Mandatory Reporting Task Force | Meeting 22

July 17, 2024, Meeting Recap - Specialized Occupations Subcommittee

Overview

The Mandatory Reporting Task Force is legislatively charged with analyzing the effectiveness of Colorado's mandatory reporting laws in keeping children safe, connecting families with the resources they need, and providing clarity to mandatory reporters. Integral to this analysis, the task force will continue to examine the relationship of these laws to systemic issues and disproportionate impacts on under-resourced communities, communities of color, and people with disabilities.

Survey Responses

Trace Faust opened the Specialized Occupations Subcommittee discussion by giving members time to fill out the survey that had been emailed and review the medical abuse policy scan document. The survey responses are intended to help draft recommendations for presentation to the entire task force at the next meeting. At the next meeting, draft recommendation language from both subcommittees will be discussed by the full task force. The goal is to facilitate a broader discussion for the entire task force to understand the decisions and their basis.

Medical Child Abuse Discussion

The task force is charged with analyzing medical child abuse and the process for reporting it. Dr. Kathy Wells was asked to provide an overview of the current conversation in the medical professional community regarding medical child abuse and illuminate the challenges and complexities of the issue.

Definitions, Terms, and Diagnosis: Medical child abuse, historically referred to as Munchausen syndrome by proxy, factitious disorder imposed upon another, or fabricated disorder imposed upon another, involves a range of behaviors from exaggerating an existing illness, perceiving unconfirmed symptoms, to inducing illness in a child. The medical community relies on caregivers for patient history and faces challenges in distinguishing between genuine advocacy and harmful behavior. Such behaviors may escalate over time, making early recognition and intervention crucial. Multiple medical providers and specialists might be involved, often without access to each other's records, complicating the identification of abuse.

Statutory Considerations: Few states have specific statutes addressing medical child abuse. The discussion revolved around whether statutory changes are needed to better address this issue.

The discussion was then opened to the full subcommittee, encouraging participants to share their professional and personal perspectives on the challenges of identifying and addressing medical child abuse.

Some of the challenges mentioned include:

- *Reporting Threshold*: The challenge lies in determining when to report inappropriate care-seeking behavior. The statute requires "reasonable suspicion," not absolute certainty. Medical providers are trained to report based on reasonable suspicion rather than conclusive proof. However, identifying reasonable suspicion in cases of medical child abuse is complex.
- *Tipping Point*: The difficulty is in pinpointing the tipping point for reporting, such as frequent medical visits for seemingly minor issues or unverified claims of illness.
- *Team Approach*: The responsibility should not fall solely on one individual. Addressing medical child abuse should be a collaborative effort among professionals to ensure the best timing and support for the family and child.

Disparities in Reporting Medical Child Abuse

There was a question about whether disparities exist in reporting medical child abuse, particularly if certain racial or socioeconomic groups are more likely to be reported or accused. Cases of medical child abuse often involve individuals with medical knowledge or means, which can make them appear credible and potentially delay reporting. However, there is no specific data available on disproportionality in reporting medical child abuse, especially in relation to minority communities.

The concern was raised that families from disadvantaged or minority communities might be unfairly accused of medical child abuse while genuinely advocating for their child's needs.

Jennifer Eyl raised a concern about how trauma in parents, such as past sexual abuse, might influence their perceptions and behavior towards their own children. She has observed a pattern where the system may focus too much on the parent’s behavior rather than the child’s needs.

Dr. Wells pointed out that the term "medical child abuse" is used to emphasize the impact on the child, even if the parent may also have underlying pathology. Both aspects—parental pathology and child impact—need to be addressed simultaneously.

Gina Lopez expressed concerns about how advocating for oneself in healthcare settings, especially for communities of color, can lead to suspicion and negative repercussions. She raised concerns about whether changes in terminology and statutes adequately address these deep-seated issues.

Medical Abuse

Stephanie Villafuerte clarified that there is no specific statute addressing medical child abuse; the general requirement is for medical professionals to report any suspicion of abuse or neglect.

The issue with medical child abuse cases is that the child may suffer significant harm before the situation is reported, as parents with medical knowledge may convincingly present their child's condition as an illness when it is not.

Aletha Jenkins shared two cases from her experience where medical child abuse involved severe parent psychosis (e.g., meth psychosis) leading to false beliefs about the child's condition.

Dr. Wells emphasized that cases with savvy parents who have medical knowledge are harder to discern and may require more than just suspicion to address properly.

Recommendations:

Several possible recommendations were discussed, including the following:

- *Enhanced Reporting Criteria*: There should be a higher threshold for reporting medical child abuse, beyond mere suspicion. This includes having more concrete evidence or a higher likelihood that abuse is occurring.
- *Medical Professional Responsibility:* The need for medical professionals to be more proactive in identifying and addressing potential medical child abuse, given that confirmation will still be needed regardless of initial reporting.
- *Need for Specialized Expertise*: Given the complexity of medical child abuse, it's crucial to involve child abuse pediatricians who are trained to identify and manage such cases. This expertise helps in distinguishing between genuine advocacy and abusive behavior.
- *Role of Training:* Pediatricians should be trained to recognize signs of abuse, but for complex cases, specialized consultation may be necessary.
- *Reporting Protocols:* There's a debate on whether to report cases before or after consulting specialists. Some argue for reporting immediately, while others suggest a consultation with experts to ensure accurate assessment.

Statutory Definition and Legislative Intent

Reporting Requirements Across Professions: Stephanie questioned why medical professionals are being asked to report a specific diagnosis or condition (e.g., medical child abuse) when other mandated reporters, like dentists or teachers, are required to report general harm without specific diagnoses. She argued that medical professionals should report any harm they observe, including suspected abuse, as part of their overall duty, rather than focusing on specific conditions.

Definition of Medical Child Abuse: Jordan Steffen clarified that the statute refers to a specific definition of medical child abuse, focusing on cases involving unnecessary or harmful medical care intentionally inflicted. This definition was established to address growing concerns about such cases in media and social media. The legislative intent was to narrow the focus to this specific form of abuse within the broader mandatory reporting scope. This involves cases where medical professionals provide unnecessary or harmful treatment deliberately.

Processes and Procedures: The directive is aimed at exploring processes and procedures for reporting medical child abuse based on the provided definition. This includes understanding the thresholds or criteria for reporting and whether additional steps, like second opinions, should be part of the process.

Addressing Disparities: Jordan acknowledged the importance of discussing disparities and broader issues while also ensuring the task force remains focused on the specific directive. The goal is to address both the specific criteria for reporting and the wider concerns related to biases and disparities.

Need for Investigation: Zane Grant emphasized the importance of a thorough investigative mechanism for cases of suspected medical child abuse. He noted that, in his experience, investigators often have to dig into details such as the number of medical consultations and pharmacy visits, which may not be feasible for doctors to do. In child welfare cases, investigators need to go beyond medical records and confidentiality constraints to get a comprehensive view of the situation.

Broader Definition: Zane advocates for a broader definition of medical neglect and abuse, similar to Michigan's approach, which includes scenarios like accidental fentanyl exposure. He argued that focusing solely on Munchausen by proxy may be too narrow and doesn't address all relevant cases of medical abuse.

Clarity on the Directive: Ashley Chase asked for clarification about why the directive was issued. From her experience as a legal advocate, Ashley finds that cases of medical child abuse are highly complex and involving county departments of human services is not beneficial because case workers and attorneys lack the specific medical expertise needed to navigate these cases.

Framework for the Discussion

The subcommittee wrestled with whether statutory changes are called for. Some expressed concern that statutory changes might create unintended consequences and make the law overly complex. The subcommittee prefers to explore options for providing clearer guidelines and training for medical professionals on how to identify and report medical child abuse effectively.

The idea of forming a specialized task force to delve deeper into the complexities of the issue was discussed, but ultimately the subcommittee decided not to make that recommendation.

Jill Cohen expressed concerns about making statutory changes based on outlier cases or media attention, which might not reflect the broader issue accurately. She is wary of implementing changes related to how medical professionals report to hotlines without clear evidence of widespread issues.

Stephanie agreed with Jill's concerns about making statutory changes without a solid data foundation and a clear understanding of the problem. She highlighted her confidence in the

current capabilities of doctors, law enforcement, and DA communities based on her experience in child welfare.

Dr. Wells expressed doubt that adding specific statutory language will improve reporting practices or resolve issues, as the current statutes already cover these situations. She expressed concern that new statutory language could have unintended consequences and might not address the core problem effectively.

Hospital Policy vs. Statutory Change

There was a reference to whether the issue might be more about hospital policies rather than needing a change in statute. The discussion questioned where the most appropriate shift or improvement should be made, whether at the policy level within hospitals or through legal/statutory changes.

Policy Scan Insights

Sam Carwyn appreciated that Pennsylvania integrates medical abuse as a form of child abuse rather than creating a separate category. This approach may make it part of a broader umbrella of child abuse rather than a distinct issue.

There was no strong consensus on specific policies from other states that stand out as particularly effective or inspiring.

Standalone Reporting: Gina clarified that child sexual abuse is treated as a separate and distinct category in the reporting statutes, not subsumed under medical abuse. It requires specific cross-referencing with other statutes and codes.

Stephanie highlighted that the issue in high-profile cases often revolves around hospital reporting policies and how medical child abuse reports can be missed or mishandled due to procedural failures, rather than the statutory language itself. The task force has previously addressed issues related to the delegation of reporting responsibilities and decided that hospitals should not have the power to delegate these responsibilities. This decision was made to prevent cases from falling through the cracks.

General Consensus

- *Procedure Over Legislation*: There is a general agreement that improving procedures and policies within institutions (e.g., hospitals) for handling and reporting medical child abuse might be more effective than changing statutory language.
- *Diagnosis vs. Reporting*: Emphasis should be placed on ensuring that the reporting process is clear and effective, rather than prescribing detailed diagnostic criteria in statutes.
- *Effective Reporting Systems*: Addressing procedural gaps and ensuring that there is no delegation of reporting responsibilities within institutions are key focus areas.

Report Drafting

The discussions, including the lack of clarity in current statutes and the challenges faced, will be reflected in the final report narrative.

Survey Results

Trace then reviewed the survey results:

- Question 1: Recommendation on Extended Reporting Timeframes
    - Support: 83.3%
    - Opposition: 16.7%
- Question 2: Modification of Reporting Requirements for Dating Violence and Sexual Assault
    - Support: 66%
    - Opposition: 33%
- Question 3: Removing Victim Advocates from Mandatory Reporters
    - Support: Majority yes
- Question 4: Clarifying Victim Advocates' Reporting Requirements
    - Support: 30% yes
    - Opposition: 70%
- Question 5: Exemption for Reporters Employed by Attorneys
    - Support: Unanimous yes

Kevin Bishop noted that there is nuance in the comments that might affect the interpretation of support for or against certain recommendations. It's important to capture these subtleties accurately in the final recommendations.

Jordan will compile the survey results and share them as pre-reads for the entire task force to review. This will help ensure that all members are informed of the detailed discussions and feedback before finalizing recommendations.

Process for Recommendations:

- *Initial Discussions:* The next full task force meeting will discuss recommendations but will not be the final vote.
- *Extended Feedback*: There will be a break between August and October to refine the report based on full task force feedback and discussions.
- *Final Vote*: Recommendations will be revisited, with dissenting opinions included verbatim in the final report.

Jordan provided a quick poll based on today's discussion:

- First Question: The subcommittee agreed (100%) that a general narrative detailing the discussions around the complexity of medical child abuse, including its impacts on marginalized communities, should be presented.

- Second Question: The subcommittee also agreed (100%) that the task force should not issue a recommendation to change the statute but should clarify that the issue of medical child abuse has been addressed in other directives.