Privilege: A Therapeutic Jurisprudence View*, 50 U. MIAMI L. REV. 249, 260–61 (1996).

[323] This "empowerment of children" approach is not without its pitfalls, however. *See* Emily Buss, *Confronting Developmental Barriers to the Empowerment of Child Clients*, 84 CORNELL L. REV. 895, 898 (1999) (concluding that "because many children lack the capacity to appreciate their influence over their lawyers or the court, lawyers often will do children a considerable disservice if they premise their representation on the empowerment ideal").

[324] For a discussion of how European courts have been more willing than U.S. courts to establish affirmative governmental duties to safeguard children's rights, see Tania Schriwer, Comment, *Establishing an Affirmative Governmental Duty to Protect Children's Rights: The European Court of Human Rights As a Model for the United States Supreme Court*, 34 U.S.F. L. REV. 379 (1999).

[325] *But see* Williams, *supra* note 84.

[326] *See* Gary B. Melton, *Toward "Personhood" for Adolescents: Autonomy and Privacy As Values in Public Policy*, 38 AM. PSYCHOLOGIST 99 (1983).

depends on maintaining the confidentiality of patient disclosures. Where the legal system recognizes exceptions to the duties of confidentiality, children's lawyers and mental health professionals may still take steps and precautions to restrict the flow of information obtained during evaluations and therapy.

By protecting the information children reveal in these evaluative and therapeutic settings, the professionals involved serve the vital role of establishing a trustful and therapeutic environment in which these children may begin to heal. There is no reason to further expose children in dependency proceedings to pain and humiliation once their very lives become the subject of litigation. A recognized goal of dependency cases should be to encourage children to trust the mental health professionals assigned to treat and evaluate them. In these delicate matters, we should strive as professionals to establish and respect the privacy rights of children whenever possible,[327] and to promote confidentiality whenever children require mental health services. Considering the total upheaval these children experience when the state intervenes and removes them from abusive or neglectful families, the reliance on mental health professionals by the court system should contribute to — not detract from — the child's stability and recovery. By recognizing the importance of children's private communications with therapists, and by moving to prevent unnecessary disclosure of children's communications, the juvenile court system will establish as a priority not simply the recognition of privacy rights and respect for the dignity of minors,[328] but the healing and well being of the abused and neglected children over whom it asserts jurisdiction.

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[327] *See generally* Gary B. Melton, *Socialization in the Global Community: Respect for the Dignity of Children*, 46 AM. PSYCHOLOGIST 66 (1991).

[328] *See* Charles Robert Tremper, *Respect for the Human Dignity of Minors: What the Constitution Requires*, 39 SYRACUSE L. REV. 1293 (1988).