Child Abuse & Neglect 101 (2020) 104261

Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg

Research article

Mandatory reporting between legal requirements and personal interpretations: Community healthcare professionals' reporting of child maltreatment

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ARTICLE INFO

Keywords:
Child maltreatment
Mandatory reporting
Health care professionals
Decision- making-ecology

ABSTRACT

Background: Healthcare professionals working at community-based services have a crucial position in raising concerns about possible child maltreatment. Yet, barriers exist to healthcare professionals adhering to mandatory reporting rules and regulations.
Objective: The current study investigated the various forms by which healthcare professionals working in community services manage mandatory reporting, their reasoning and experience with formal requirements. The study has utilized the decision-making-ecology model as a conceptual framework.
Participants and setting: The study was carried out in the largest district of the largest health-management organization in Israel, across fourteen sites located at seven cities. Eighteen healthcare professionals of various occupational groups participated in in-depth semi-structured interviews.
Results: The results reveal that out of the of 52 recent cases that have been suspected for possible child maltreatment, only 58 % were reported as legally required. Yet, about half were reported in delay. Practitioners were more likely to report after additional evidence accumulated and increased the level of suspicion or after failing to manage the issue by other means of support. The analysis identified multiple factors that combined to impact the decision-making regarding reporting. Those were clustered around the individual case, healthcare professional, organizational setting, and external context.
Conclusions: Our results emphasize the importance of workplace-environmental conditions in promoting optimal reporting behaviors, including working in multi-disciplinary teams, availability of rapid expert consultation, provision of emotional-support, and reciprocal exchange of information with child-protection-services.

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https://doi.org/10.1016/j.chiabu.2019.104261
Received 24 June 2019; Received in revised form 24 September 2019; Accepted 3 November 2019
Available online 07 January 2020
0145-2134/ © 2019 Published by Elsevier Ltd.

1. Introduction

In western countries, it is evident that high profile cases of child death due to abuse and neglect shape child protection services, policy, and legislation. A notable example is England, where most reforms introduced by governments have been a reaction to findings of serious cases and child death reviews (Munro, 2011). In Israel, it was the tragic death of three-year-old Moran Denemias in 1989, that triggered mandatory reporting legislation. The Israeli law was designed to be broad, it obligates any member of the public, to report to the police or a social worker with special legal authority (known as "social worker to the youth law"), any "reasonable suspicion" of offence against children and young people by their primary caregivers (Penal Code, Amendment no. 26, 1989). A particular duty to report with harsher sanctions for non-compliance (up to six months of imprisonment) is imposed on professionals of selected occupations that work closely and regularly with children and young people, including doctors, nurses, and paramedical practitioners (Amendment no. 108, 2010).

Mandatory reporting policy is a strategy aimed to facilitate the identification of child maltreatment incidences, by enhancing reporting of suspected child maltreatment cases to the state's protective agencies. Although it is highly common world-wide, there is a lack of consensus regarding its costs and benefits (Fraser, Mathews, Walsh, Chen, & Dunne, 2010; Konijnendijk, Boere-Boonekamp, Fleuren, Haasnoot, & Need, 2016; Mathews & Kenny, 2008; Pietrantonio et al., 2013). Arguments against mandatory-based reporting relate to the criminalization of the problem, leading to the precedence of the legal process over the delivery of help, and to a perceived danger of overreporting of innocent families. Critics of the policy also mention the deflection from opportunities to exercise discretion or professional judgement, and failure to take into consideration social and cultural circumstances, (Goldstein & Laor, 2007; Mathews & Kenny, 2008; Vulliamy & Sullivan, 2000).

The current study should not be mistaken for evaluation of reporting legislation effectiveness. Rather, it was designed to achieve in-depth insight into reporting practices of health care professionals (HCPs) in community-based clinics in Israel. Utilizing the decision-making ecology (DME) as conceptual framework, we investigated how community HCPs manage their mandatory reporting duty and factors affecting their reporting behavior. Recently, the DME framework has been steadily moving into the research of professionals' decision-making in child protection services (CPS), directing considerable attention to the context in which decisions are made (Baumann, Dalgleish, Fluke, & Kern, 2011).

1.1. HCP reporting practices

HCPs are recognized as having a unique and crucial position in raising concerns about maltreatment and advocating for the health and well-being of children (Fraser et al., 2010; Pietrantonio et al., 2013). They have opportunities to observe injuries, frequently for the first time, and the training to assess their nature (Fraser et al., 2010; Konijnendijk et al., 2016; Vulliamy & Sullivan, 2000). The decision to report is a critical nexus at which the role of HCPs and CPS overlap. Yet, a consistent pattern found in countries such as Canada, the US, Korea, Australia, and Israel is a policy-practice gap in regard to HCPs' adherence to their mandatory reporting duty when having suspicions, even at high levels, of child abuse and neglect (CAN), leading to a considerably lower reporting rate compared to personnel of the social and educational systems (Flaherty et al., 2008; Fraser et al., 2010; Hye-Mi & Ji-Soo, 2018; Pietrantonio et al., 2013; Sege et al., 2011). For example, in Israel during 2017, approximately 48,500 new cases were reported to SWYLs due to claims of CAN and other sources of danger. Out of all new cases, 3546 reports were made by HCPs: 2046 by hospital personnel, 1120 by community-services professionals, and 380 reports were made by children's clinic nurses (Israel National Council for the Child, 2018).

Variations in the likelihood of reporting suspicions of child abuse and neglect (SCAN) among HCPs is a recurring finding (Flaherty et al., 2008; Fraser et al., 2010; Herendeen, Blevins, Anson, & Smith, 2014; Pietrantonio et al., 2013; Sege et al., 2011). HCP characteristics identified in the local and international literature as having an impact on reporting practices in various settings include having a parental role; training in child maltreatment; knowledge about where, how, and how soon to report; attitudes towards reporting duty; prior experience with CPS; fear of violent or legal reprisal; concerns about losing the family as a patient; and worries of making a report that would not be substantiated (Feng, Fetzer, Chen, Yeh, & Huang, 2010; Foster, Olson-Dorff, Reiland, & Budzak-Garza, 2017; Fraser et al., 2010; Herendeen et al., 2014; Konijnendijk et al., 2016; Pietrantonio et al., 2013; Tirosh, Shechter, Cohen, & Jaffe, 2003; Vulliamy & Sullivan, 2000).

As to the impact of case characteristics, the likelihood to report was found to vary by child's age, type of abuse, type of injury and its circumstances, and prior familiarity with the family (Flaherty et al., 2008; Fraser et al., 2010; Herendeen et al., 2014; Sege et al., 2011). Also playing a role in HCPs' reporting decisions are opportunities for consultation with colleagues and the time invested in completing procedures and testifying in court (Foster et al., 2017; Herendeen et al., 2014; Vulliamy & Sullivan, 2000). Finally, studies show that lack of follow-up by CPS, leaving HCPs unaware of the eventual outcomes of their report, plays a role in their reluctance to report (Feng et al., 2010; Sege et al., 2011; Vulliamy & Sullivan, 2000). How do professionals deal with SCAN when deciding not to report? Some common responses found among pediatric providers and physicians are to make a referral to another professional or to attempt to manage the issue in the clinic without outside intervention (Flaherty, Jones, Sege, & CARES Group, 2004; Flaherty et al., 2008; Herendeen et al., 2014; Sege et al., 2011).

1.2. The Israeli context

In comparison to other countries, including the USA, Australia, and Canada, the Israeli law demonstrates a broad approach to mandatory reporting. This is evident in several elements such as, reporting duty being enshrined in the criminal law, definitions of

which persons have to report, on what types of abuse and neglect they should report, what types of perpetrators must be reported, and whether the duty applies to past or present harm. Furthermore, The Ministry of Health Ordinances (no.25/03 and 26/03 in 2003) specifically stipulate that in community settings, it is the individual professional who first recognizes the SCAN that holds responsibility for reporting it immediately to the police or to social workers to the youth law (SWYLs).

1.3. Conceptual framework: decision-making ecology

The DME model begins with the concept of the decision-making continuum, which comprises several key decisions made along child protection service provision (Baumann, Dalgeish, Fluke, & Kern, 2011; Fluke, Baumann, Dalgleish, & Kern, 2014). Taken to the context of healthcare, two consecutive decision-making points are: 1) the assessment of the child's condition for suspicion of maltreatment and 2) the decision about reporting these suspicions to the appropriate authority (Sege et al., 2011). As mentioned, this article focuses on the latter decision (the issue of CAN identification is explored in an accompanying article, see authors' own, in press).

The DME serves as a useful organizing framework for -potential multiple influences that may contribute to decision-making, by classifying them into case, worker, organization, and external factors (Baumann et al., 2011; Fluke et al., 2014). The category-specific characteristics that explain the variance in decision-making are still a matter of further research, specifically in regard to the organization and external context (Fluke, Chabot, Fallon, MacLaurin, & Blackstock, 2010; Font & Maguire-Jack, 2015; Smith, Fluke, Fallon, Mishna, & Pierce, 2018). Furthermore, a dedicated body of research that empirically tested the DME indicates complex relationships, including direct and indirect influences, between these factors when making decisions (Graham, Dettlaff, Baumann, & Fluke, 2015). It is suggested that CPS professionals have an individual threshold for a necessary amount and weight of evidence to transform their judgements into action. This threshold can be changed in response to influences of the different factors (Baumann et al., 2011; Font & Maguire-Jack, 2015). Finally, the DME emphasizes the actual consequences of the decisions made, which are assumed to exert influence back onto all factor categories and thereby impact the next decision (Baumann et al., 2011; Fluke et al., 2014).

The current study was designed to address three key weaknesses of contemporary research in the field of HCPs reporting practices of SCAN. First, instead of identifying the factors that influence individual professionals' decisions about mandatory reporting in isolation from their work environment (e.g., Benbenishty et al., 2014; Flaherty et al., 2008; Fraser et al., 2010), the present study captured HCP performance within their organizational and external context and investigates them as a complex whole. Second, despite notable differences between hospital-based and community-based settings, such as in terms of case history information, time, and resources available for professionals, the empirical inquiry typically focuses on hospital practices or combine together data relating to the two working environments (e.g., Benbenishty et al., 2011; Glasser & Chen, 2006; Pietrantonio et al., 2013). The present study took exclusively into account the characteristics of community-based setting, which is often a primary entry point into the child protection process. The third feature of previous studies relates to the point that research is usually directed at making predictions about HCPs' response to SCAN. This tendency is manifested in a data collection method of utilizing self-report structured questionnaires on large samples (e.g., Feng & Levine, 2005; Sege et al., 2011). The overarching purpose of the current study was to understand HCPs' reasoning or reconstruct their sense making of the situation at the time they decided whether to make a report. Meeting this objective implies relying on qualitative methods. Specifically, this study aimed to gain insight into the following questions: 1) How do HCPs in community services adhere to the mandatory reporting obligation? and 2) What factors of the case, decision-maker, clinic, and external context influence their reporting behavior?

2. Methods

2.1. Sample and data collection

The study was carried out in the largest district of the largest health-management organizations (HMO) in Israel. The researchers were provided by the HMO with contact information of community services' staff, which were deliberately selected to represent heterogeneity in site and professional characteristics. Another selection criterion was a reasonable career length on site, in order to ensure experience in CAN reporting. Of the HCPs successfully approached, along the eight-month period of data collection, 67 % agreed to participate in the study (seven professionals could not be reached, one was absent on maternity leave, one retired, and four refused participation due to workload pressures).

The study was conducted in 14 sites located at seven cities at the north of Israel: five sites were located in small cities (population < 40,000), five in midsize cities (population > 50,000), and four in a large metropolitan (population > 250,000). Sites represented diverse practice settings: 12 sites provided special services (e.g., child development clinic) and six sites were primary care clinics. Half of the sites worked in multi-disciplinary teams that integrated social workers. The sites also served different patient populations, including Ultra-Orthodox Jews, Arabs, and immigrants.

Overall, 18 HCPs of various occupational groups participated in the study: seven pediatricians (among them two who were center managers), five senior nurses, four social workers, one physiotherapist, and one occupational therapist. The majority (67 %) were females. Seniority at the clinic varied greatly between practitioners and ranged from two to 16 years of experience; most professionals stayed at the site over four years. It is important to note that 11 participants mentioned being more involved and interested in the issue of CAN. Among them, two professionals were members of a regional "violence committee". These committees include multidisciplinary experts on identification, assessment, and reporting of SCAN, and assume responsibilities for providing consultation to

HCPs, developing training and skills, monitoring practice, and collecting data.

For data collection, a semi-structured interview including open-ended questions was used. Considering a possible gap between participants' statements about their intentions to report and actual daily practice (Ben-Natan, Faour, Naamhah, Grinberg, & Klein-Kremer, 2012), an interview guide was developed to produce as much information as possible about experiences, challenges, dilemmas, attitudes, and beliefs, while providing the researchers enough flexibility to follow the interviewees' train of thought wherever it led. Considering that an open and honest dialogue may be inhibited due the illegal nature of inaction in this context, the interview guide was purposely designed to build a good researcher-interviewee rapport. Interviews were conducted at participants' work place, and were tape recorded and transcribed verbatim. The study complied with the ethical requirements of both Institutional Review Board (IRB) at the University of Haifa and the Israel Ministry of Health guidelines. Permission to conduct the study was granted by the district management of the HMO. Beyond that, each participant was free to agree or withdraw without any ramifications, as was explained in the requirement process. A written consent was obtained from all participants prior to the interview and considerable measures were taken to guarantee confidentiality and anonymity to participants.

2.2. Data analysis

The process of qualitative data analysis followed the deductive approach (Bradley, Curry, & Devers, 2007; Gilgun, 2014). Accordingly, the DME served as an organizing framework for the codes or a "start list" (Miles & Huberman, 1994), while allowing new and disconfirming evidence to present itself. The next steps involved comparing the patterns of the DME conceptual model with patterns, themes, relationships, sequences, and differences constructed from the data at the participant-level and site-level. Several strategies were used in this study for enhancing trustworthiness and assuring quality control in qualitative analysis, including auditing, peer debriefing and support, and negative case analysis (Gilgun, 2014).

3. Results

The results are organized according to the study questions, starting with findings about participants' reporting behavior in regard to recent SCAN cases and turning to the factors that affect reporting decision-making. Finally, findings relating to the availability of feedback about the actual outcomes of reported cases are presented.

3.1. Experience with SCAN cases and reporting

All participants had experienced at least one case of SCAN during their work at the present clinic. Overall, 52 SCAN cases were described, ranging from one to seven cases per professional. Some cases were fresh, and some were engaged with a couple of years earlier. In resemblance to national data (Israel National Council for the Child, 2018), neglect, including prevention of medical treatment, was the most frequent type of maltreatment suspected (N = 26 cases), followed by physical abuse (N = 22 cases), and sexual abuse, which was less reported (N = 10 cases). Four additional cases involved other sources of risk for the child.

Out of the 52 cases that raised suspicions of possible CAN, 30 cases (58 %) were reported as legally required. Most were reported to CPS and one to the police. Reports were made directly or by proxy through the clinic social worker. In 53 % of these cases (16/30), professionals kept their suspicions latent for some time and delayed reporting until further evidence was accumulated (e.g., the child's sibling arrived at the clinic with similar injuries) or more information was actively collected (e.g., through a home visit) or after support services (e.g., eating disorder clinic in the community) were proven unsuccessful in solving the problem. As for the rest of the cases, in 31 % of the cases (16/52), no report was made, and in 11 % of the cases (6/52), reports were made to another HCP, either a member of a violence committee or a colleague from the service. In 59 % of the cases (13/22) that were not reported either to CPS or the police, professionals managed suspected CAN by using alternative means, including referring the child and family to another professional for assessment or support (e.g., a hospital, child development clinic, social services), referring parents (who were not the alleged perpetrators) to make the report, or collecting more information about the child's condition.

3.2. Facilitators and barriers to reporting SCAN

Factors that facilitated or impeded participants' reporting behavior are presented below according to the DME model categories.

3.2.1. Case features

Practitioners were more likely to make a report as the level of suspicion increased, whether due to the credibility of the source of evidence or due to the severity of harm to the child. Examples are cases where reporting occurred after a parent's aggressive or problematic behavior towards the child, the spouse, or a professional was witnessed directly or after the child's disclosure. Furthermore, a third of the interviewees mentioned severe injuries were more likely to be reported than minor ones, as illustrated in the following remark by a social worker:

> If the parents tell me it was only a spank or something like that, I will not rush to report. It is an unpleasant touch, but it can happen to anyone. Only if it is a clear case of violence—bruises, scratches—then you cannot avoid reporting it.

This quote also reveals an empathetic approach towards parents and the normalization of their behavior, which was a shared attitude of several interviewees.

The perceived engagement of the family with the helping professions was another case factor affecting decision-making. Eight participants mentioned that the past or present involvement of the family with the social services is an important piece of information they seek and consider when deciding whether to report. This knowledge increased their confidence in their assessment, leading some practitioners to feel more comfortable in reporting but others to feel that reporting is redundant, as demonstrated by the following remarks. The first remark was said by a social worker and the second by a pediatrician:

> If she [manager of social services department] tells me, 'Yes, I am familiar with the family. They are so and so,' then it makes it easier for me knowing this is not a new report, because it is very difficult to do something like this when this is the first time.
> I know if the social services are involved…If it is not clear then, I call them and speak with the social worker…If they [the family] are not familiar [to the social services], then I report.

In addition to the social services, parents' perceived level of cooperation with the health services was a factor mentioned by a third of the participants: compliance with treatment or medical recommendations inhibited or delayed reporting. For example, a social worker described two families with similar living conditions of severe hardship that risked the child's developmental needs. Depending on the mother regularly attending their weekly meetings and following her recommendations, one family was referred to social services for support and the other was reported to SWYL for suspected neglect. Furthermore, it should be noted that a relationship of trust to children as well as parents could serve as an entry point to disclosure and to the access to services and protection. On the other hand, mandatory reporting could also be detrimental to relationships of trust, as it may remove children from current therapeutic and medical arrangements, and may harm the trust relationships between medical staff and child (Brown & Strozier, 2004; Oz & Balshan, 2007).

3.2.2. Professionals' characteristics

Regarding professionals' characteristics, in terms of knowledge and training in child maltreatment, all but one of the interviewees participated in post-qualification training programs (e.g., courses, workshops, and seminars) along their career, and a third also participated in training programs delivered at departmental meetings. Generally, professionals expressed confidence about reporting guidelines and procedures; they felt knowledgeable regarding how the report is to be made and to whom or could easily access the information, using the organization portal website or hardcopy leaflets and posters. As put by one pediatrician*: We all know to whom [we need] to report and how to report. Carrying it out is more difficult.*

Throughout the interviews, eight professionals shared feeling anxious about making a mistake when the diagnosis of CAN is uncertain, which can have a high cost to the child, family, and themselves if held accountable. They dreaded mistakes that could lead to leaving a child in danger and later *"seeing his picture in the newspaper"* (false negative errors) or *"removing form home a child who would not have been harmed" and unnecessarily stigmatizing the family with "a damaging mark that can be interpreted against them"* (false positive errors). Five pediatricians mentioned reporting allows them *"peace of mind"* and an emotional relief from the discomfort associated with uncertainty and the burden of carrying responsibility for the child's safety and well-being. All social worker participants also raised concerns about reporting leading to a breakdown in working relationships with parents and pushing them away from the service, which can indirectly harm the child, for example: *"Something that has great impact is the fear of losing the relationship, that they (family) flee therapy."*

3.2.3. Working environment conditions

Regarding the impact of organizational resources, the availability of an in-service social worker was an important factor in facilitating staff reporting practices. All professionals who had access to a social worker at their clinic indicated feeling more comfortable informing them about SCAN and leaving the actual process of making a report to their responsibility. Beside the notable help of social workers in simplifying procedures, they were also appreciated as CAN experts that could be easily contacted and consulted with, as illustrated in the following remark by a pediatrician, the clinic manager:

> In every case of child abuse suspicion, I am fortunate the center includes social workers, I involve the social workers' supervisor if she is here or call her at home… I get the assistance of the center's social workers to contact SWYL, which often are not available on the phone, and make a report through them.

In effect, all interviewees found it helpful to discuss their suspicions of CAN with other professionals at the service (supervisors or colleagues) through scheduled departmental meetings or informal interactions, before making decisions about reporting. Social workers also mentioned discussing cases with colleagues from the social services. An interesting initiative, in this regard, was described by a pediatrician who developed an on-line method for joint decision-making with the local children's clinic manager using flags (red or white) to signal their judgments:

> If she [the clinic manager] raises a red flag and the child is my patient, then I need to see him/her. If I get the impression it is a matter of a red flag, then we immediately report [the case] to the SWYL. We don't wait a second. If I raise a red flag and she a white one, then we sit and think. We give it another chance, make another examination, and follow-up on the child. If we both raise a white flag, then there is no threat, and we leave an indication on the child's record.

In addition, thirteen participants mentioned that if they had a question, they could call or e-mail the violence committee's experts, immediately discuss their concerns, and receive advice on how to respond. For a few participants, the committee was also valued for the emotional support its members provided. In a way, the committee functioned as an experts' support hotline, as demonstrated by the following remark by a pediatrician:

> There is the issue, some of it psychological, that you are not alone in this thing, that you can talk and refer it. In fact, there is the issue of risk management and some kind of sympathetic ear, but also professional guidance.

A barrier to reporting was the lack of availability of an in-clinic diagnostic test for physical and sexual abuse. A practical solution described by five participants was to send the child to a hospital for a skeletal survey or a rape kit test, without explaining the reason to the parents. Such referral also meant fulfilling their responsibility and delegating the mandatory reporting duty to the hospital personnel. The following remark made by a nurse illustrates this point:

> I see bleeding on the diaper, a few months old baby, six months at most. I asked the doctor to refer them to the emergency unit. Of course, we don't write 'abuse' as the diagnosis so that the patents wouldn't be alarmed. I personally speak with the hospital's social worker and inform her that the family is coming.

A final feature of the work environment, which was experienced by all participants, involved exposure to patients' violence at the clinic (for example, physical aggression or threats). When questioned about the possible impact a parent's violent behavior towards staff may have on the decision to report, eight participants indicated it would not affect them; eight mentioned it would serve as evidence to support their concerns for the child's safety, and thus, encourage them to report; and six believed staff members would be too afraid to make a report.

3.2.4. External context

External factors that affected practitioners' decision-making included the mandatory reporting policy itself and close relationships with the local community. According to eight professionals, the law provided them immunity from moral dilemmas and questioning the righteousness of their actions and protected them when facing difficult decisions. For example, a social worker described how the legal obligation to report facilitated her discussion of the issue with the child's parents.

Close relationships with local families were described by 11 participants as a factor in reporting. A key feature of practice within a community setting was HCPs' capacity to develop continuous working relationships with their patients. Working in small communities also yielded situations of overlapping of personal and professional life, for example, when participants were community residents. Relationships with community members operated as a two-edged sword in terms of reporting. On the one hand, limited experience with the family meant less knowledge about family history, less certainty of CAN assessment, and less confidence in reporting. On the other hand, a close relationship with the family led to judgments being less objective and governed by emotions, which made it harder to consider abuse, and thus, it was more likely that an alternative explanation for an injury would be accepted. Here is an illustrative example made by a nurse:

> I've known the family for 10 or 15 years, and even if there is a case of a burn that repeats itself twice in a short time, I assess it to be very likely a matter of an accident. The child is very, very naughty—I know him—he is very active, so I don't take it seriously and I don't alert our system or the social services' system. Yet, it is in my thoughts that maybe there is this one percent, that maybe I am missing something.

3.3. Feedback about report outcomes

Finally, as to the actual consequences of their reports, information was available in regard to only 57 % (17/30) of the reported cases described. It is suggested that this finding was not uncommon. Four professionals voiced their discouragement and disappointment by not receiving sufficient feedback from CPS about the eventual outcomes of the reports, as demonstrated by the following remark by a pediatrician:

> In regard to all cases, I never got feedback. Was it indeed the diagnosis? How was it treated? Once it is out of our department, it is lost. We don't know what the SWYL did or did not do. Maybe there was nothing in it, but what was the outcome of the investigation? So once there is a suspicion, a report, and it is out—we are obliterated.

Some participants described taking the initiative of collecting information from hospital personnel, CPS workers, or violence committee members on the investigation conclusions and the progression of the case, yet, follow-up practices were highly time consuming, for example, *"In regard to some of the cases, I find out what happened, but the situation today is that I barely have time for this."* Few participants continued to be involved in the formal child protection process by participating in CPS case conferences, court proceedings, or police investigations.

4. Discussion

Professional decision-making in the field of child protection, regardless of occupational branch, involves unavoidable uncertainty about what has happed and what will happen to the child (Munro, 2019a). The full details of family life may never be known and there is no single line of explanation that accounts for evident harm or visible signs (Flaherty et al., 2006; Sege et al., 2011). Decisions are also affected by the amount of time available to make them relative to the urgency of the child's condition (Munro, 2019a). Appreciating child protection decisions are made in uncertain dynamic situations, this study investigated how healthcare professionals manage their mandatory reporting duty of suspected child abuse and neglect. The study focused on the practice of HCPs working at community services and utilized the decision-making ecology model as its conceptual framework. Our findings identified

multiple factors of the individual case, healthcare professional, organizational setting, and external context that combined to impact reporting decision-making. This study contributes to the understanding of reporting behaviors among healthcare practitioners working at community settings, in the face of the complexities of their work environment.

The key finding of this study is that HCPs do not report, according to legislation and regulations, every child for a condition that invokes the "reasonable suspicion" criterion that mandates a report. Rather, they selectively decide to report under particular situations and tend to do so in some delay. Considering the events that eventually led to making a report together with professionals' responses in not reported cases, show that practitioners are more likely to report after more evidence accumulates and increases their level of suspicion or after failing to manage the issue by other means of support.

These practices are neither original nor unexpected. HCPs' avoidance of reporting before being certain about the diagnosis and confidence about being able to work it out with the family within the health services, are well documented trends in the literature, and are the most common explanation provided by HCPs for not reporting SCAN (Eisikovits, Davidov, Sigad, & Lev-Wiesel, 2015; Flaherty, Jones, Sege, & Group, 2004, 2008; Herendeen et al., 2014; Sege et al., 2011). Another consistent research finding was that professional decision-making can be enhanced by the reflection of perceptions and assessments with other professionals, at the best with professionals with specialized expertise.in the context of mandatory reporting. However, this option is not embedded yet into the healthcare systems in Israel.

Furthermore, these findings are in line with the "decision threshold" idea presented by the DME (Baumann et al., 2011). From this perspective, professionals' decisions were influenced by their personal threshold, over which, evidence was intense enough to drive them into acting by reporting. Case evidence mounting up to sufficiently influence the shift in decision threshold included the assessed severity of harm to the child; factual data such as test results and first-hand observations of maltreatment; perceived lack of cooperation by parents; and indication that support to the family has not benefitted the child. Yet, as much as HCPs wanted to be confident in the accuracy and soundness of their diagnosis prior to reporting, they inevitably jeopardized the important quality of acting fast.

In general, HCPs' practice at the reporting conjuncture was not a matter of handing off the baton to the next runner in a relay race of child protection, as described in other studies (Eisikovits at al., 2015; Feng et al., 2010). Rather, professionals spoken to during this research convey a sense of enormous responsibility to make the correct assessment and obligation to invest as much as it takes for the benefit of children and families. It was well-recognized through the study that there is much commitment and priority within the health services system to the issue. Our findings show that the healthcare systems provide its workforce with the conditions and resources to address mandatory reporting duties, including qualification and training, in-service learning opportunities, and user-friendly, highly accessible procedures.

The use of a qualitative research method in this study contributed to obtaining comprehensive data and the thorough analysis of how and why practice unfolded the way it did, information that could not have been obtained through other methods. The open dialogue with HCPs allowed in-depth understanding of what happens when they meet vulnerable children and families, where they face most difficulty, and what resources they need in order to improve their reporting behaviors. The study highlights the contribution of interdisciplinary collaboration to HCPs' reporting practice, in accordance with findings from other studies (Benbenishty et al., 2011; Feng et al., 2010; Vulliamy & Sullivan, 2000). Furthermore, evidence shows that the effectiveness of interdisciplinary work at the clinics was powered by the colocation of its staff, which facilitated a culture of joint working. The integration of social work skills and professionalism within healthcare community services was indicated as a great advantage for staff. Social workers as team members facilitated information sharing between agencies and contributed their specialist knowledge. Generally, opportunities to consult with others when facing difficult judgements were highly valued by HCPs. All professionals in this study, regardless of their occupation and seniority, appreciated having another perspective on the case before making a decision. When the service did not offer an official forum for consultation, professionals initiated discussions with colleagues or members of the violence committee.

Evidence from the current study reinforces what has been identified as a factor in HCPs' decision making, namely, their emotions (Hye-Mi & Ji-Soo, 2018; Piatrantonio et al., 2013). The emotions described were the result of the professionals' assessment of what is at stake and their sensitivity for the conflicting interests of stakeholders involved, such were the

anxiety about making difficult decisions individually, fear of violent parents, and dread of raising the child maltreatment issue with familiar community members. The emotive impact of reporting practice may have led some professionals to take an empathic response towards parents and use the law to reconcile complex dilemmas. Yet, beyond the micro context of specific performance on specific cases, there was evidence to SCAN cases imposing an emotional burden on the workforce. Finally, our findings show that information sharing at the intersection of health and social services was deficient. Professionals were not given adequate feedback regarding the results of their report. The importance of understanding the outcomes of decision-making to enhancing practice capacity is well-recognized in the DME model and is empirically supported by prior research on HCPs' reporting of SCAN (Baumann et al., 2011; Feng et al., 2010; Sege et al., 2011; Vulliamy & Sullivan, 2000).

Before turning to discuss the implications of this study, some methodological weaknesses should be acknowledged, given they may limit the ability to generalize. The current study is limited in sample size and retrospective perspective, thus findings may not represent the full range of HCPs' experience and practice. Nevertheless, it supports the application of the DME model to a new setting of healthcare community practice and adds new evidence about the influence of factors in each category, particularly the organizational and external context, on reporting decisions, and therefore can contribute to policy and practice.

4.1. Implications for policy and research

The analysis identifies several systemic conditions that can lead to more effective reporting practices. First, the study supports

recent tendencies in the UK and beyond to deliver services for children and families by working in multi-disciplinary teams. The Multi-Agency Safeguarding Hub (MASH) program adopted in the UK, has shown proven evidence-based effectiveness in leading to substantial improvements in services, as well as being highly cost-effective (Author's own, 2019). Second, HCPs in community services who make difficult decisions about reporting CAN cases should receive adequate support from their organizations. It is suggested that HCPs would benefit from an experts' hotline that would allow them rapid access to child abuse specialists from the time of the initial assessment of SCAN (Flaherty, 2004). Sufficient emotional support should also be established for professionals in becoming resilient to dealing with the emotional impact of reporting decision-making. This can be made through ongoing training and consultation opportunities. Finally, in order to protect children and ensure their well-being, professionals of different agencies should work in concert (Author's own, 2019). Good quality and continuous information sharing between service providers is essential for early and effective intervention in child abuse and neglect cases (Munro, 2011, 2019). The focal message of this study is that social workers should become more involved in reciprocal exchange of information with their allied healthcare professionals for better protection of children to be achieved.

This research provides evidence-based understanding of important issues in making reporting decisions when working in healthcare community services, which can be drawn on and inspire future research efforts. An example is HCPs' exposure to workplace violence, a problem that according to research shows a consistent rising frequency of incidents (Goldblatt et al., 2017). The literature in regard to social workers, and child protection workers in particular, shows that direct client contact is a predictor of workplace violence that can negatively affect workers' assessment and decision-making practices (Author's own, 2015; Littlechild, 2005; Koritsas, Coles, & Boyle, 2008). Finally, the DME framework used in this research has proven to be highly advantageous in allowing more holistic understanding of why full compliance with mandatory reporting is difficult to achieve. Yet, additional work needs to be done on developing this approach regarding the healthcare professions.

4.2. Conclusion

Based on the premise that mandatory reporting legislation can facilitate the identification of child maltreatment incidences, this study portrays the every-day practice challenges health care professionals at community settings are faced with given their legal duty, and directs attention to conditions of the work environment that can promote optimal reporting behavior, including working in multi-disciplinary teams, opportunities for rapid consultation with experts, provision of emotional support, and a reciprocal exchange of information with child-protection services.

Acknowledgement

This study was funded by the Israel National Institute for Health Policy Research, Tel Hashomer, Israel. Grant ID 2016/11/R.

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