Forensic Evaluations and Mandated Reporting of Child Abuse

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Statutes requiring physicians to report suspected cases of child abuse create a potential conflict for psychiatrists working in the forensic setting. What happens in the case in which a forensic psychiatrist, during the course of an evaluation requested by a defense attorney, learns about child abuse perpetrated by the evaluee? A complicated legal, ethics-related, and interpersonal dilemma emerges. Reporting the abuse may contribute directly to further legal harm to the evaluee and place a strain on the relationship with the attorney. However, not reporting the abuse potentially involves ignoring a legal mandate and risking further harm to a child. This article first reviews mandated reporting statutes across the states. Next, the arguments for and against reporting are outlined. Existing solutions to the problem are reviewed, and several alternative solutions are explored. Finally, an approach to negotiating the dilemma that can be used by forensic psychiatrists in practice is suggested.

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Since their inception, statutes mandating physicians to report suspected cases of child abuse have posed a difficult dilemma for psychiatrists who learn of abuse perpetrated by their patients: make a report and jeopardize the relationship with the patient, or don't make a report and risk ignoring an important legal and ethically mandated obligation. For psychiatrists who perform forensic evaluations, the dilemma can be even more complex. Consider the following scenario:

> A forensic psychiatrist is retained by a defense attorney to evaluate a client who is facing criminal charges after allegedly molesting a young child. The client is a man with a long history of a psychotic illness, and the attorney is requesting an evaluation to establish an insanity defense. During the evaluation, which occurs at the correctional institution where the client is incarcerated awaiting trial, the client says that voices told him to molest the child in question. The forensic psychiatrist then tries to tease apart the psychotic symptoms from the criminal behavior. She asks the evaluee whether there have been other instances when voices have commanded him to behave in a certain way, as well as whether there have been other instances of molesting children that did not involve hearing voices. In an effort to answer these questions, the client discloses that he has recently molested other children, whom he identifies by name.

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The forensic psychiatrist in this situation is faced with the difficult decision of whether or not to disclose what she has learned. She realizes that making a report to a child protective agency could lead to an investigation of the evaluee and jeopardize her relationship with the referring attorney, as any attorney would understandably be upset if a psychiatric evaluation led to further legal harm to his client. However, if she chooses not to report, she is potentially ignoring her own legal mandate and risking criminal penalties, tort liability, sanctions by the medical licensure board, and leaving an abused child untreated. Neither prospect is appealing.

In this article, we seek to elucidate the challenges posed to forensic psychiatrists by statutes requiring them to report cases of suspected child abuse. We begin by reviewing mandated reporting statutes across the states. We then outline the ethics-related, legal, and practical considerations involved in deciding whether to report. We review existing solutions to the problem and explore alternative solutions. Finally, we suggest an approach for thinking through these complicated matters that can be used by forensic psychiatrists in practice.

Child Abuse and Mandated Reporting Statutes

Child abuse is undoubtedly a serious problem in the United States. In 2006, the most recent year for which national data are available, 910,000 children

were determined to be victims of abuse or neglect, and 1,530 children died as a result of this maltreatment.[1] Despite the existence of statutes since the 1960s that require certain individuals to report suspected cases of child abuse to a child protective agency (henceforth "mandated reporting statutes"), the prevalence of child abuse has remained relatively constant in the 16 years since national data have been collected (Ref. 1, p 36). Add to this the generally accepted belief that child abuse is underreported, and it is clear that the problem is both widespread and severe.

Mandated reporting statutes first were enacted in the 1960s in response to growing concern about under-recognition of battered child syndrome in schools and hospitals. In 1974, Congress passed the Child Abuse Prevention and Treatment Act (CAPTA), which provided federal funding to states that implemented child protection programs.[2] The funds provided by CAPTA supported prevention, assessment, investigation, prosecution, and treatment efforts that were in compliance with the terms of the Act. One of the provisions of CAPTA was that, in order to receive federal funding, states had to enact mandated reporting laws, and as a result, all states either created new statutes or revised their existing ones. Since that time, all 50 states and the District of Columbia have maintained some form of mandated reporting statute.[3]

Although mandated reporting statutes are superficially similar across the states, they vary considerably in the details of who must report, the circumstances under which they must report, and the procedure by which they must do so.[3] Forty-eight states designate individuals from certain professional groups as mandated reporters, and 18 states require all people to report (in addition to specifying certain professions). Typical mandated reporters include social workers, teachers and other school personnel, physicians and other health care workers, mental health professionals, childcare providers, medical examiners or coroners, and law enforcement officers. Some states also include commercial film processors, substance abuse counselors, and clergy among those required to report. Twenty-two states (including the 18 that mandate all persons to report) require reporting by attorneys.[4]

In addition to specifying individuals who are mandated to report child abuse, most states also stipulate who is exempt from reporting. All but four state statutes address the matter of privileged communication with regard to child abuse reporting, either specifically affirming or denying certain privileges (Ref. 3, p 3). Attorney-client privilege is most often affirmed, while physician-patient and husband-wife privileges are most commonly denied. The clergy-penitent privilege lies somewhere in the middle of the spectrum; 26 states currently require members of the clergy to report. Even in those states that recognize the clergy-penitent privilege, the privilege is typically interpreted narrowly to include only those communications made during a confession.[5]

The procedures by which child abuse must be reported also vary significantly among the states. Most states require reporting when a person who is acting in his official capacity has reason to believe that abuse has occurred, although some require that the reporter observe the abuse directly. Some states require as little as 24 hours between the time that abuse is suspected and the time that a report must be made, while others allow a greater amount of time to elapse. Sixteen states require that a reporter divulge his identity and contact information in the report, while the others allow anonymous reporting. Thirty-nine states specifically protect the identity of the reporter from disclosure to the alleged perpetrator, even when other information in the report may be disclosed (Ref. 3, p 4).

Efforts to protect reporters of child abuse typically extend even beyond nondisclosure of their identities. All states provide some form of immunity from liability for persons who report suspected instances of abuse or neglect in good faith, whether these reports are mandated or made voluntarily.[6] A majority of states provide additional immunity for reporters who participate in an investigation of suspected abuse, as well as for those who participate in judicial proceedings that may arise from the investigation. In the converse scenario, those who fail to report when mandated to do so are typically treated harshly. The criminal penalty for failing to report is usually a misdemeanor punishable by a fine, but most states also allow a civil action to be brought by representatives of the abused child against mandatory reporters who fail in their duty. The result is a system that is heavily weighted toward the protection of children; it encourages all persons to report, mandates some individuals to do so, attempts to protect reporters who act in good faith, and punishes those who fail in their capacity as mandated reporters.

There is no question that mandated reporting laws have led to an increase in the number of cases of suspected child abuse that are reported and investigated each year. Between 1995 (the first year that national data were collected) and 2006 (the most recent year for which data are available), referrals of suspected abuse to child protective agencies rose more than 50 percent, from 2 million to 3.3 million referrals per year (Ref. 7, § 2.1; Ref. 1, p 5). The majority, approximately 56 percent, of these reports are made by professionals (Ref. 1, p 6). However, despite the increased reporting and referral of suspected cases of abuse to child protective agencies, the number of children determined to be victims of abuse has remained constant over the past 10 years, at a rate in 2006 of approximately 12.1 per 1000 children (Ref. 1, p 26). The reasons for the relatively steady rates of victimization are unclear, as the problem has not been studied thoroughly. Nevertheless, there remains some question about the efficacy of reporting laws in achieving their ultimate goal: protecting children from harm.

In addition to questions about efficacy, mental health professionals have raised concerns about other negative consequences of mandated reporting. Child abuse investigations can be lengthy and cumbersome, and allegations of abuse come with significant stigma, even if ultimately unsubstantiated. Furthermore, given the disarray of social services for children in most states, there is no guarantee for a would-be reporter that a child taken from an abusive family situation will be placed in a better environment. Mental health clinicians have also raised concerns about the negative impact on the therapeutic relationship that making a report can have. As a result, studies have shown that professionals of all kinds, from teachers to pediatricians, are often reticent to report suspected abuse.[8,9] By one estimate, 30 to 40 percent of psychologists have elected not to report suspected child abuse at some time,[10] and behavior among other mental health professionals is likely to be similar. Most often, the reason for not reporting is described as a lack of substantiation of the allegation, as well as a belief that more harm than good will come to the child.[11]

Dilemma for Forensic Psychiatrists

Mandated reporting statutes are complex in and of themselves, but they are just one of the considerations that forensic psychiatrists face when deciding how to handle the clinical scenario outlined at the outset of this article. Mandated reporting statutes delineate one obligation—to report suspicions of abuse to a child protective agency—but this must be weighed alongside important ethics-related and practical considerations that are also involved in the decision. In addition, the forensic psychiatrist must consider the role of attorney-client privilege in this complicated scenario. The result is that strong arguments can be made both for and against reporting the suspected abuse, with no clear resolution to the dilemma.

The Argument for Reporting

The forensic psychiatrist in our clinical scenario may reasonably begin her search for a clear plan of action by examining her professional ethics guidelines and asking, "What is the right thing to do?" She would be likely to recall the ethics-based principles of respect for persons and truth-telling,[12] and she may draw an analogy between reporting the abuse and disclosing any other sensitive material that a defendant might tell her in a forensic report. She would employ a risk-benefit analysis to this situation just as she would when deciding what to include in a report. Given that a child's well-being is potentially at stake, she may decide that making a disclosure is necessary despite the potential harm to the evaluee. Her professional ethics would not prevent her from taking this action; they would guide her to disclose the minimally required information about the suspected abuse (truth-telling), but to be as respectful as possible to the evaluee when making that disclosure (respect for persons).

After examining the ethics involved in her decision, the forensic psychiatrist would then turn to the practical aspects of reporting. She would note that, in most states, making a report of child abuse simply involves calling a hotline number and filling out a brief form, which typically takes no more than a few minutes. She might weigh this relatively small investment of time and energy against the serious possibility that a child will not receive appropriate treatment or that other victims will remain unidentified. She may also note the potentially catastrophic consequences to herself if it were ever discovered that she did not fulfill her mandated reporting obligation: a licensing board investigation or malpractice suit. She could reason that making a report is the right thing,

and, in the long run, the less risky thing to do, both for herself and for the child in question.

Finally, the forensic psychiatrist would consider whether attorney-client privilege has any bearing on her decision. She may initially think that any statements made to her by a defendant during the course of a forensic evaluation are protected under attorney-client privilege, but she would soon learn that the interaction between attorney-client privilege and child abuse reporting is actually much more complicated.[4,13] She would first try to determine whether an attorney faced with a similar disclosure by a client would be mandated to report in her state, which may not be entirely clear. Even if it is clear that her state recognizes the attorney-client privilege as an exception to mandated reporting, the question of whether physicians who are retained by attorneys fall within the scope of that privilege may remain unanswered. In the majority of states, there is no case law or legislation that clarifies this question. Although some have argued that the intent of mandated reporting statutes is to exempt attorneys and their agents (such as investigators or experts) from the reporting obligation, the forensic psychiatrist would be unlikely to find specific legal precedents to support this position (except in Maryland, as outlined below).

Taking the ethics-based, practical, and legal factors into consideration, the forensic psychiatrist could reasonably arrive at the decision to report the suspected child abuse. She would note that her obligation as a mandated reporter is clearly defined in her state's statute. Her professional ethics do not prevent her from making a report as long as she remains respectful of the evaluee when disclosing the information. From a practical standpoint, making a report is not cumbersome, and it might protect her from a licensure board complaint or malpractice suit in the future. In the absence of clear case law or legislation stating that attorney-client privilege outweighs the psychiatrist's mandated reporting obligation, she would conclude that she must report.

The Argument Against Reporting

Although a review of the ethics of truth-telling and respect for persons might not help guide the forensic psychiatrist in our scenario, an important principle of traditional medical ethics—first, do no harm—provides a compelling argument for not reporting the suspected child abuse. Psychiatric evaluations are undertaken as part of a criminal defense with the expectation (by both the defendant and his attorney) that the outcome will, at worst, simply not be helpful to the legal case. Nobody expects a psychiatric evaluation to result in the filing of additional charges against the defendant. One could argue that a physician taking an action that results in further legal harm to the evaluee violates the principle of nonmaleficence. Furthermore, such an action is contrary to the original intent of the psychiatric consultation. Why would an attorney ever request a psychiatric evaluation knowing that his client could emerge from it worse off than when he started? Viewed in this light, the decision to report the suspected abuse simply seems wrong.

Next, the psychiatrist would consider the practical consequences of making a report. First, she might note that the evaluee is currently incarcerated and that he does not pose a substantial risk to children as long as he remains in jail. She might also reason that the chance of a malpractice suit or licensure board complaint being filed against her if it were discovered that she did not report is somewhat remote. In fact, these ramifications are likely to be less of an immediate concern than her relationship with the retaining attorney. At best, the attorney might disagree about the psychiatrist's duty to report but understand her decision to do so. At worst, making a report could lead to a very unpleasant interpersonal interaction and to being taken off the case. The psychiatrist may not be hired for future cases by the attorney, and if she practices in an area where referrals are highly dependent upon reputation and word of mouth, the decision could substantially hurt her forensic practice. This practical consideration may sway her not to report.

Finally, the forensic psychiatrist may be convinced by the argument that a disclosure of abuse made by the defendant is protected under the umbrella of attorney-client privilege. The courts have held that a psychiatrist who is retained by a defense attorney as part of a criminal defense cannot be compelled to disclose the results of the evaluation in a judicial proceeding if doing so would be harmful to the client,[14] so it stands to reason that the same rule should apply to out-of-court disclosures, such as those made by a psychiatrist to a child protective agency or to law enforcement. Although there may be no case law or legislation to confirm this in most jurisdictions, one could reasonably argue that the attorney-client priv-

ilege exception to mandated reporting is intended to extend to all who work in service of the attorney.

Thus, an equally compelling argument against reporting by the forensic psychiatrist in our scenario can be made. She could reason that the ethics of nonmalificence guides her not to disclose the suspected abuse, as she should not cause harm to the evaluee. She would understand that making a disclosure could ruin her relationship with the retaining attorney and possibly damage her forensic practice. Finally, she could argue that statements made to her by the defendant fall within the scope of attorney-client privilege, and if the attorney is not mandated to report child abuse, neither is she.

Maryland's Mandated Reporting Statute

In most jurisdictions, the relationships between attorney-client privilege, patient-physician privilege, and mandated reporting remain messy and undefined. Some states, such as Oregon, recognize both physician-patient and attorney-client privileges as exceptions to mandated reporting,[15] while others, such as Mississippi, specifically deny both privileges and require reporting by physicians and attorneys.[16] Most states lie somewhere between, either denying one of these privileges while recognizing the other, or remaining silent on the matter of privileged communications altogether. Thus, in most states, there is still a conflict between mandated reporting statutes and privileged communications with regard to forensic psychiatric evaluations.

Only Maryland has tackled this conflict head-on. In 1964, the state enacted a mandated reporting statute that required physicians to report suspected child abuse, but a subsequent appellate court decision created an exception for patients who were referred for psychiatric evaluation by an attorney.[17] It was unclear whether this exception applied to all patients who were referred by an attorney or only to those who were already facing criminal charges, and this uncertainty caused some confusion among psychiatrists in practice. In a published opinion in 1990, the Maryland Attorney General clarified that reporting by psychiatrists is required regardless of the referral source "unless the mental health provider is participating in the preparation of a defense to a criminal proceeding that has already been initiated" (Ref. 18, p 1). This clause created an explicit exception to mandated reporting for abuse that was discovered by a psychiatrist during the course of a forensic evaluation.

Unfortunately, the reasoning articulated in the attorney general's opinion focused mainly on the peculiarities of Maryland law and sought to distinguish attorney-referred psychiatric evaluations that were part of an ongoing criminal defense from those that were not. This was relevant to the dilemma in Maryland at the time, but it did not provide clear guidance for other states trying to resolve similar conflicts. The core question—whether the mandated reporting obligation for psychiatrists was outweighed by attorney-client privilege—was not addressed in detail. As a result, no attorneys general in other states have issued similar opinions to clarify the decision.

Other Possible Solutions

Maryland resolved this dilemma by carving out an exception to mandated reporting for psychiatrists participating in a criminal defense. This solution is one way to resolve the problem, but several others are worthy of consideration. One alternative solution is the abolition of mandated reporting statutes altogether. There is some reason to doubt the effectiveness of the statutes in achieving their intended goal of protecting children from abuse,[19] and some have suggested that they are in need of widespread reform.[20] At the present time, research regarding the effectiveness of the statutes is in its infancy. If the data eventually demonstrate that these statutes do not effectively reduce child abuse, repealing the statutes may be the next logical step. This, of course, would resolve the particular dilemma for forensic psychiatrists that this article has sought to address.

Another possible solution is to mandate all attorneys to report suspected child abuse. As described above, attorneys are currently largely exempt from mandated reporting (either by not being specified as a professional group required to report or by explicit recognition of the attorney-client privilege), but some have questioned whether the matter should be reconsidered.[4] Although requiring attorneys to make disclosures about their clients could raise significant ethics-related and practical concerns, some have argued that these concerns are not sufficiently different from those of other professionals, such as physicians and teachers, to warrant a different rule regarding reporting of child abuse.[21]

Yet another possible solution to this dilemma involves designating exceptions to mandated reporting

for mental health professionals working with certain patient populations who are likely to have perpetrated child abuse, such as pedophiles. Maryland attempted this strategy in the late 1980s by amending its mandated reporting statute so that physicians who were treating patients with pedophilia were not required to report abuse that had occurred prior to the beginning of the treatment.[22] This change was made to encourage patients with problematic sexual behavior to seek treatment without fear of criminal prosecution for past acts (Ref. 19, p 450). However, even before the strategy's efficacy could be assessed, the law was dubbed the "Pedophile Protection Bill" in the lay media, and it was so politically unpopular that it was repealed the following year.[23] One could reasonably assume that the reaction in other states would be similar.

Guidance from *Tarasoff v. Regents of the University of California*

In many regards, the duty for psychiatrists to issue a *Tarasoff*[24] warning is similar to the duty to report suspected child abuse. Both obligations involve breaching confidentiality between the psychiatrist and patient for the good of a third party—an abused child, in the case of mandated reporting, or a potential victim of violence, in the case of *Tarasoff* warnings. In addition, both scenarios involve potential further harm to the patient, as either type of disclosure by the psychiatrist could result in a criminal investigation and charges filed against the patient. Thus, an analysis of case law and legislation related to *Tarasoff* warnings in the forensic setting may provide some useful guidance when considering the question of child abuse reporting. *People v. Clark*,[25] a 1990 California Supreme Court decision, has many parallels to the scenario we have been considering throughout this article.

In *Clark*, a defendant was charged with first-degree murder, arson, and attempted second-degree murder after allegedly burning down the house of his former therapist and killing her husband in the fire. At the request of his attorney, the defendant was examined by a forensic psychiatrist. He told the psychiatrist about plans to kill two additional persons, and the psychiatrist issued a *Tarasoff* warning to those individuals. The psychiatrist later testified about the threats at the defendant's trial, and the defendant was convicted on all counts. On appeal, the defendant argued that the psychiatrist should have been precluded from testifying at trial, as any statements made to her were protected under psychotherapist-patient and attorney-client privileges.

The majority opinion in *Clark* discusses only briefly whether the *Tarasoff* warning made by the forensic psychiatrist was proper; it simply affirms the trial court's ruling that the warning was necessary to prevent future harm (Ref. 25, p 150). The matter of whether the psychiatrist should have been allowed to testify about the threats during the murder trial was examined in more detail. The court rejected the defendant's argument that the statements to the psychiatrist were protected under the psychotherapist-patient privilege, but it agreed that the statements were protected under attorney-client privilege, taking the view that the threats were "communications made in the attorney-client relationship" (Ref. 25, p 152) and therefore should be inadmissible in any criminal proceeding.

In essence, *Clark* set a precedent that the forensic psychiatrist who examines a defendant at the request of the defense attorney should make a *Tarasoff* warning if she deems it necessary, but the testimony about that warning may be precluded from a future criminal proceeding because of attorney-client privilege. Subsequent cases in California have readdressed the question of psychotherapists' testimony about *Tarasoff* warnings in criminal proceedings, first expanding and then limiting the scope of that testimony.[26,27] However, it is important to note that none of these cases has suggested that a forensic psychiatrist should not issue the *Tarasoff* warning itself. The point of contention is only whether testimony about that warning is admissible in future criminal proceedings.

Applying this analogy to child abuse reporting suggests that forensic psychiatrists are obligated to report suspected child abuse to a child protective agency, but their testimony about that report in a future criminal proceeding may be limited. However, it is important to note that *Tarasoff* is not a perfect analogy for mandated child abuse reporting. Although the intent of both *Tarasoff* warnings and child abuse reporting is to prevent third parties from harm, the scope of the information that triggers a child abuse report is arguably much broader than the scope of the information that triggers a *Tarasoff* warning. For example, a *Tarasoff* warning would not be issued if the patient who is currently incarcerated discloses past violence against a child (as long as there is no current threat), but such a disclosure may trig-

ger a report to a child protective agency. Thus, one could argue that child abuse reporting has the potential not only to prevent future harm, but also to punish individuals for prior bad acts, regardless of the current threat to the child. Therefore, child abuse reporting may warrant different treatment from *Tarasoff* warnings with respect to forensic evaluations.

Negotiating the Dilemma

The core dilemma addressed in this article is far from settled, and forensic psychiatrists practicing in most jurisdictions are left to negotiate on a case-by-case basis. These matters are complicated, and there is no clear answer about how to handle the situation. However, the following suggestions can be helpful when faced with making a decision about whether to report abuse that was discovered during a forensic evaluation.

Know Your Obligation. As described above, the specifics of mandated reporting statutes vary significantly from state to state, so it is important first to understand what is legally required in a given state. Consultation with an attorney can be helpful in this regard, but be wary of discussing the topic only with the retaining attorney, as he may not fully understand the physician's obligation and may have the client's best interest as his first priority. If possible, it is best to discuss it with an attorney who has no stake in the outcome of the case. Anonymous consultation with the state child protective agency can also be helpful, but again, be wary of the agency's potential bias toward maximizing reporting.

Think About Confidentiality Warnings, Both to the Client and in Discussions With the Attorney. In all forensic evaluations, the evaluee is informed at the outset about the limitations of confidentiality. When the psychiatrist is retained by the evaluee's own attorney, the psychiatrist typically tells the evaluee that the information learned during the evaluation will be disclosed to others only if the evaluee and his attorney believe it will be helpful to the legal case. However, this warning does not take into account the circumstances in which the psychiatrist may be obligated to disclose information to a third party, such as imminent harm to others (*Tarasoff* warnings) or suspected child abuse. A better confidentiality warning may include a statement about the psychiatrist's mandated reporting obligation before beginning the evaluation. In addition, it may be helpful to remind the attorney to discuss the psychiatrist's obligation as a mandated reporter with his client before the evaluation, particularly in cases involving known child abuse. Although this measure may not prevent all cases of accidental disclosure (i.e., blurting something out) during the evaluation, it may help to prevent unnecessary harm from coming to the evaluee.

If You Decide to Report, Discuss Your Mandated Reporting Obligation With the Retaining Attorney Before Making the Report as a Way of Preserving the Working Relationship. Although reasonable minds can disagree about a psychiatrist's obligation to report, most people would agree that it is better for the attorney to hear about such a report from the psychiatrist before it is made rather than from the child protective agency or from law enforcement after the fact. Once an evaluee has disclosed an instance of abuse, the psychiatrist should contact the retaining attorney as soon as possible. Although the subsequent conversation may be awkward or contentious, it is always best to be as open as possible about the decision to report. A thoughtful, well-reasoned explanation of the mandated reporting obligation may be the only way to preserve the working relationship with the attorney.

When Making a Report, Do So in a Way That Discharges Your Obligation but Does Not Deliberately Cause Harm to the Evaluee. While mandated reporting statutes impose a legal requirement to report suspected cases of abuse, they usually do not specify what degree of detail about the abuse must be reported. A court has held that "a mental health provider owes a duty to any person, who is the subject of any public report or other adverse recommendation by that provider, to use due care in formulating any opinion upon which such a report or recommendation is based."[28] Therefore, some degree of discretion is advisable when making a report of suspected child abuse. Child protective agencies may urge the reporter to disclose everything he or she knows, and law enforcement officers may contact the reporter to obtain further details to aid in their investigation. However, it is important to remember the ethics of maintaining respect for persons when deciding what to say in a report. A forensic psychiatrist has no duty to help the police "get the bad guy," nor should

she urge the evaluee to disclose every detail of the alleged abuse for the sole purpose of reporting it to authorities.

Conclusions

At the present time, whether forensic psychiatrists who are retained by a criminal defense attorney are mandated to report suspected child abuse remains an unresolved question in most states. It leaves the forensic psychiatrist with the difficult task of balancing complex ethics-related, legal, and practical considerations and deciding how to handle the dilemma on a case-by-case basis. Only Maryland has specifically clarified in an attorney general's opinion that psychiatrists who are retained as part of an ongoing criminal defense are exempt from mandated reporting. Until other courts and legislatures follow suit, consultation with psychiatric and legal colleagues, careful consideration of confidentiality warnings before beginning a forensic evaluation, and discussions with the retaining attorney before making a report of suspected child abuse can all help to navigate the dilemma more smoothly.

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