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Practical strategies

Mandatory reporting of child abuse and neglect: Crafting a positive process for health professionals and caregivers

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ABSTRACT

Health professionals working with children and their families are often required by law to report to governmental authorities any reasonable suspicion of child abuse and/or neglect. Extant research has pointed toward various barriers to reporting, with scant attention to positive processes to support the reporting process. This paper focuses on the context for mandatory reporting and evidence-informed practice for supporting a more structured and purposeful process of mandatory reporting. These practical strategies discusses: (1) the factors that positively influence the relationship between a child's caregivers and the mandated health professional reporter; (2) a framework and specific skills for discussing concerns about maltreatment and reporting to child protective services with the caregiver(s); and (3) the need for further training and education of health professionals.
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Introduction

Child maltreatment is a global health and social problem that impacts both (a) a significant number of children and their families and (b) the psychological and physical health and well-being of victims (Gilbert et al., 2009; Hibbard, Barlow, MacMillan & the Committee on Child Abuse and Neglect and American Academy of Child and Adolescent Psychiatry, Child Maltreatment and Violence Committee, 2012). The financial burden associated with child maltreatment includes costs associated with health care for the child and the indirect costs associated with the responses of the criminal justice system, child protection services (CPS), education, (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Waters et al., 2004). Using country-specific national methods, it was estimated that in 2006, children in the US experienced maltreatment at a rate of 17.1 per 1,000 children in the general population, while Canadian rates of substantiated child maltreatment in 2008 were estimated at 14.1 per 1,000, and Australian rates of substantiated cases in 2010–2011 were estimated at 6.1 per 1,000 (AIHW, 2012; PHAC, 2010; Sedlak et al., 2010). However, estimates of child maltreatment should be interpreted cautiously, as the true extent of child maltreatment is uncertain and widely regarded to be more prevalent than official reporting or community surveys can determine (Fallon et al., 2010; GAO, 2011; MacMillan, Jamieson, & Walsh, 2003; Sedlak et al., 2010).

Given their role with children and families, health professionals are in a unique position to intervene on behalf of children and to advocate for their welfare and protection. However, health professionals experience challenges and barriers to addressing suspected or confirmed child abuse and neglect (CAN) with families. Some of these include a lack of standardized training in identification and management of CAN cases and lack of knowledge in understanding the process of

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initiating a report to CPS where mandated by law. Additional contributory factors in the failure to report CAN include the health professionals' discomfort related to addressing maltreatment concerns directly with the child's parents or caregivers (hereafter referred to as "caregivers") because of concerns about the impact on the caregivers and/or themselves. This article is intended to discuss the issue of duty to report and to provide practical strategies for assisting the health professional with discussing concerns about CAN and his/her role as a mandated reported with the caregiver.

Overview of mandatory reporting

The UN Convention on the Rights of the Child established that government is the main body responsible for preventing and responding to violence against children, considering children as rightful participants, with particular attention to ensuring that children are recipients of the safeguard mechanisms supporting human rights (Pinheiro, 2006). The Convention on the Rights of the Child requires all signatory nations to establish integrated child protection systems to ensure a coordinated response to child abuse and neglect (Svevo-Cianci, Hart, & Rubinson, 2010). These integrated systems are commonly divided into three main areas: (1) mandates (laws, regulations, and policies); (2) mechanisms/interventions (education, service programs, and data management); and (3) child outcomes (performance measures of the child's health, development, and well-being) (Svevo-Cianci et al., 2010). An additional consideration is the resource provision to support recovery following exposure to violence, where mandatory reporting is conceptualized as a key element in the resilience-in-the-context-of-maltreatment process (Wekerle, 2013). Mandatory reporting of suspected or confirmed CAN represents one common, key strategy to address violence against children. Legally requiring certain individuals to report child abuse is justified with the assumption that early detection of abuse helps prevent serious injuries and relieves the victims of the responsibility to seek help for themselves, thus enhancing coordination between legal, medical, and service responses (Krug et al., 2002). The Convention emphasized that when countries have higher legal standards than the standards identified in the Convention to address violence against children, the higher legal standards prevail (Pinheiro, 2006).

Legislation mandating health professionals to report concerns for CAN is available in many countries across the world (US, Canada, Australia, Argentina, Israel, Poland, Sri Lanka, etc.). However, a number of countries (United Kingdom, New Zealand, etc.) do not mandate health professionals to report concerns for CAN (Krug et al., 2002). Additionally, mandatory reporting of CAN varies between jurisdictions. Differences exist regarding the type of maltreatment that is required to be reported and in some cases the source of the maltreatment. In Canada, US, and Australia all forms of CAN (physical, sexual, and psychological abuse and neglect) is generally reportable by law with some exceptions. For instance, in the US, the States of Idaho and Illinois do not require reports of psychological maltreatment and in Australia, Victoria and the Australian Capital Territory do not require reports of neglect and psychological abuse (Matthews & Kenny, 2008). In some Canadian provinces and US states, the legislation requires reports of abuse or suspected abuse by persons other than the parents. Additionally, the types of harms included in the definitions of CAN outlined in the mandatory reporting legislation varies. For instance, the exposure of children to intimate partner violence is expressly identified as reportable in some jurisdictions in Australia and Canada but few states in the US include this form of maltreatment in their mandatory reporting legislation (Matthews & Kenny, 2008). In almost every case across the US, Canada, and Australia, no proof of maltreatment must be present for the mandate to hold (Cheng, Munn, Jack, & MacMillan, 2006; Child Welfare Information Gateway, 2010; Matthews & Kenny, 2008). Nevertheless, significant variability exists between jurisdictions (both between countries and within countries) regarding the degree of harm to a child that is required to initiate a report to CPS (Matthews & Kenny, 2008). Therefore health professionals must be aware of the legislation that governs their locale. Country specific websites are available in many jurisdictions that can guide the health professional on where to find state legislation and other mandatory reporting resources. In the US, The Child Welfare Gateway website (www.childwelfare.gov/) provides information about statutes and child welfare services and related organizations by State. Similarly, in Canada this information can be found on the Canadian Child Welfare Research Portal website (www.cwrp.ca/) for individual provinces and territories and the Australian Government, Australian Institute of Health and Welfare website (http://www.aihw.gov.au/child-protection/) provides information for child protection services for each Australian state and territory. Additionally, most US states have anonymous toll-free numbers that serve as the first step in reporting suspected child maltreatment (Child Welfare Information Gateway, 2010). Furthermore, opportunities for consultation and collaboration with the local CPS can assist the health professional to evaluate the options and needs of a given situation, as well as set the stage for in-service education as laws are refined over time (AIHW, 2012; Cheng et al., 2006; Child Welfare Information Gateway, 2010; Portal, 2011).

Who is reporting maltreatment?

Health professionals are in a unique position to identify CAN and intervene on behalf of children and families. However, health professionals account for only a small number of reports to CPS. Reports from professionals (community health or social services, school, hospital, police etc.) represented almost 70% of the 235,842 investigations conducted in 2008 in Canada (PHAC, 2010). Community health and social services accounted for 12% and hospital personnel made up 5% of Canadian reports to CPS whereas school representatives accounted for the greatest number of reports to CPS at 24% (PHAC, 2010). In the US, three fifths of the reports to CPS made in 2010 came from professional personnel with the following breakdown: social service personnel accounted for 11.5%, education and law enforcement accounted for 16.4% and 16.7% respectively and medical workers accounted for 8.2% of the total reports by professionals (The Administration on Children,

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