Chapter 15

Health and Mental Health Professionals and Facilities

Reporting

Child abuse and neglect often are identified for the first time when a child is taken to an emergency room or other medical facility or provider for treatment. As discussed in Chapter 2, the very first child abuse reporting laws were designed largely to override doctor–patient confidentiality so that doctors could disclose information about children they saw who were abused without violating confidentiality requirements. Although reporting laws have expanded to cover many other professionals—and in North Carolina, to cover everyone—health care professionals continue to be a key source of reports of child abuse, neglect, and dependency. (For definitions of the conditions that require reporting by medical personnel, see Chapter 5, "The Conditions Defined: Neglect, Abuse, Dependency, and Maltreatment.")

In addition to the duty to report suspected child abuse, neglect, or dependency to a department of social services, physicians and hospitals have long had a duty to make reports directly to law enforcement in some instances. This duty, which may apply when patients are adults as well as when they are children, exists when a physician or hospital learns of

- an injury that appears to be caused by or related to the discharge of a firearm, poisoning, or use of a knife or sharp instrument if it appears that a criminal act occurred; or
- a grave bodily injury or grave illness that appears to be the result of an act of criminal violence.[1]

In 2008, the North Carolina General Assembly expanded medical personnel's duty to report to law enforcement to include

> cases involving recurrent illness or serious physical injury to any child under the age of 18 years where the illness or injury appears, in the physician's professional judgment, to be the result of nonaccidental trauma.[2]

The report is required without regard to who may have caused the child's injury or illness. In some cases reports will be required both to law enforcement, pursuant to this duty, and to the county department of social services because there is cause to suspect that a child victim is abused, neglected, or dependent. Anyone who makes a good-faith report to law enforcement or social services, or to both, has immunity from civil or criminal liability.[3] Although immunity does not guarantee that a civil or criminal action will not be brought against someone who makes a report, unless the person bringing such an action alleges and can prove that the report was made in bad faith—that is, maliciously—the action should be quickly dismissed.

Professional Ethics and Reporting Responsibilities

Health care professionals sometimes confront very difficult issues when trying to honor both their statutory duty to report suspected child abuse, neglect, and dependency and their professional ethic of confidentiality.[4] *Confidentiality* refers to the ethical mandate to protect patient and client privacy, and it is considered a cornerstone of the professional, treatment, or therapeutic relationship. Conflicts may occur, for example, when a psychotherapist becomes aware that a young client or patient has been victimized or that an adult client or patient may have harmed a child.

The statutory requirement to report supersedes confidentiality.[5] At the same time, the ethical codes of psychologists, physicians, counselors, social workers, and others require that these professionals not exceed the reporting that is required by law. Health care professionals, therefore, are sensitive to the fine points of the meaning of key terms such as *caretaker*, *abuse*, *neglect*, and *serious physical injury*. (These terms are discussed in Chapters 4 and 5.) In addition to making reports only when the law requires reporting, professionals must consider the scope of information they can properly disclose when making a report. It may be helpful to remember that the duty

to report includes a duty to include in the report, to the extent the person making the report knows,

1. the nature and extent of any injury or condition resulting from abuse, neglect, or dependency; and
2. any other information the person making the report believes might be helpful in determining the need for protective services or court intervention.[6]

After a report is made—and regardless of who made the report—a health care professional may be required to disclose confidential information. In conducting an assessment or providing protective services, the social services director (or the director's representative) is authorized to make a written demand on any agency or individual for any information or reports that are relevant to the assessment or to the provision of protective services.[7] Unless the information is protected by the attorney–client privilege or its disclosure is prohibited by federal law, the agency or individual is required to give the director access to and copies of the information.[8] If a juvenile court action is filed and the court appoints a guardian ad litem to represent the child's interests, that individual has similar authority to acquire confidential information relevant to the case.[9] And, of course, the court can order the disclosure of confidential information.

A health or mental health professional who exceeds his or her legal reporting responsibilities, thereby violating a patient's or client's confidentiality without statutory authority to do so, risks being sanctioned for an ethics violation within his or her profession. In other words, a fine line separates required and prohibited reporting for professionals with obligations of confidentiality.

The statutes that mandate reporting, however, do not operate alone in setting parameters on when a health or mental health professional can or should disclose confidential information without a client's or patient's consent. Neither the ethical duty to maintain confidentiality nor the statutory doctor–patient privilege is absolute. So, even when it is clear that there is no duty to report to social services—for example, because the person who harmed a child is not a parent, guardian, custodian, or caretaker—health care professionals should consider whether they have legal authority or an ethical or moral duty to take other action to protect clients, patients, or others from serious and foreseeable harm.

Federal law strictly controls the disclosure of protected health information. It allows a disclosure when a provider in good faith believes it is "necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public," but the disclosure may be made only to someone who is "reasonably able to prevent or lessen the threat."[10]

North Carolina statutes and court opinions provide some guidance. A mental health confidentiality statute, for example, lists numerous instances in which a mental health professional may disclose confidential information, including "when in his opinion there is an imminent danger to the health or safety of the client or another individual or there is a likelihood of the commission of a felony or violent misdemeanor."[11] The North Carolina Court of Appeals has held that the doctor–patient privilege does not apply in involuntary commitment proceedings.[12] But neither state statutes nor case law has fully explored the scope of potential exceptions to the duty to protect a client's or patient's confidentiality.

In a frequently cited California case, *Tarasoff v. Regents of University of California*,[13] the court held that a psychiatrist who knows or should know that a patient presents a danger to a third person has a duty to warn the intended victim. In a much more recent North Carolina case, a woman's estate sued a psychiatrist for alleged negligence in failing to warn a wife of her husband's violent propensities and failing to have the husband involuntarily committed. Affirming the trial court's dismissal of the action, the North Carolina Court of Appeals held that "unlike the holding in *Tarasoff*, North Carolina does not recognize a psychiatrist's *duty to warn* third persons."[14] Despite the fact that this was a case of first impression in North Carolina, the court did not analyze the holdings of courts in other states that have considered the issue or provide any rationale for its conclusion that no such duty exists in this state.

Health care professionals must be familiar with their own codes of professional ethics. They should contact the ethics bodies of their professional associations or their licensing boards for guidance when conflicts between a duty or desire to report or provide information and the obligation to respect confidentiality are difficult to resolve. In keeping with the doctrine of informed consent for the provision of professional services, these professionals also should make clients and patients aware of the exceptions to confidentiality as part of the process of contracting for evaluation and

treatment services. Finally, health care professionals who have been trained in other states need to become familiar with the North Carolina statutes. Reporting laws, although universal, differ dramatically from state to state in their specific provisions and definitions.

"Baby Doe": Disabled Infants with Life-Threatening Conditions

The federal Child Abuse Amendments of 1984 required states, as a condition of receiving certain federal child welfare funds, to include in their definitions of "neglected juvenile" a specific category of disabled infants from whom treatment is being withheld.[15] In 1985, the North Carolina Social Services Commission adopted a rule that defined "neglected juvenile" to include a specific reference to those disabled infants,[16] but in 2006 the rule was rewritten and the definition of "neglected juvenile" was deleted altogether. The Juvenile Code defines "neglected juvenile" to include a child who is "not provided necessary medical care" but includes no specific reference to these disabled infants.[17]

In 2008, the state Division of Social Services added to its child welfare policy manual provisions that address this category of infant in some detail.[18] The manual provision, mirroring the wording in federal law, states that a disabled infant (under one year of age) with a life-threatening condition is "neglected" if

1. the infant is being denied appropriate nutrition, hydration, or medication; or
2. the infant is not receiving medically indicated treatment that, in the treating physician's reasonable medical judgment, is most likely to be effective in ameliorating or correcting the life-threatening condition, unless it is also the physician's reasonable medical judgment
    - that the infant is chronically ill and irreversibly comatose; or
    - that medical treatment would merely prolong dying, would not ameliorate or correct all of the life-threatening conditions, or would otherwise be futile in terms of the infant's survival; or
    - that the provision of medical treatment would be virtually futile in terms of the infant's survival, and under the circumstances the treatment would be inhumane.[19]

The state policy manual also requires every county social services director to

- make contact with every hospital or health care facility in the county that treats infants;
- provide each hospital or facility with information about the mandatory reporting law and procedures, including specific contact information, for making reports both during and after working hours; and
- obtain the name and telephone number of the person in the hospital or facility who will act as a liaison with the county social services department and update this information at least yearly.[20]

Substance-Exposed Infants

If a child tests positive at birth for illegal drug exposure, is the child abused (or neglected or dependent)? Answering that question requires additional information. However, as discussed below, indications of prenatal drug exposure are sufficient to create "cause to suspect" abuse, neglect, or dependency and to require a report to the county department of social services.

States' responses to children who show evidence at birth of exposure to alcohol or drugs vary. Some states have enacted specific reporting requirements relating to these children, and others have amended their reporting laws to include these children's conditions in the abuse and neglect definitions that determine what must be reported.[21] One state supreme court, interpreting a state statute that did not refer specifically to drug-exposed infants, held that a newborn who tests positive for an illegal drug at birth due to the mother's drug abuse "is *per se* an abused child."[22]

In North Carolina, neither the Juvenile Code nor any appellate court decision says that a child's testing positive for drugs at birth, without more, is sufficient to render the child an abused, neglected, or dependent juvenile. However, the federal Child Abuse Prevention and Treatment Act includes a child welfare funding condition that requires states' social services departments to accept reports about substance-exposed infants, conduct assessments, and develop protection plans for these children.[23] The federal law requires a state that accepts funds under Title IV-E of the Social Security Act, as North Carolina does, to provide assurance that the state either has and is enforcing a law, or is operating a program, that includes the following:

> (ii) policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born and identified as being affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition in such infants,
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> . . .
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> (iii) the development of a plan of safe care for the infant born and identified as being affected by illegal substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder.[24]

In addition, the federal Individuals with Disabilities Education Act requires that states mandate the referral for early intervention services of any child under age three who is (1) involved in a substantiated case of abuse or neglect or (2) identified as being affected by illegal substance abuse or having withdrawal symptoms as a result of prenatal drug exposure.[25]

Policy of the North Carolina Division of Social Services states that "prenatal drug exposure does not constitute neglect per se" but that the county social services department "has a responsibility to assure that the living environment will not be injurious to the newborn."[26] County social services departments expect hospitals to make reports when there are indications that a newborn has been exposed to alcohol or drugs. They accept these reports and conduct assessments in response to them. However, the department's assessment must extend beyond the question of whether the infant tested positive at birth for alcohol or drugs. A report will be substantiated only if the social services department also finds

1. that the child is not receiving or will not receive proper care from the child's parent, guardian, custodian, or caretaker; or
2. that the parent is not able to provide proper care for the child and does not have a suitable alternative arrangement.[27]

In other words, the child's condition is assessed in terms of the care the child receives or is likely to receive after birth, not on the basis of the mother's conduct before the child was born.

Emergency Custody in Abuse Cases

Procedures

In an emergency, either a law enforcement officer or a social worker with a county department of social services may take a child into temporary physical custody without a court order. An emergency exists when there is reasonable cause to believe

1. that the child is abused, neglected, or dependent; and
2. that the child would be injured or could not be taken into custody if the officer or social worker first took time to obtain a court order.[28]

Social services then must further assess the case and determine whether to file a petition and seek a court order allowing social services to retain custody of the child pending a court hearing.

When someone brings a child to a medical facility for diagnosis or treatment and a physician or other person at the facility has cause to suspect that the child has been abused, that person obviously must make a report to the department of social services. In an emergency, as defined above, that person probably would seek the assistance of a law enforcement officer or social services worker who could take the child into custody immediately. Occasionally, however, a parent may attempt to take the child from the medical facility before a social worker or law enforcement officer can arrive.

The Juvenile Code provides a special procedure through which a physician or an administrator of a medical facility may seek authority from a district court judge to keep physical custody of a child and provide necessary treatment if there is cause to suspect that the child has been abused.[29] The four steps in this process are as follows:

1. Certify need to retain custody. A physician who examines the child certifies in writing that the child is suspected of being abused and should remain at the facility for medical treatment or that, based on the medical evaluation, it is unsafe for the child to return to the parent, guardian, custodian, or caretaker.
2. Obtain judicial authority. The physician or administrator contacts, most likely by telephone, the chief district court judge (or someone the judge has designated to act in his or her place) and asks for authorization to retain physical custody of the child in the facility.[30] The date and time that the physician or administrator receives judicial

authorization to retain custody must be noted on the physician's written certification.

3. Notify director of social services. If authorization to retain custody is granted, the physician or administrator (or someone that person designates) immediately notifies the director of the department of social services in the county in which the facility is located—even if the child's residence is in a different county. The director will treat the notification as a report of suspected abuse and begin an assessment.
4. Distribute copies of certification. A copy of the certification is given to the child's parent, guardian, custodian, or caretaker. Copies also are placed in the child's medical and court records.

These procedures are likely to work well only if judges, medical professionals, and social services professionals in the community are familiar with them before an emergency arises. Medical professionals and facilities need to know

- who the chief district court judge is and who, if anyone, he or she has designated to authorize custody in these cases;
- how to contact the chief district court judge or any designee(s); and
- whether forms to facilitate the required documentation are available locally—from the court, medical facilities, or the social services department—or should be developed.

It is important to remember that these procedures apply only in cases of suspected abuse, not in cases in which a child's neglect or dependency is the cause for the medical professional's concern. Even in abuse cases the procedure is not mandatory. The physician or administrator may make the required report to social services about the suspected abuse and rely on a law enforcement officer or social worker to assume temporary custody of the child if that is called for.

Time Limits and Juvenile Court Action

Authorization pursuant to this procedure allows the child to be kept in the medical facility without the parents' consent or a court order for up to twelve hours. The department of social services, however, may file a juvenile court petition and obtain a nonsecure custody order authorizing continued

custody, as long as it is able to do so within the twelve-hour period. (This period is twenty-four hours if any part of the twelve-hour period falls on a weekend or holiday.) The social services department must file a petition within that time period if its preliminary assessment shows that

1. in the certifying physician's opinion, the child needs medical treatment to cure or alleviate physical distress or to prevent the child from suffering serious physical injury; and
2. in the physician's opinion, the child should remain in the custody of the facility for at least twelve hours; and
3. the parent, guardian, custodian, or caretaker either cannot be reached or will not consent to the child's treatment in the facility.

The petition will be heard in juvenile court like any other juvenile petition alleging abuse. Only the social services director and the certifying physician, together, can voluntarily dismiss the petition.

If the facts do not meet the criteria described above that require the filing of a petition, the social services director determines after an assessment—as he or she would in any other case—whether a petition should be filed. If the social services director decides not to file a petition, the physician or administrator may ask the prosecutor to review the director's decision, as in other reports of abuse, neglect, or dependency. (See "Formal Review of Case Decisions" in Chapter 12.)

Finally, if the court determines that medical treatment the physician or facility provided to the child was necessary and appropriate, the court may charge the cost of the treatment to the child's parents, guardian, custodian, or caretaker. If the parents are not able to pay, however, the court may charge the cost of the treatment to the county of the child's residence.

Treating Child without Parent's Consent

The judicial authority for a physician or medical facility to retain custody of a child in an emergency, described above, includes authorization to provide necessary treatment for the child. Although a medical professional generally cannot legally provide treatment for a child without the consent of the child's parent (or guardian or a person standing in loco parentis to the child)

or a court order, a physician may treat a child without either in the following circumstances:

1. a parent or other person who could provide consent cannot be located or contacted with reasonable diligence during the time within which the child needs to receive the treatment; or
2. the child's identity is not known, or the necessity for immediate treatment is apparent and the delay caused by any effort to obtain consent would endanger the child's life; or
3. the delay caused by an attempt to contact a parent or other person who could give consent would seriously worsen the child's physical condition.[31]

If the treatment the child needs involves a surgical procedure, the surgeon must obtain a second physician's agreement that the surgery is necessary.[32] However, in a rural area or community where the surgeon is not able to contact another physician, this requirement does not apply.[33]

When a minor has the capacity to give informed consent, the minor's consent is sufficient and parental consent is not required when the minor seeks medical care for

- the prevention, diagnosis, or treatment of certain communicable diseases;
- pregnancy (but not abortion or sterilization);
- abuse of alcohol or controlled substances; or
- emotional disturbance.[34]

Judicial Authority for Emergency Medical Treatment When Parent Objects

The preceding section described a physician's authority to treat a child when a parent is not available to consent or the law does not require parental consent. If a parent is available but objects to the child's receiving treatment, a physician still may provide treatment if another physician concurs that the medical procedure is necessary to prevent immediate harm to the child.[35] If a parent refuses to consent and the physician cannot contact another

physician for a concurring opinion, the procedures described below can be used to seek a district court judge's authorization to provide the treatment.[36]

1. The physician signs a statement (or, in an acute emergency, makes an oral statement to a district court judge) setting out
   - the nature of the emergency and the needed treatment, and
   - the parent's refusal to consent to the treatment, and
   - the impossibility of contacting a second physician for a concurring opinion on the need for treatment in time to prevent immediate harm to the child.[37]
2. A judge examines the physician's written statement (or considers the physician's oral statement) and finds
   - that it complies with the statute, and
   - that the proposed treatment is necessary to prevent immediate harm to the child.
3. The judge issues written authorization for the proposed treatment or, in an acute emergency, authorizes treatment in person or by telephone.
4. If either the physician's statement or the judge's authorization is oral, it is reduced to writing as soon as possible. The judge's written authorization for treatment should be issued in duplicate as follows:
   - one copy for the treating physician, and
   - one copy to be attached to the physician's written statement and filed as a juvenile proceeding in the office of the clerk of superior court.
5. After a judge authorizes treatment in this manner, and after proper notice, the judge conducts a hearing on the question of payment for the treatment, with two possible results:
   - the judge may order the parent or other responsible parties to pay for the treatment; or
   - if the judge finds that the parent is not able to pay, the judge may order that the costs of the treatment be charged to the county.

Depriving a child of necessary medical care is a form of neglect, and a physician or other person who believes that a parent is refusing to consent to necessary medical treatment for a child must make a report to the county department of social services.

Child Medical Evaluation Program/ Child Family Evaluation Program

A thorough assessment of suspected child abuse or neglect often requires the assistance of a medical or mental health professional.[38] The Child Medical Evaluation Program/Child Family Evaluation Program (CMEP/CFEP) coordinates medical and mental health professionals who are available across the state to assist county social services departments in assessing whether a child has been abused or neglected. A child medical evaluation assesses the condition of a child who may have been abused or neglected. A child/family evaluation, usually conducted by a psychologist, provides a more extensive assessment of the family unit.[39] The CMEP/CFEP operates through a contractual arrangement between the North Carolina Division of Social Services and the Department of Pediatrics at the University of North Carolina at Chapel Hill School of Medicine.

The program provides medical and psychological assessments through a roster of participating professionals with specific training relating to child abuse and neglect. While an assessment may identify a child's and his or her family's treatment needs, the program does not include the provision of ongoing medical or psychological services.[40]

The program has contributed to understanding and coordination between social services and medical professionals, accessible and appropriate evaluations of children who may be abused or neglected, better testimony and evidence in cases that go to court, and increased skills and awareness among large numbers of professionals who are involved in these cases.

The program's staff at the University of North Carolina at Chapel Hill provide training for participating medical and mental health providers and also participate frequently in training for social workers, law enforcement officers, and judges.

Notes

1. North Carolina General Statutes (hereinafter G.S.) § 90-21.20(b). The North Carolina General Statutes can be viewed online at www.ncga.state.nc.us/gascripts/Statutes/StatutesTOC.pl.
2. G.S. 90-21.20(c1).
3. G.S. 7B-309 and 90-21.20(d).

4. This section is based in part on comments submitted to the author by William V. Burlingame, Ph.D., January 3, 2001, for a previous edition of this book. Dr. Burlingame and others discussed the intersection of legal and ethical issues relating to reporting in Erica Wise, Ph.D., "Child Abuse/Neglect Reporting: Issues and Controversies," *National Register of Health Service Providers in Psychology* (Fall 2010), www.nationalregister.org/trr_fall10_wise.html.

5. See G.S. 7B-310, providing that privileges are not grounds for failing to report suspected child abuse, neglect, or dependency or for excluding evidence in a court proceeding.

6. G.S. 7B-301.

7. G.S. 7B-302(e).

8. *Id.*

9. G.S. 7B-601(c).

10. 45 C.F.R. § 164.512(j) (Oct. 1, 2011), which is part of the privacy regulations promulgated under the authority of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. §§ 1320d–1320d-9 (2010).

11. G.S. 122C-55(d). The statute gives this authority to a "responsible professional," which G.S. 122C-3(32) defines as "an individual within a facility who is designated by the facility director to be responsible for the care, treatment, habilitation, or rehabilitation of a specific client and who is eligible to provide care, treatment, habilitation, or rehabilitation relative to the client's disability." While this might seem to restrict the scope of the disclosure authorization to those who work in certain settings, it must be read along with the definition of "facility," which "means any person at one location whose primary purpose is to provide services for the care, treatment, habilitation, or rehabilitation of the mentally ill, the developmentally disabled, or substance abusers." G.S. 122C-3(14).

12. *In re* Farrow, 41 N.C. App. 680, 683, 255 S.E.2d 777, 779–80 (1979).

13. 17 Cal. 3d 425, 131 Cal. Rptr. 14, 551 P.2d 334 (1976).

14. Gregory v. Kilbride, 150 N.C. App. 601, 610, 565 S.E.2d 685, 692 (2002), *review denied*, 357 N.C. 164, 580 S.E.2d 365 (2003).

15. *See* 42 U.S.C. 5106g(5); 45 C.F.R. § 1340.15(b).

16. N.C. Admin. Code (hereinafter N.C.A.C.) tit. 10A, subch. 70A, § .0104 (Nov. 1985).

17. *See* G.S. 7B-101(15).

18. *See* N.C. Department of Health & Human Services, Division of Social Services, "Medical Neglect of Disabled Infants with Life Threatening Conditions," *in* Section 1438, Chapter VIII, of the Division of Social Services' online *Family Support and Child Welfare Manual* (hereinafter *State Manual*), http://info.dhhs.state.nc.us/olm/manuals/dss/csm-60/man/CS1438.htm#TopOfPage. The entire manual and manuals for other social services programs can be accessed from http://info.dhhs.state.nc.us/olm/manuals/manuals.aspx?dc=dss.

19. *Id.* Comparable language is in federal regulations at 45 C.F.R. § 1340.15, www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol4/pdf/CFR-2011-title45-vol4-sec1340-15.pdf. *See also* Appendix to Part 1340—Interpretative Guidelines Regarding 45 CFR 1340.15—Services

and Treatment for Disabled Infants, www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol4/pdf/CFR-2011-title45-vol4-part1340-app-id628.pdf.

20. *See* "Medical Neglect of Disabled Infants with Life Threatening Conditions," *in* Section 1438, Chapter VIII, *State Manual*, cited in full in note 18, http://info.dhhs.state.nc.us/olm/manuals/dss/csm-60/man/CS1438.htm#TopOfPage.

21. *See* U.S. Department of Health & Human Services, Administration for Children & Families, Child Welfare Information Gateway, "Parental Drug Use as Child Abuse: Summary of State Laws," May 2009, www.childwelfare.gov/systemwide/laws_policies/statutes/drugexposed.cfm.

22. *In re* Baby Boy Blackshear, 90 Ohio St. 3d 197, 200, 736 N.E.2d 462, 465 (2000) [interpreting a statute that defined "abused child" to include one who "[b]ecause of the acts of his parents, . . . suffers physical or mental injury that harms or threatens to harm the child's health or welfare," *id*. at 199, 736 N.E.2d at 464 (internal quotation marks, citations omitted)].

23. U.S. Department of Health & Human Services, Administration for Children & Families, The Child Abuse Prevention and Treatment Act, *Including Adoption Opportunities & The Abandoned Infants Assistance Act, As Amended by* P.L. 111-320, The CAPTA Reauthorization Act of 2010, www.acf.hhs.gov/programs/cb/laws_policies/cblaws/capta/capta2010.pdf.

24. 42 U.S.C. §§ 5106a(b)(2)(B)(ii), (iii).

25. 20 U.S.C. § 1437(a)(6).

26. *See* "The Impact of Drug and Alcohol Abuse," *in* Section 1440.XI, Chapter VIII, *State Manual*, cited in full in note 18, http://info.dhhs.state.nc.us/olm/manuals/dss/csm-60/man/CS1440-10.htm#P213_31521.

27. A substantiation, if one is made, most likely would be based on the child's status as a neglected child if the child is not receiving proper care or supervision, or as a dependent child if the parent is not able to provide adequate care. *See* G.S. 7B-101(9) and (15).

28. G.S. 7B-500. Custody without a court order can continue for only twelve hours or, if part of that time occurs on a weekend or holiday, twenty-four hours. Except in an emergency, a child may be taken into custody only with a court order. G.S. 7B-501(b).

29. G.S. 7B-308. The evolution of this law is interesting. In the early 1970s, former G.S. 110-118(d) gave a physician authority on his or her own to retain temporary physical custody of the child in this circumstance. It put the burden on the parents to seek a court hearing if they objected. A 1975 amendment added a requirement that the physician who retained custody of a child ask social services to file a petition and seek a court order for temporary custody. In 1977, another amendment added authority for the medical facility to render necessary medical treatment to the child. The requirement that the physician get authorization from a district court judge to retain custody of the child appeared first in the 1979 rewrite of the Juvenile Code, and it has been in the law since then. *See* 1979 Sess. Laws ch. 815, sec. 1.

30. The statute authorizes the chief district court judge to designate someone to act in his or her place in regard to this procedure and does not restrict whom the chief judge may designate. It seems clear from the wording of the statute (G.S. 7B-308) that this authority must be sought on a case-by-case basis and that a chief district court

judge should not attempt to use an administrative order or other means to give a facility or physician blanket authority to assume custody in cases of suspected abuse.

31. G.S. 90-21.1.

32. G.S. 90-21.3.

33. *Id*.

34. G.S. 90-21.5. A minor can obtain an abortion without the consent of a parent, guardian, or custodian only in a medical emergency or after obtaining a court order waiving the requirement for parental consent. G.S. 90-21.6 to 90-21.10.

35. G.S. 90-21.1

36. G.S. 7B-3600.

37. See G.S. 90-21.1, described above, which addresses when a physician may treat a minor without the consent of the parent.

38. *See In re* Browning, 124 N.C. App. 190, 194, 476 S.E.2d 465, 467 (1996) (holding that a parent's objection to his children being evaluated, although based in part on his religious beliefs, was not a lawful excuse for interfering with a social services investigation).

39. The Child/Family Evaluation Program replaced the Child Mental Health Evaluation Program (CMHEP), which also was known as the Child Forensic Evaluation Program.

40. Extensive information about the program is available on its website, University of North Carolina at Chapel Hill, School of Medicine, *Child Medical Evaluation Program*, www.med.unc.edu/cmep. The Child/Family Evaluation Program is described at www.med.unc.edu/cmep/services/cfep-training. *See also* Section 1422, Chapter VIII, *State Manual*, cited in full in note 18, http://info.dhhs.state.nc.us/olm/manuals/dss/csm-60/man/CS1422.htm#TopOfPage.