

## **Tipping the scales: factors influencing the decision to report child maltreatment in primary care.**

### **Abstract**

Child maltreatment is an important public health issue linked to significant physical and mental health complications across the lifespan. Given the association between child maltreatment and health, general practitioners (GPs) and primary care nurses (PNs) are well-placed to identify and respond to this issue and are mandated to report suspected child maltreatment in many jurisdictions. Research has found that primary care doctors and nurses need support when responding to child maltreatment. This scoping review sought to answer the following question: what factors influence GPs and PNs decision to report child maltreatment when fulfilling their mandatory reporting duty? By exploring these factors, areas where support is needed were pinpointed.

A systematic search was run across four databases: Medline (Ovid) PsycINFO, Embase and CINAHL. Articles that reported on studies conducted in a location that had mandatory reporting legislation specific to child maltreatment and had a study population sampled from primary care were included in analysis. Thirty-three articles met the inclusion criteria.

This review found that four principal factors influenced the decision to report child maltreatment: personal threshold of suspicion of abuse; relationship with the family; faith in the child protection system; and education and discussion. We conclude that improving the support and training to address these four areas may be beneficial for GPs and PNs in responding to child maltreatment.

## Introduction

Child maltreatment (CM) is a prevalent public health issue encompassing any act or omission of care by a parent or other caregiver that results in harm, potential for harm or threat of harm to a child (Gilbert et al., 2009; Hamby, Finkelhor, Turner, & Ormrod, 2010). These acts can be classified into five main groups of abuse: physical; sexual; emotional/psychological; neglect; and exposure to domestic violence (Gilbert et al., 2009). International studies suggest that between 16% and 36% of children worldwide have experienced some form of abuse (World Health Organisation, 2016).

Child maltreatment can be linked to many negative mental and physical health conditions for children and adult survivors of CM. Child maltreatment is associated with learning difficulties, behavioural problems and mental health issues for children (Felitti et al., 1998; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). A critical review by Hart and Rubia (2012) found neuropsychological studies that suggest a link between CM and deficits in IQ, memory, attention and emotional processing in children. Reporting a higher number of adverse childhood experiences (ACEs), including CM, was correlated to a lower quality of life in adolescents (Vink et al., 2019). Another study using the ACE questionnaire found that CM primarily accounted for mental health symptoms in adolescents (Negriff, 2020). A prospective cohort study of young people found that participants who had experienced emotional abuse were significantly more likely to report heavy alcohol use (Kisely, Mills, Strathearn & Najman, 2019). This supports Felitti et al (1998) in their speculation that those with higher ACE scores engage in health harming behaviour, such as heavy alcohol use or smoking, as a stress coping mechanism. Engaging in such behaviours leads to poorer health outcomes which may explain why adult survivors of CM are more likely than the general population to experience physical health complications including obesity and heart disease (Felitti et al. 1998). Additionally, the odds of adult survivors experiencing serious depression

are more than twice the general population. Adult survivors of CM are also 12 times more likely to commit suicide (Felitti et al. 1998; Salokangas et al. 2018; Pournaghash-Tehrani, Zamanian & Amini-Tehrani, 2019). Those who experienced CM were also significantly more likely to perpetrate CM, criminal violence and intimate partner violence (Milaniak and Widom, 2015; Oliver, 1993). Research shows this group has an increased risk of re-victimisation (Widom, Czaja & Dutton, 2008). This demonstrates the perpetuation of the cycle of violence.

### **Mandatory reporting for health professionals**

Recognising the link between CM and health, many countries have taken steps to ensure early intervention within the health sector. In the United Kingdom (UK), for example, it was decided not to legislate mandatory reporting but instead to have mandatory child-safeguarding training for health professionals (HM Government, 2016). While there is no legal mandate to report, there is strong encouragement within workplace culture to report suspicions of CM (HM Government, 2016). Meanwhile, other countries including the United States (US), Canada and Australia introduced mandatory reporting laws for health professionals (Mathews & Kenny, 2008). However, the introduction of these laws over different jurisdictions has led to differing legislation both across and within these countries. Differences relate to: what level of abuse needs to be reported as CM; the definition of ‘child’ and ‘young person’; which professions are required to report; and the level of suspicion and the extent of harm required to activate reporting duty (Mathews, 2014). There is, however, an aspect of the law that is consistent across most jurisdictions: general practitioners (GPs) and primary care nurses (PNs) are mandated to report their reasonable belief or suspicion of CM to statutory authorities (Mathews, 2014).

In this review, we have decided to focus on primary care because we want to promote early intervention for CM. Mandatory reporting laws have the same goal as they acknowledge the

prime position primary care doctors and nurses occupy within the community to identify and respond to CM early. However, several studies provide evidence that fulfilling the mandatory duty to report CM is challenging, particularly for those working in primary care who have an ongoing relationship with patients and their families (Flaherty et al., 2006; Flaherty, Jones, & Sege, 2004; Flaherty, Schwartz, Jones, & Sege, 2013; Flaherty, Sege, Binns, Mattson, & Christoffel, 2000; Flaherty, Sege, Mattson, & Binns, 2002; Flaherty et al., 2008; Kuruppu, Forsdike, & Hegarty, 2018). Possible reasons for why it is so challenging include: inadequate knowledge and experience of recognising and reporting CM; loyalty to the family or fear of caregivers' reactions; and negative reporting experiences resulting from a lack of feedback from child protection or a perceived ineffectiveness of child protection (Flaherty et al., 2006; Flaherty, Jones, & Sege, 2004; Flaherty, Schwartz, Jones, & Sege, 2013; Flaherty, Sege, Binns, Mattson, & Christoffel, 2000; Flaherty, Sege, Mattson, & Binns, 2002; Flaherty et al., 2008; Kuruppu, Forsdike, & Hegarty, 2018).

There is a need for evidence-based interventions to support mandated reporters in their duty to report suspected CM. While evidence regarding the factors influencing GPs' and PNs' decision to report CM exists (Flaherty et al., 2006; Flaherty, Jones, & Sege, 2004; Flaherty, Schwartz, Jones, & Sege, 2013; Flaherty, Sege, Binns, Mattson, & Christoffel, 2000; Flaherty, Sege, Mattson, & Binns, 2002; Flaherty et al., 2008; Kuruppu, Forsdike, & Hegarty, 2018), this evidence has neither been scoped nor synthesised collectively. To fill this gap, the present scoping review sought to answer the following question: *what factors influence GP's and PNs' decision to report CM when fulfilling their mandatory reporting duty?* Such a synthesis could assist in establishing patterns, which could provide useful evidence to inform interventions or target education and training for primary care health professionals responding to CM.

## **Method**

### **Search Strategy**

This review followed the methodology described by Arksey and O'Malley (2005). The review question was broken into three aspects (Child maltreatment; mandatory reporting; and GPs and PNs) with their respective synonyms to used build the search strategy. For example: 'Child maltreatment' was combined with 'child abuse and neglect'; 'mandatory reporting' with 'obligation'; and 'GPs and PNs' with 'family physician\*' or 'general practice nurse' (see appendix A for full search strategy) (McTavish et al., 2017).

The search strategy was applied to four databases in June 2018: Medline; PsycINFO; Embase; and CINAHL. No date restrictions were applied and only papers in English were included.

### **Inclusion and Exclusion Criteria**

Quantitative, qualitative and mix-method studies were all considered. Studies included were those that: were published empirical research; reported on GPs and PNs (or an equivalent group such as primary care paediatricians); discussed factors influencing reporting (including barriers and facilitators of reporting); and were conducted in countries or regions that had mandatory reporting laws at the time the study was conducted.

Articles were excluded if they were not presenting empirical research (i.e. editorials/commentaries). Studies were excluded if the majority of the study population consisted of hospital care providers, social workers or any other group outside of GPs and PNs (or equivalent groups). Studies focused on factors which influenced the identification of CM only and did not discuss its relationship to the decision to report were excluded. Studies conducted in a location that did not have mandatory reporting laws specific to CM were also excluded (see table 1 for full exclusion and inclusion criteria).

## Data extraction, synthesis and analysis

The titles and abstracts of the 779 studies identified through the systematic search were screened independently by the first and second author. Of these, the full texts of 71 studies were read by the first and second author to determine inclusion. Any disagreements were resolved by consulting a third reviewer (third or fourth author). The reference lists of studies identified through the systematic search were hand-searched by the first author and any relevant papers meeting the inclusion criteria were added to the list of included papers (see figure 1). A charting process was undertaken whereby key information and findings were tabulated for analysis (supplementary file table 3). The key information extracted from each of the primary research reports were: authors; year of publication; country where the study was conducted; aim; methods (quantitative or qualitative); study population; and key findings relating to the scoping review question.

### Figure 1: PRISMA Diagram

The data extraction table was imported into NVivo 12 (QSR International) for inductive thematic analysis. The data was coded according to the thematic analysis method set out by Braun and Clarke (2012). This involved a process of initial coding whereby the essence of a finding was captured in a short sentence or 'code'. The initial codes were then grouped into focused codes in answer to the research question. For example, the initial codes 'failing to report because not enough evidence' and 'failing to report because of uncertainty' were grouped to form the focus code 'failing to report because lacking evidence and certainty'. A process of analytical coding was then undertaken, which involved all four authors analysing the focus codes to allow the most salient themes that answered the review question to be developed.

## Findings

### Characteristics of Included Studies

Thirty-three papers from eight different countries were identified through the systematic search. Seventeen papers reported studies from the US (Badger, 1989; Flaherty et al., 2004; Flaherty et al., 2000; et al., 2002; Flaherty et al., 2006; Flaherty et al., 2008; Gunn, Hickson, & Cooper, 2005; Herendeen, Blevins, Anson, & Smith, 2014; Jones et al., 2008; Laskey et al., 2012; Lawrence, Brannen, Lawrence, & Brannen, 2000; Levi & Brown, 2005; Marshall & Locke, 1997; Morris, Johnson, & Clasen, 1985; Saulsbury & Campbell, 1985; Zellman, 1990; Zellman, 1992), seven from Australia (Blaskett & Taylor, 2003; Francis et al., 2012; Fraser, Mathews, Walsh, Chen & Dunne, 2010; Raman, Holdgate & Torrens, 2012; Schweitzer, Buckley, Harnett & Loxton, 2006; Van Haeringen, Dadds & Armstrong, 1998; Winefield & Castell-McGregor, 1986), two from Sweden (Lagerberg, 2001; Talsma, Bengtsson Bostrom, & Ostberg, 2015) and two from Brazil (Leite, Beserra, Scatena, Silva, & Ferriani, 2016; Rolim, Moreira, Gondim, da Silva Paz, & Vieira, 2014). The remaining studies were from Turkey (Demircin et al., 2017), Austria (Kraus & Jandl-Jager, 2011), Italy (Romeo et al.) and Israel (Shor, 1998). Twenty-eight studies were cross-sectional studies (Badger, 1989; Demircin et al., 2017; Flaherty et al., 2000; Flaherty et al., 2002; Flaherty et al., 2006; Flaherty et al., 2008; Fraser et al., 2010; Gunn et al., 2005; Herendeen et al., 2014; Kraus & Jandl-Jager, 2011; Lagerberg, 2001; Laskey et al., 2012; Lawrence et al., 2000; Levi & Brown, 2005; Marshall & Locke, 1997; Morris et al., 1985; Raman, Holdgate, & Torrens, 2012; Rolim et al., 2014; Romeo et al., 2016 ; Saulsbury & Campbell, 1985; Schweitzer et al., 2006; Shor, 1998; Talsma et al., 2015; Van Haeringen et al, 1998; Winefield & Castell-McGregor, 1986; Zellman, 1990; Zellman, 1992), four used qualitative methods (Flaherty et al., 2004; Francis et al., 2012; Leite et al., 2016), one used mixed methods (Blaskett & Taylor, 2003) and one was a meta-synthesis of qualitative studies (McTavish et al., 2017). No

other reviews and no theses/dissertations met the inclusion criteria. Some studies focused on a particular type of CM (e.g. physical abuse), while others considered CM more generally. The composition of the study populations differed across the studies. Most of the US studies looked at paediatricians working within a primary care setting. Others compared professionals working in primary care to those working in hospital environments. In the interests of keeping terminology consistent, the study populations of all the papers will be collectively referred to as ‘clinicians’, unless a particular paper is being discussed. In this instance, the study population will be referred to by the term used to refer to them in their respective article. A full summary of the included papers can be found in supplementary file table 3.

Four themes regarding the factors influencing the decision to report CM emerged from inductive thematic analysis: *personal threshold of suspicion*; *knowing the family*; *having little faith in the system*; and *education and discussion*. Each theme will be presented in turn with direct quotes from the participants of the original studies to emphasise particular points.

### **Personal threshold of suspicion**

A major influencer of the decision to report CM is the level of suspicion a clinician might have about a child’s injury (Badger, 1989; Blaskett & Taylor, 2003; Demircin et al., 2017; Flaherty et al., 2004; Flaherty et al., 2000; Flaherty et al., 2002; Flaherty et al., 2006; Flaherty et al., 2008; Francis et al., 2012; Fraser et al., 2010; Gunn et al., 2005; Herendeen et al., 2014; Jones et al., 2008; Kraus & Jandl-Jager, 2011; Laskey et al., 2012; Lawrence et al., 2000; Leite et al., 2016; Levi & Brown, 2005; Marshall & Locke, 1997; McTavish et al., 2017; Morris et al., 1985; Raman et al., 2012; Rolim et al., 2014; Romeo et al.; Saulsbury & Campbell, 1985; Schweitzer et al., 2006; Shor, 1998; Talsma et al., 2015; Van Haeringen et al., 1998; Winefield & Castell-McGregor, 1986; Zellman, 1990; Zellman, 1992). However, there did not appear to be a consistent approach to reaching the threshold of suspicion that

would prompt reporting CM. Each clinician seemed to have their own personal threshold of suspicion that would activate their reporting duty (Flaherty et al., 2006; Levi & Brown, 2005; Morris et al., 1985). This is demonstrated by a study where participants were presented with vignettes and asked to indicate the likelihood of actually reporting the case to authorities (Morris et al., 1985). Of the ten vignettes, no one patient would have been reported by all participants (Morris et al., 1985). One vignette was highly suggestive of abuse but only 58% of participants said that they would report that patient (Morris et al., 1985). This finding demonstrates the inconsistencies that exist in clinicians' personal threshold of suspicion. This is further explained by a GP from a mixed-methods study by Blaskett and Taylor (2003)

p.174:

*'It comes back to forming a belief . . . you have to suspect it strongly to do that [report], now how is anybody going to engage when I feel strongly about it...and even if I explain [to someone else] what I mean does that correspond to what others think meets the necessary level of a formed belief as required in the legislation? . . .how do you arrive at a consensus threshold?'*

This highlights that different individuals have differing thresholds of suspicion that would activate their duty to report (Flaherty et al., 2006; Levi & Brown, 2005; Morris et al., 1985). Some clinicians would need a higher level of suspicion (and therefore have a high personal threshold of suspicion) before deciding it was appropriate to report a child. There were several factors that influenced the personal threshold of suspicion: evidence gathered from the patient's injury; history and situation; and attitudes.

Studies indicated that level of suspicion was determined by the amount of evidence for the presence of abuse (Blaskett & Taylor, 2003; Flaherty et al., 2000; Flaherty et al., 2002; Flaherty et al., 2008; Fraser et al., 2010; Herendeen et al., 2014; Jones et al., 2008; Laskey et al., 2012; Marshall & Locke, 1997; Schweitzer et al., 2006; Shor, 1998; Talsma et al., 2015; Van Haeringen et al., 1998; Zellman, 1992). This means that some clinicians require more evidence than others before deciding to report. In many studies, the primary reason for failing

to report was having a lack of evidence to support a claim of abuse and therefore being uncertain that abuse occurred (Badger, 1989; Blaskett & Taylor, 2003; Flaherty et al., 2004; Flaherty et al., 2000; Flaherty et al., 2006; Francis et al., 2012; Kraus & Jandl-Jager, 2011; Laskey et al., 2012; McTavish et al., 2017; Morris et al., 1985; Rolim et al., 2014; Romeo et al.; Saulsbury & Campbell, 1985; Talsma et al., 2015; Winefield & Castell-McGregor, 1986; G. Zellman, 1990). Three pieces of information that were key to determining the possibility of abuse were: a lack of explanation or an explanation inconsistent with the injury; a delay in seeking care for the child; and the child's developmental age (Flaherty et al., 2002; Flaherty et al., 2008; Jones et al., 2008; Schweitzer et al., 2006; Talsma et al., 2015; Van Haeringen et al., 1998; Zellman, 1992).

Suspicion was heightened if parents sought care days after the injury occurred and if the explanation of the injury was inconsistent with the developmental age of the child and the location and type of injury (Flaherty et al., 2002; Flaherty et al., 2008; Jones et al., 2008; Schweitzer et al., 2006; Talsma et al., 2015; Van Haeringen et al., 1998; Zellman, 1992).

Suspicion was also raised if the injury was a sign of severe physical or sexual abuse (Fraser et al., 2010; Lawrence et al., 2000; McTavish et al., 2017; Morris et al., 1985; Raman et al., 2012; Saulsbury & Campbell, 1985; Shor, 1998), which may be because these types of abuse are more easily evidenced and most jurisdictions mandate reporting of physical and sexual abuse. Clinicians found it harder to identify emotional abuse and neglect and therefore, symptoms reflecting these types of abuse were less likely to meet their personal threshold of suspicion and result in a report (Fraser et al., 2010; Lawrence et al., 2000; McTavish et al., 2017; Morris et al., 1985; Raman et al., 2012; Saulsbury & Campbell, 1985; Shor, 1998).

Three other factors may also influence the decision to report CM: the patient's history; the child's race and socioeconomic status; and clinician attitudes towards physical discipline. The patient's history was considered, with repeated injuries or previous involvement with child

protection raising suspicion (Flaherty et al., 2002; Flaherty et al., 2008; Jones et al., 2008; Laskey et al., 2012; Schweitzer et al., 2006; Zellman, 1992). Schweitzer et al. (2006) surveyed 91 Queensland medical practitioners found that belief that the incident was an isolated incident predicted non-reporting (Schweitzer et al., 2006). The child's situation in life, including their race and socioeconomic status, seemed to influence the decision to report CM to a lesser extent, with studies often presenting conflicting evidence about their influence (Flaherty et al., 2008; Zellman, 1992; Laskey et al., 2012). Clinicians who indicated a high tolerance for physical discipline were significantly less likely to report abuse (Morris et al., 1985). However, this factor was discussed in only one older study.

In summary, reaching a certain level of suspicion was found to be a predictor for reporting in several studies (Flaherty et al., 2002; Flaherty et al., 2006; Herendeen et al., 2014). It was clear, however, that different individuals had differing thresholds of suspicion that would activate their duty to report (Flaherty et al., 2006; Levi & Brown, 2005; Morris et al., 1985). This indicates that a personal threshold of suspicion must be met before mandatory reporting duty is activated. This level of suspicion was raised when there was solid evidence of abuse and when the patient's history and explanation did not match the injury.

### **Knowing the family**

Another crucial consideration in the decision to report CM was clinicians' relationship with the family (Badger, 1989; Blaskett & Taylor, 2003; Flaherty et al., 2004; Flaherty et al., 2006; Francis et al., 2012; Jones et al., 2008; Kraus & Jandl-Jager, 2011). When the threshold of suspicion was crossed, and reporting become an option, clinicians weighed their reporting duty against the consequences for the doctor-patient relationship. This was a particular issue for those working in rural settings. Francis et al. (2012) conducted qualitative interviews with 17 medical practitioners, nurses, police and teachers in rural Victoria (Francis et al., 2012). They found that these professionals felt that their visibility in the community was a negative

of practising in rural areas (Francis et al., 2012). It became difficult for professionals to gain distance to make a judgement about reporting (Francis et al., 2012). This is evidenced by a nurse who said (Francis et al., 2012, p. 63):

*[I] just saw the mum in the supermarket yesterday which is the...part of my role that I can't escape from.* (Nurse)

These professionals felt that it was hard to focus only on the child, given what they knew about the family's circumstances and how well they were known to the family (Francis et al., 2012). Likewise, Blaskett and Taylor (2003) conducted a mixed methods study where they interviewed 31 health professionals. Two of the GPs interviewed had experienced angry reactions from parents (Blaskett & Taylor, 2003). However, these GPs clearly stated that this would not dissuade them from reporting CM (Blaskett & Taylor, 2003). All GPs interviewed felt that recrimination from reporting 'was inevitable in small communities' (a GP) (Blaskett & Taylor, 2003, p. 173). One GP said (Blaskett & Taylor, 2003, p. 173):

*'You can't just separate yourself from the community because you are intimately connected to that community...but the fact is my professional obligations mean that I may have to get involved with what others might consider a private matter'* (a GP)

Other studies had similar findings. In their survey of 61 rural clinicians, Kraus and Jandl-Jager (2011) found that a personal relationship with patients interfered with the decision to report CM (Kraus & Jandl-Jager, 2011). Further, a small qualitative study found that primary care physicians feared the reaction of parents after referring a child to authorities (Leite et al., 2016, p. 5):

*'Fear of the reaction of the aggressor, we are still afraid, afraid of the aggressor, afraid that something will happen to us.'* (Nurse).

The most common negative consequence experienced by clinicians was the loss of the family as patients after reporting (Badger, 1989; Blaskett & Taylor, 2003; Flaherty et al., 2000; Flaherty et al., 2006; Gunn et al., 2005; Herendeen et al., 2014; Jones et al., 2008; Leite et al., 2016; Morris et al., 1985; Romeo et al.; Winefield & Castell-McGregor, 1986). Clinicians

were afraid to wrongly accuse a family, and this precipitated the need to build evidence (Badger, 1989; Blaskett & Taylor, 2003; Flaherty et al., 2000; Flaherty et al., 2006; Gunn et al., 2005; Herendeen et al., 2014; Jones et al., 2008; Leite et al., 2016; Morris et al., 1985; Romeo et al.; Winefield & Castell-McGregor, 1986). In Badger's (1989) survey of 120 clinicians, those in solo-practice were more concerned about the effect of reporting on the doctor-patient relationship. Other studies highlighted the dual advantages and disadvantages to having a good relationship with the family. The paediatricians in a focus group conducted by Flaherty et al. (2004) stated that relationships with families both facilitated and impeded their assessment of the cause of an injury. Some felt that knowing a family would make it more likely that they would accept their explanation of an injury while others argued that knowledge of issues within the family might contribute to suspicion (E. G. Flaherty et al., 2004).

In general, knowing the family was a factor that presented emotional complications for clinicians during the decision-making process, especially within rural communities.

Clinicians weigh the risk of damaging the doctor-patient relationship with the benefit of reporting suspected CM.

### **Having little faith in the system**

The fear of damaging the doctor-patient relationship was compounded by the fear of the consequences of involving statutory child protection for the child and the family. A survey of 85 clinicians found that when deciding to report abuse, they consider what effect child protection would have if the child *was* abused and what effect child protection would have if the child *was not* abused (Flaherty et al., 2000). A few studies cited that one of the top reasons for failing to report was the perception that there would be no benefit for the child and the family (Badger, 1989; Blaskett & Taylor, 2003; Demircin et al., 2017; Flaherty et al., 2000; Marshall & Locke, 1997; Schweitzer et al., 2006; Zellman, 1990). This was

corroborated by findings from two other studies. A cross-sectional survey of 616 Brazilian primary care nurses found that if a nurse believed that implementing a reporting system was disadvantageous to the family or themselves, the act of reporting CM would be more problematic (Rolim et al., 2014). Fraser et al.'s (2010) study of 930 Australian registered nurses also found that negative attitudes to reporting explained a lower likelihood of reporting. This shows that a child protection system perceived to be defective would discourage the building of trust between clinicians and the child protection system.

While most studies communicated a negative perception of their respective child protection systems, two studies reported that the majority of their participants thought child protection involvement resulted in benefits for the child and the family (Blaskett & Taylor, 2003; Flaherty et al., 2006). In their survey of 452 Australian health professionals, Blaskett and Taylor (2003) found that only a minority believed that child protection was ineffective and therefore concluded that past experiences with child protection was not a determinate of reporting behaviour (Blaskett & Taylor, 2003). Yet, when interviewing nurses in the same study, there was evidence that past experiences did have a great individual impact on the decision to report for some clinicians (Blaskett & Taylor, 2003, p. 146):

*'I rang child protection...he said... "it's only just a mild bit of neglect and we just don't have the resources to follow up on every case like this. Thank you for your call and we'll make a note of it." And that was it!!... It didn't inspire me to report... If I ever came across another case where I had a little bit of doubt... I would hesitate... even though it is mandatory... simply because I think they would say "Unless you've got something concrete to show, we just haven't got the resources to follow it up."'*  
(Nurse)

Most studies reported this perception that child protection was unhelpful because of a lack of resources and feedback after a report. This perception weakened the trust and faith clinicians had in the system to adequately respond to their suspicions of CM. This was reflected in other studies where past experience with child protection seemed to be a barrier to reporting CM

(Blaskett & Taylor, 2003; Flaherty et al., 2004; Flaherty et al., 2000; Flaherty et al., 2006; Flaherty et al., 2008; Gunn et al., 2005; Kraus & Jandl-Jager, 2011; McTavish et al., 2017).

A consequence of having little faith in the child protection system was clinicians feeling the need to work with families themselves to resolve issues. When clinicians felt that their suspicions would not be taken seriously enough, they either referred to other health services or monitored and managed patients on their own. This led to the attitude prevalent in some studies that the clinician working with the family outside of child protection intervention was a superior method of responding to CM. (Flaherty et al., 2006; Herendeen et al., 2014; Saulsbury & Campbell, 1985; Talsma et al., 2015).

### **Education and discussion**

Some studies noted the effect of education and training on reporting behaviour (Badger, 1989; Flaherty et al., 2000; Flaherty et al., 2002; Fraser et al., 2010; Jones et al., 2008; Lawrence et al., 2000; Romeo et al.; Talsma et al., 2015). The studies were overwhelmingly conclusive that education and training has a positive influence on reporting (Badger, 1989; Flaherty et al., 2000; Flaherty et al., 2002; Fraser et al., 2010; Jones et al., 2008; Lawrence et al., 2000; Romeo et al.; Talsma et al., 2015). Many studies reported that recent training seemed particularly effective (Badger, 1989; Flaherty et al., 2000; Flaherty et al., 2002; Fraser et al., 2010; Lawrence et al., 2000; Romeo et al.). When compared to those who did not report, one study found that those reporting were 10 times more likely to have received formal CM education in the last 5 years (Flaherty et al., 2000). Flaherty et al. (2000) found that education made a difference in reporting but was unable to conclude if education increased identification of CM or increased clinicians' comfort with reporting. Other studies support the latter. A survey of 930 nurses by Fraser et al. (2010) found that completing child protection training resulted in improved preparedness to report and those with training were significantly more likely to report their suspicions. Another study looking at the effect of

attending a workshop on attitudes to reporting found that after attending the workshop, participants felt better able to recognise abuse and neglect, were more aware of their ethical and mandated duty to report and were less concerned about the doctor-patient relationship (Badger, 1989). However, another study found that CM training focused on identifying physical and sexual abuse (Lawrence et al., 2000). Clinicians felt the need for more specific training (McTavish et al., 2017; Romeo et al.).

While not an explicit factor in the decision to report CM, gaining support from colleagues seemed to be an important step in the process of reporting. Clinicians would discuss their suspicions with a range of people including co-workers, CM experts, social workers, child protection workers, emergency department clinicians and paediatricians (Flaherty et al., 2004; Flaherty et al., 2000; Francis et al., 2012; Lagerberg, 2001; McTavish et al., 2017). There was an interesting trend for nurses to defer the responsibility for reporting instead of gaining support for support for a decision they actively made (Francis et al., 2012, p. 63):

*I reported my suspicions to the doctor that was looking after the child. (Nurse)*

According to Blaskett and Taylor (2003), nurses were also less engaged in collegial discussions about identifying and reporting CM (Blaskett & Taylor, 2003). Overall though, clinicians used colleagues to confirm their suspicions and gain support for their decision to report. Gaining support was part of developing a ‘well founded belief’ or reasonable suspicion that CM had occurred (Blaskett & Taylor, 2003).

### **Discussion and conclusion**

Four themes arose from this literature review: *personal threshold of suspicion; knowing the family; having little faith in the system; and education and discussion*. The level of suspicion a clinician had about a patient was influenced by: the evidence they could gather; and the

child's history and situation. Knowing the family was a factor that resulted in emotional complications when deciding to report CM. Lack of faith in the child protection system resulted from a perceived poor response and lack of feedback after a report. Education seemed to impress the importance of reporting CM on clinicians and made them more comfortable with the process of identifying and reporting. Clinicians also often relied on discussion with their colleagues to confirm their suspicions as part of 'building a case' that would initiate investigation from child protection.

The themes also intersect with one another as summarised in Figure 2. The personal threshold of suspicion is influenced by each of the other three themes. Knowing a family can give a clinician an insider perspective and they can use their knowledge of the family's context to inform their decision to report their suspicions of CM (Flaherty et al., 2004). In this sense, awareness of potential red flags could raise or lower suspicion accordingly. However, intimacy with a family may also blind a clinician to the possibility of CM as an explanation for symptoms, therefore raising the personal threshold of suspicion (Flaherty et al., 2004; Gunn et al., 2005).

The lack of faith in the child protection system also contributed to raising the personal threshold of suspicion. Authorities imposed the need for clinicians to have evidence to show the seriousness of a case, despite the law in some jurisdictions specifying that clinicians do not need to gather evidence (Blaskett & Taylor, 2003; Mathews & Kenny, 2008).

Experiences where clinicians felt as if their suspicions were being ignored raised the personal threshold of suspicion where, in future, more evidence would need to be gathered before the clinician decided it was appropriate to report (Blaskett & Taylor, 2003). In this instance, another pathway may become open to them, (Flaherty et al., 2000; Flaherty et al., 2006; Herendeen et al., 2014; Jones et al., 2008; McTavish et al., 2017; Saulsbury & Campbell, 1985; Talsma et al., 2015; Van Haeringen et al., 1998; Zellman, 1990). Clinicians may

choose or may feel compelled to monitor and manage the child and their family themselves. Clinicians felt this response was better than reporting for the following reasons: its potential to preserve the doctor-patient relationship; and the clinicians' intimate knowledge of the family which would help inform their management (Flaherty et al., 2000; Flaherty et al., 2006; Herendeen et al., 2014; Jones et al., 2008; McTavish et al., 2017; Saulsbury & Campbell, 1985; Talsma et al., 2015; Van Haeringen et al., 1998; Zellman, 1990). Patients seem to agree that clinician management preserves the doctor-patient relationship as meta-synthesis of qualitative studies reported that children and caregivers saw mandatory reporting as 'a betrayal of trust' and 'unfair' (McTavish et al., 2019).

The fluctuation in the personal threshold of suspicion, and the influence of knowing the family and the lack of faith in the system, may be partly offset by education and discussion. The studies included in this review shows that education has the power to lower the personal threshold of suspicion when it is inappropriately raised by increasing awareness of CM and its consequences (Badger, 1989; Flaherty et al., 2000; Flaherty et al., 2002; Fraser et al., 2010; Jones et al., 2008; Lawrence et al., 2000; Romeo et al.; Talsma et al., 2015). They also show that education can cause a re-evaluation of priorities so that the doctor-patient relationship becomes less of an emotional complication for clinicians (Blaskett & Taylor, 2003; Flaherty et al., 2008; Gunn et al., 2005; Hamby et al., 2010; Herendeen et al., 2014; Schweitzer et al., 2006; Zellman, 1990). Education about the child protection system may assist clinicians in understanding its capabilities, limits and dynamics so that they can manage their expectations of the system and the law. The effectiveness of education regarding the identification of, and response to, victim/survivors of abuse has been discussed in the literature. Stenson et al. found that training in domestic violence had a positive association with all aspects of care and knowledge (Stenson & Heimer, 2008). Likewise, McLindon et al.'s survey of 471 health professionals found that at least one day of domestic violence

training was associated with good clinical care including identifying and responding to domestic violence (McLindon, Humphreys, & Hegarty, 2019).

## **Figure 2: Theme Summary**

### **Strengths and limitations**

An interesting limitation of this review was the scarcity of discussion in the included studies about the influence of a child's race and socioeconomic status on the decision to report CM. Only three articles considered these factors and their findings conflicted with one another. There was also no discussion on how clinicians' cultural background may influence their decision to report. Additionally, there was great variety in the studies regarding study population and type/s of CM considered. This made it difficult to synthesise evidence for particular types of CM and populations. All included quantitative studies were cross-sectional studies. Limitations of cross-sectional studies include their inability to determine causal relationships or in-depth exploration of the reasoning behind an answer, which may uncover further nuances in the factors influencing the decision to report CM. All studies were based on self-reports and some relied on retrospective data (i.e. estimating how many CM cases were seen in a period) and this may introduce certain biases such as memory or self-report biases. For example, every professional may feel more confident about completing any task after training, even if training has had no real impact. Further limiting this review is the exclusion of non-English papers.

However, this review was conducted systematically with two independent reviewers. This increases the rigor of this review. To the authors' knowledge, no scoping review focusing on reporting of CM by GPs and PNs has yet been completed.

### **Recommendations**

The idea of each clinician having their own personal threshold of suspicion is new and therefore, there are no resources that appear to address this issue. Existing supports, such as

the guidelines from the World Health Organisation, only contain information that help guide the identification of and response to CM (World Health Organisation, 2017). They do not provide guidance about aligning the personal threshold of suspicion with that of the laws relevant to the jurisdiction within which the clinician is practicing. There is a clear need for a guideline that is aimed at establishing a clear threshold of suspicion that is consistent for every clinician.

Advice on how to navigate adverse emotional reactions of families when discussing suspicions of CM and the duty to report is also needed. Current guidelines focus on how to engage a child in a conversation about safety to identify CM (Geis, 2008; WHO, 2017). However, in a clinical setting, a clinician often must manage the family's reaction as well as the child's, especially in rural settings. Current guidelines also lack a child-centred focus on how to support a family instead of or beyond reporting CM. Clinicians currently undertake this emotionally taxing role with little or no support (Kuruppu et al., 2018). Including management options that are more child-focused in a guideline, in addition to those focussing on parents that are currently known, could help support clinicians in this endeavour.

Every study recommended continuing education in the areas of recognising and reporting abuse. It must be noted that, out of the 33 papers included in this review, this was the only enabler of reporting CM that was identified. The literature shows that education has a positive impact on identifying and managing patients experiencing CM (Badger, 1989; Flaherty et al., 2000; Flaherty et al., 2002; Fraser et al., 2010; Jones et al., 2008; Lawrence et al., 2000; Romeo et al.; Talsma et al., 2015). Education about the scope of the issue can help raise awareness of CM among clinicians and promote the importance of identifying and responding to CM (Flaherty et al., 2008; Hamby et al., 2010; Herendeen et al., 2014; Marshall & Locke, 1997; Mathews & Kenny, 2008; Winefield & Castell-McGregor, 1986; Zellman, 1992). More importantly, there needs to be more focus in education on: interpreting

and applying mandatory reporting law regarding CM; what to expect from child protection; and how to access experts or peers working in this area as resources to enable clinicians to test patients' cases with others to formulate a 'reasonable belief' (Blaskett & Taylor, 2003). Further research into the enablers of identifying and responding to CM should be conducted to pinpoint more opportunities for supporting clinicians. More research should also be done on the influence of the race, culture and socioeconomic status of both the child and the clinician on the decision to report CM, especially in the context of minority groups and Indigenous peoples. Additionally, more current research into the influence of clinicians' attitudes towards discipline on the decision to report CM needs to be conducted. This information would be especially relevant for multicultural societies where clinician attitudes resulting from cultural background may be misaligned with mandatory reporting law.

In conclusion, we included 33 articles in our scoping review and generated four main factors that influence clinician's decision to report CM when fulfilling their mandatory reporting duty: personal threshold of suspicion; knowing the family; having little faith in the system; and education and discussion. These four factors need to be addressed in future programs to enhance mandatory reporting of CM for clinicians. However, it is important to note that the law in most jurisdictions does not require evidence to be gathered by mandated reporters. It deliberately uses the term 'reasonable suspicion' to keep the threshold of suspicion low in order to capture the most amount of cases (Mathews, 2014). However, this is impeded by clinicians' varied understanding of reasonable suspicion and child protection's perceived lack of response, leading to a personal threshold of suspicion that is higher than that set by the law (Levi & Brown, 2005). This review has raised several challenges for primary care clinicians engaging in mandatory reporting of CM. For mandatory reporting to be effective, these challenges need to be addressed. (McTavish et al., 2017; Sullivan & Hagen, 2005; WHO, 2013).

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