‘It’s a necessary evil’

Experiences and perceptions of mandatory reporting of child abuse in Victorian general practice

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Background and objective
General practitioners (GPs) and practice nurses (PNs) are mandated to report child abuse; however, only 2–4% of reports are made by Victorian health professionals. This is concerning, given that the estimated prevalence of physical child abuse alone in Australia is 5–18%. The aim of this study was to explore GPs’ and PNs’ experiences and perceptions of mandatory reporting of child abuse in Victoria.

Methods
Semi-structured interviews with 17 Victorian GPs and PNs were undertaken and thematically analysed.

Results
Participants had limited understanding of mandatory reporting in Victoria, struggled with negotiating the risks of reporting child abuse and felt unsupported by their practice and Child Protection Services.

Conclusion
GPs and PNs must negotiate their legal obligation, with the emotional burden associated with the decision to report. Updated education on reporting processes and more support for GPs and PNs are recommended.

CHILD ABUSE is defined as any non-accidental behaviour by parents, caregivers, other adults or older adolescents that includes physical, sexual and emotional abuse and neglect.[1] According to the Australian Institute of Criminology, approximately 12% of all homicide victims between 2010 and 2012 were children under the age of 17 years.[2] Child abuse can lead to major long-term consequences, such as impaired cognitive functioning, learning difficulties, behavioural problems and mental health issues, which can extend into adulthood.[3,4] Adult survivors of child abuse are more likely than the general population to experience physical health complications and are more than twice as likely to have serious depression.[5] Adults exposed to frequent instances of abuse or household dysfunction during childhood are 12 times more likely to attempt suicide.[5]

Given the association between child abuse and health, general practitioners (GPs) and practice nurses (PNs) occupy a prime position within the community to identify and respond to child abuse.[6] Currently, Victorian doctors, nurses and midwives are mandated to report **suspicion** of **significant** harm resulting from child abuse. However, only 2–4% of reports are made by Victorian GPs and hospital specialists, with police and school personnel being the most common source of notification.[7,8] The low reporting rate is concerning, given GPs’ and PNs’ frequent contact with families, the morbidity and mortality associated with child abuse and its estimated prevalence of 5–18%.[9]

While the effects of child abuse have been extensively researched, only a few quantitative studies have explored factors influencing reporting decisions of GPs.[10–12] In Turkey, Demircin and colleagues found in a sample of 390 GPs and hospital specialists that some failed to report child abuse because of the emotional burden of reporting child abuse cases.[13] Winefield and Castell-McGregor found that 11% of 193 South Australian GPs reported fewer cases than they had suspected, partly because of confusion regarding legal terminology.[12] The main body of research on health professionals’ experiences of mandatory reporting has been conducted in the US by Flaherty and colleagues.[14–20] Their research recommends that training be updated for family physicians and improvements be made to support communication between family physicians and child protection agencies.[21–23] However, there is a lack of qualitative research providing in-depth exploration of Australian GPs’ and PNs’ experiences of mandatory reporting of child abuse. Such an exploration is needed to ensure appropriate training and supports are in place, particularly given the discrepancy between the prevalence of child abuse and current reporting rates. As such, this paper reports on findings from a project that explored GPs’ and PNs’ experiences of mandatory reporting of child abuse within the context of Victorian mandatory reporting laws.

Methods

Semi-structured interviews were used to enable a rich and complex understanding of GPs’ and PNs’ experiences.[24] Participants from rural and metropolitan Victorian practices were recruited by purposive and snowball sampling and by advertisements placed in learning and teaching e-bulletins. Participants were eligible if they were currently practising in Victoria. Interviews took place via telephone (n = 14) or face to face (n = 3) and covered topics such as participants’

experiences of reporting child abuse, barriers or facilitators encountered when reporting child abuse and participants' opinions on the current reporting system. All interviews were conducted by the first author and took an average of 42 minutes (range: 14–67 minutes). Interviews were audio-recorded with prior consent and transcribed verbatim. Interviews were thematically analysed using an inductive approach,[25] first by descriptive coding with the aid of NVivo11(QSR International), then categorising common codes into themes. To ensure rigor, the coding framework was reviewed and applied by the co-authors across two-thirds of the total number of transcripts. Ethics approval was obtained from the Human Ethics Advisory Group, Department of General Practice at the University of Melbourne (ID: 1748630.1).

Results

Twelve GPs (six female, six male) and five PNs (all female) participated, with an average age of 49 years and 18 years of practice in a metropolitan area (only one participant was rural). Table 1 shows the demographics of the participants. Of the 17 participants, 10 had never reported child abuse within Victoria.

Four themes were identified from the data:

- Lack of understanding of mandatory reporting law
- Weighing the risks of reporting child abuse
- The system is broken
- 'In general practice, no one teaches you'.

Overall, there appeared to be an emotional overlay to the work of reporting child abuse.

Lack of understanding of mandatory reporting law

GPs and PNs appeared uncertain about the content of Victorian mandatory reporting law. Many questions arose concerning who was mandated to report child abuse and who received and managed a report of child abuse.

> *So, would I be mandated to report if I was suspicious or is it just the doctors?* – PN1

> *I would like … to know … who is involved and what the process is after I've reported … what the consequences [of reporting] are … and what sort of clinician or person does what after I've reported.* – GP8

Many GPs and PNs differed in what they would report, with some declaring they would report any suspicion of any type of abuse, including exposure to domestic violence, while others felt they needed evidence of more significant harm before reporting. The law only requires suspicion of significant physical and sexual harm to be reported and it does not require health professionals to gather evidence. The inconsistencies between what GPs and PNs would report suggests that GPs and PNs do not consciously observe the thresholds of harm and certainty specified within Victorian reporting law, possibly because of unfamiliarity with these thresholds and the 'establishing a diagnosis' focus of clinical practice:

> *They [GPs] don't understand that all you need is a suspicion of the diagnosis … You don't have to establish that the child abuse is actually occurring. But we are trained in a way where we have to establish diagnoses … Whereas in the instance of child abuse, you don't actually establish that diagnosis. Somebody else can.* – GP2

The perceived lack of guidelines and information on the reporting process provides a barrier to reporting.

Weighing the risks of reporting child abuse

Participants' emotions, particularly guilt and fear, were strongly expressed when considering the impact on the doctor–patientrelationship of reporting child abuse to authorities. Guilt resulted from potentially causing parents to feel targeted and stereotyped as a 'bad parent'. Participants also feared making an incorrect diagnosis of child abuse or that the parents would find out that they had made a report. Some GPs and PNs were discouraged to report after a previously difficult or distressing experience with the reporting process, thus affecting future willingness to report.

> *It takes a lot to make that phone call … you feel bad in a way … just in case you're wrong … and if they find out that you're the ones that have reported them … because people don't realise that … you're doing it just to rule out anything or … to make sure everyone's coping. They just … think you're targeting them as a bad … parent. Which is not always the case.* – PN3

Table 1. Participant demographics

	GPs (n)	PNs (n)
Gender		
Male	6	0
Female	6	5
Age range (years)		
20–30	0	1
31–40	2	1
41–50	3	1
51–60	4	2
61–70	3	0
Years in practice*		
0–10	2	4
11–20	3	1
21–30	4	0
31–40	3	0
Location of practice		
Metropolitan	11	5
Rural	1	0
Size of practice†		
Small	5	1
Medium	4	2
Large	3	2
Trained		
In another state	0	0
In another country	7	0
Practiced		
In another state	3	0
In another country	7	0
Experience of reporting		
Reported in Victoria	6	1
Reported outside Victoria	2	0
Never reported	4	4

**Years participant had been a GP or PN in Australia*
†Small: three or fewer GPs, medium: four to six GPs, large: more than six GPs
GPs, general practitioners; PNs, practice nurses

I think the consultation finished with her [the parent] storming out … I was distressed and thought 'what a stupid bloody law'. – GP7

These two quotes reflect the difficulties involved in reporting child abuse. Fears about reporting conflicted with its potential benefits, making GPs and PNs question whether reporting child abuse was worth the risk of damaging the patient–doctor relationship.

The system is broken

Participants indicated that the current mandatory reporting system lacked communication and support for mandated reporters. There appeared to be a lack of internal structural supports for GPs and PNs to make reports of child abuse. Two PNs expressed confusion regarding the integration of mandatory reporting with practice policy, highlighting the paucity of mandatory reporting guidelines available to GPs and PNs within their practices.

I don't know how this mandatory reporting correlates with the organisational policies. – PN4

Most participants reservedly supported mandatory reporting of child abuse but questioned its effectiveness for reducing child abuse.

I think it is great. Mandated reporting should be there but then we have to have some facilities for this. – GP11

I think that it's a necessary evil that we have mandatory reporting. – GP2

I would regard it [mandatory reporting] as a very blunt instrument for dealing with a complex problem … I think the mandatory reporting thing is really a politician's response to demands that something be done, where it actually doesn't achieve anything useful.– GP7

GPs and PNs also felt that contact with Child Protection Services (CPS) was a 'daunting' experience. Many felt intimidated by CPS's methods of inquiry. This often led to frustration, exacerbated by a lack of feedback on the progress of a report, which prevented the mandated reporter from gaining closure.

They interrogate me as if I'm a problem! – GP11

For general practitioners, the real problem is making a report and then not finding out what happens. It can be soul-destroying … you never know what the outcome of that call was … and then you wonder 'why did I bother?' – GP2

These quotes reveal that GPs feel unsupported in their role as mandated reporters.

'In general practice, no one teaches you'

There was substantial reliance on conferring with colleagues to gain support for their decision to report child abuse.

However, participants acknowledged that healthcare professionals needed more education on the signs and symptoms of child abuse that required a report. Some felt that this education may be enhanced by CPS conducting information sessions.

It would be great to conduct an information session from the government body for all the healthcare professionals about the policies and the mandatory requirement and what happens … when the healthcare provider doesn't recognise or … they forget to report and something happens to the child – what are the consequences of that? And also what happens after the phone call – it's not just the child gets taken away … what [is] the process they have to confirm there was child abuse. So … starting from the policy and the consequences of not reporting and what exactly happens after reporting. I think if we're all clear on that … they'll be more people reporting. – PN4

Providing GPs and PNs with information on the consequences of failing to report and the methods of case investigation may alleviate fears and facilitate appropriate reporting.

Discussion

Overall, this study found that low reporting rates of child abuse, compared with its prevalence, may be due to GPs and PNs having to negotiate their mandatory reporting duty with the emotional burden or 'emotional labour' of the task. 'Emotional labour', coined by sociologist Arlie Hochschild, describes the emotional work required to undertake certain parts of an occupation, such as the decision to report child abuse.[26] The experience of mandatory reporting of child abuse entails the difficult responsibility of applying a bureaucratic reporting system to complex cases of child abuse. This responsibility was often undertaken without support and with competing priorities, such as parents' wishes, which caused significant emotional labour for mandated reporters.

While all participants knew that GPs were mandated reporters, they were unaware of PNs' obligation to report. This result echoed a quantitative study of 148 Victorian GPs and hospital staff conducted in 1998 by Holland, which reported 95% (n = 141) of doctors incorrectly stated who was mandated to report.[27] Our similar findings imply that the educational needs of Victorian health professionals regarding mandatory reporting have not been fulfilled over the past 20 years.

GPs and PNs were more afraid of the consequences of reporting than the legal ramifications of failing to report. Previous Victorian and international research has also found that doctors fear for themselves and their relationship with their patient in relation to reporting child abuse.[28,29] In our study, GPs' and PNs' distress was caused by the concern over parents' reactions to the subject of child abuse. In following their reporting duty, GPs and PNs navigated a complex situation where they had to manage their patients' emotions while also managing their own. Such emotional labour placed strain on the GP or PN and complicated the reporting process. This was reflected in one US study that described the discussion of mandatory reporting in a focus group of six paediatric primary care physicians as 'emotionally charged',[15] while a Turkish study found that physicians failed to report

partly because they wanted to avoid the emotional burden of child abuse.[13]

The distress surrounding the decision to report was amplified by the lack of support and feedback from CPS. Distressing encounters with CPS increased the emotional strain of reporting. The lack of feedback prevented GPs and PNs from gaining closure and seemed to negatively affect their confidence in acting on their suspicions, making them feel undervalued and ignored. This instilled in GPs and PNs a sense of distrust and a lack of faith in CPS to manage these complex cases and protect mandated reporters. GPs and PNs felt that the system did not recognise the emotional complexity surrounding the reporting of child abuse and, thus, it had not provided support for mandated reporters to manage the emotional difficulties in reporting child abuse. Likewise, Flaherty et al (2000) found that the lack of feedback and the perceived ineffectiveness of CPS intervention were the most common reasons for non-compliance with mandatory reporting law.[17]

This study had some limitations. The advertisements for this study would have attracted participants who had an interest in child abuse and mandatory reporting, which may introduce self-selecting bias. Additionally, the majority of participants were from a metropolitan setting, and therefore these findings may not resonate with a broader group. The PN sample consisted only of female nurses, and the small sample size may have limited and biased the potential number and type of themes that could be identified across this population. However, the sample size of 17 participants for this qualitative study is considered a strength. The sample contained a good range of experience in practice as a GP or PN, and the GP group was gender-balanced.

Implications for general practice

This research has shown that non-compliance with mandatory reporting law may be attributable to several barriers such as a lack of information and guidelines on the reporting process and a lack of system support. Individual practices can provide support for mandated reporters by clarifying the reporting process via establishing clear practice protocols for responding to child abuse that recognise the mandatory reporting duty of PNs and GPs. Protocols for staff and practice safety should also exist in the event of any threat after a staff member reports child abuse. This would be aided by having regular practice meetings to discuss these protocols and provide the opportunity for possible suspicions of child abuse to be explored within a supportive team environment. More may also be gained by including a local CPS representative in these meetings, to provide extra information and support to GPs and PNs. Supports such as these may diminish the fear of reporting and may alleviate some of the emotional labour inherent in the process of deciding to report child abuse.[15,17]

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References

1. Child Family Community Australia. What is child abuse and neglect? CFCA Resource Sheet. Canberra: Australian Institute of Family studies, 2015. Available at https://aifs.gov.au/cfca/publications/what-child-abuse-and-neglect [Accessed 6 October 2017].
2. Child Family Community Australia. Child deaths from abuse and neglect. CFCA resource sheet. Canberra: Australian Institute of Family Studies, 2017. Available at https://aifs.gov.au/cfca/publications/child-deaths-abuse-and-neglect [Accessed 28 March 2018].
3. Wolfe DA, Crooks CV, Lee V, McIntyre-Smith A, Jaffe PG. The effects of children's exposure to domestic violence: A meta-analysis and critique. Clin Child Fam Psychol Rev 2003;6(3):171–87.
4. De Maio J, Kaspiew R, Smart D, Dunstan J, Moore S. Survey of recently separated parents: A study of parents who separated prior to the implementation of the Family Law Amendment (Family Violence and Other Matters) Act 2011. Melbourne: Australian Institute of Family Studies, 2013; p. 123.
5. Child Family Community Australia. Effects of child abuse and neglect for adult survivors. CFCA resource sheet. Canberra: Australian Institute of Family Studies, 2014. Available at https://aifs.gov.au/cfca/publications/effects-child-abuse-and-neglect-adult-survivors [Accessed 6 July 2018].
6. Gilbert R, Kemp A, Thoburn J, et al. Recognising and responding to child maltreatment. Lancet 2009;373(9658):167–80. doi: 10.1016/S0140-6736(08)61707-9.
7. Australian Institute of Health and Welfare (AIHW). Child protection Australia 2002–03. Canberra: AIHW, 2004; p. 22.
8. Child Family Community Australia. The prevalence of child abuse and neglect. CFCA resource sheet. Canberra: Australian Institute of Family Studies, 2017. Available at https://aifs.gov.au/cfca/publications/prevalence-child-abuse-and-neglect [Accessed 6 July 2018].
9. Australian Institute of Health and Welfare (AIHW). Child protection Australia 2013–14. Canberra: AIHW, 2015; p. 70.
10. Schweitzer RD, Buckley L, Harnett P, Loxton NJ. Predictors of failure by medical practitioners to report suspected child abuse in Queensland, Australia. Aust Health Rev 2006;30(3):298–304.
11. Raman S, Holdgate A, Torrens R. Are our frontline clinicians equipped with the ability and confidence to address child abuse and neglect? Child Abuse Rev 2012;21(2):114–30.
12. Winefield HR, Castell-McGregor SN. Experiences and views of general practitioners concerning sexually-abused children. Med J Aust 1986;145(7):311–13.
13. Demirçin S, Tütüncüler A, Aslan F, Velipaşaoğlu Güney S, Atılgan M, Gülkesen H. The knowledge level and opinions of physicians about the medical and legal procedures related to physical child abuse. Balkan Med J 2017;34(2):140–46. doi: 10.4274/balkanmedj.2015.1195.
14. Flaherty EG. Does the wording of the mandate to report suspected child abuse serve as another barrier to child abuse reporting? Child Abuse Negl 2006;30(4):341–43.
15. Flaherty EG, Jones R, Sege R; Child Abuse Recognition Experience Study Research Group. Telling their stories: Primary care practitioners' experience evaluating and reporting injuries caused by child abuse. Child Abuse Negl 2004;28(9):939–45.
16. Flaherty EG, Schwartz K, Jones RD, Sege RD. Child abuse physicians: Coping with challenges. Eval Health Prof 2013;36(2):163–73. doi: 10.1177/0163278712459196.
17. Flaherty EG, Sege R, Binns HJ, Mattson CL, Christoffel KK. Health care providers' experience reporting child abuse in the primary care setting. Pediatric Practice Research Group. Arch Pediatr Adolesc Med 2000;154(5):489–93.
18. Flaherty EG, Sege RD, Griffith J, et al. From suspicion of physical child abuse to reporting: Primary care clinician decision-making. Pediatrics 2008;122(3):611–19. doi: 10.1542/peds.2007-2311.
19. Jones R, Flaherty EG, Binns HJ, et al. Clinicians' description of factors influencing their reporting of suspected child abuse: Report of the Child Abuse Reporting Experience Study Research Group. Pediatrics 2008;122(2):259–66. doi: 10.1542/peds.2007-2312.
20. Sege R, Flaherty E, Jones R, et al. To report or not to report: Examination of the initial primary care management of suspicious childhood injuries. Acad Pediatr 2011;11(6):460–66. doi: 10.1016/j.acap.2011.08.005.

21. Fraser J, Mathews, B, Walsh, K, Chen L, Dunne, M. Factors influencing child abuse and neglect recognition and reporting by nurses: A multivariate analysis. Int J Nurs Stud 2010;47(2):146–53. doi: 10.1016/j.ijnurstu.2009.05.015.
22. Lines LE, Hutton AE, Grant J. Integrative review: Nurses' roles and experiences in keeping children safe. J Adv Nurs 2017;73(2):302–22. doi: 10.1111/jan.13101.
23. Talsma M, Bengtsson Boström K, Östberg AL. Facing suspected child abuse--What keeps Swedish general practitioners from reporting to child protective services? Scand J of Prim Health Care 2015;33(1):21–6. doi: 10.3109/02813432.2015.1001941.
24. Morgan DL. Focus groups as qualitative research. 2nd edn. London: Thousand Oaks, Calif, 1997.
25. Grbich C. Qualitative data analysis: An introduction. 1st edn. London: SAGE, 2007.
26. Hochschild AR. The managed heart: Commercialization of human feeling. Berkeley: University of California Press, 2012.
27. Holland GVG. The influence of mandatory reporting legislation on doctors' reporting behaviour. MSS thesis. Canberra: Australian Catholic University, 1998.
28. Regnaut O, Jeu-Steenhouwer M, Manaouil C, Gignon M. Risk factors for child abuse: Levels of knowledge and difficulties in family medicine. A mixed method study. BMC Res Notes 2015;8:620. doi: 10.1186/s13104-015-1607-9
29. Lazenbatt A, Freeman R. Recognizing and reporting child physical abuse: A survey of primary healthcare professionals. J Adv Nurs 2006;56(3):227–36. doi: 10.1111/j.1365-2648.2006.04030.x

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