Doctors' confusion concerning their rights and obligations under Victoria's mandatory reporting legislation is likely to limit the success of this law in improving the situation for abused children. The results of this survey by ***Grant Holland*** *indicate that the introduction of such legislation requires careful planning and should be accompanied by appropriate training for practitioners.*

Mandatory reporting of abuse

The influence of legislation on doctors' reporting behaviour

THE introduction of mandatory reporting legislation in Victoria, in November 1993, was heralded as a major initiative for child protection services in that State. It followed a child abuse death which attracted widespread media and public attention and pushed the issue of child abuse again into its cyclic spotlight.

The State's response to this case was to make it compulsory for a number of nominated professional groups to report cases of suspected or actual child sexual and/or physical abuse to child protection authorities. The State argued that by imposing a legal obligation to report, the historical failure of some professional groups to report abuse would be rectified, and that many cases of hidden abuse would be uncovered.

In particular, the Government cited doctors in Victoria as being one professional group whose notification rates were well below those of doctors in other Australian States. One of the major goals of the legislation was to lift such low reporting rates by doctors, as well as a number of other professional groups.

The study reported in this paper explored the legislative and philosophical history regarding the child abuse issue and its eventual relationship with the medical profession. The research found that the medical profession had a long-standing concern for abused children. Indeed, doctors have played a crucial role in bringing the issue of child abuse not only to their colleagues' attention but also to the attention of the general public.

Questionnaires were used in the study to gather quantitative and qualitative information regarding doctors' knowledge of, and attitudes to, mandatory reporting legislation, and the impact of these factors on their reporting behaviour. The results support the small amount of overseas and Australian research which reveals that numerous factors may influence a significant number of doctors not to report suspected or actual cases of child sexual and/or physical abuse, regardless of the legislation that has mandated them to do so. One in five doctors in this study stated that they would not report all cases of suspected or actual sexual and/or physical abuse.

A range of reasons contributed to this non-compliance with reporting laws. In particular, emphasis was given by doctors to the lack of certainty they felt regarding the abuse actually occurring. Mandatory reporting laws, however, require only reasonable suspicion of abuse. No evidence or proof of abuse is required before reporting.

As well as their uncertainty as to proof of abuse, doctors also cited confusion surrounding abuse and reporting definitions as contributing to their reasons for not reporting all cases of child sexual and/or physical abuse. In conjunction with personal and

situational factors influencing reporting, this study also revealed that a high percentage of doctors have inadequate and inaccurate knowledge regarding mandatory reporting legislation.

The results revealed that some policy and legislative interventions that attempt to deal with child abuse, such as mandatory reporting, may fall short of their goals if they are not carefully planned, strategically implemented and supported with appropriate training and education. The implications for abused children are tragically clear.

Methodology

As indicated by various researchers (most recently Gluskie 1993, p.32; Booth 1993, p.34; Schepis & Edney 1994, p.739; Warner & Hansen 1994, p.20; Mazza, Dennerstein & Ryan 1996, p.14) there is a range of personal, situational and systemic factors that may impede a professional's legal obligation to report child abuse. These impediments have the potential to seriously undermine the achievement of the goals of legislative intervention such as mandatory reporting.

There was a range of reasons why this research on mandatory reporting focused on medical practitioners. A literature review indicated that doctors' association with child abuse research has a historical link with the publishing of detection and management guidelines as far back as the 1960s (Cooper & Ball 1987, p.20). Furthermore, doctors were one of the first groups of professionals to be mandated to report the suspected abuse of children in the United States and, finally, Australia.

Medical practitioners also occupy a unique position in terms of the opportunity they have to become involved in matters related to child health prevention and the detection of injury, disease, illness and abuse. In particular, with appropriate training, doctors can raise questions and observe the early signs (physical and other) that indicate the possible abuse of children (Untalan & Mills 1992, p.45; Kempe & Helfer 1968; South Australian Health Commission 1987, p.3; Finkelhor 1986, p.234).

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According to the Victorian government department responsible for child protection, doctors have a crucial role in detecting and reporting child abuse, given that:

- Doctors are in contact with children continually. Infants are likely to be taken to the family doctor five times in their first year, four times a year when aged three, three times a year when aged six, diminishing to twice a year when aged ten, then marginally more often than twice a year over the teenage years.
- Children are taught to trust doctors who may be some of the first people a child discloses abuse to.
- Doctors have particular training which assists them in identifying physical and behavioural signs of abuse and neglect.
- It is likely that doctors will come into contact with child abuse in the course of their careers (H&CS 1993, p.24).
- Medical practitioners are presented with a wide array of family and health problems and are likely to deal with children who are sexually abused (Community Services Victoria 1991, p.7).

During the period of the study – August to October 1995 – newspapers and other media were monitored for any events that might impact on or influence the information given by doctors to the questionnaire (e.g. a child death caused by abuse, or child protection complaints). There were no such reports in the media at that time.

Of the 200 doctors approached, 148 responded to the questionnaires. This indicated a response rate of 74% which, according to Winefield and Castell-McGregor (1987, p.27), is a relatively high response rate for this type of research within this professional group.

Demographics

In a telephone conversation in 1995, an executive member of the Australian Medical Association (AMA), Victorian branch, "estimated" that 75% of its registered members were male and 25% female. At the time, the association had no method of data retrieval to accurately assess this. However, in a telephone conversation in 1996, an AMA representative did note that the graduates coming out of medical schools comprise a 50:50 gender mix and expected that the 75:25 membership ratio would even out over time.

The results of a question in the current study indicated that the gender

mix of respondents was slightly down for male doctors as per the AMA estimate (64% as opposed to an estimated 75%), and slightly up for female doctors (35% as opposed to 25% AMA estimate). This minor discrepancy may be due to a number of factors including:

- an inaccurate estimate by the AMA of the gender mix;
- the "evening out over time" of the gender mix is further advanced than the AMA believes;
- an inaccurate survey sample;
- a greater response to the questionnaire method or topic by female doctors;
- a less favourable response to the questionnaire method or topic by male doctors; and
- a combination of the above factors.

Nevertheless, it appears that the sample was a reasonably representative cross-section of the gender of medical practitioners.

Just under 50% of doctors were in the 35–49 age bracket, indicating that their formal child abuse knowledge and training may stem from university courses undertaken in the 1970s and 1980s. Over one-third of respondents were in the 20–34 age bracket, indicating that they were likely to have had relatively recent exposure to modern (1980s, 1990s) child abuse education in their formal training. The group most likely to have outdated formal child abuse training were the 50+ age group. This group comprised 17% of the sample.

Naturally, the hypotheses and generalisations regarding training, education and age of doctors do not take into account those doctors who undertake regular postgraduate training in child abuse issues, or mature age medical students.

The results from questions regarding years in practice as a medical practitioner also concur with the above training time-frames. The average number of years in practice for doctors in this survey was 14.7 years, again indicating a time-frame of training stemming from the 1980s onwards.

There appeared to be a broad age range of doctors surveyed, with no over-weighted age category of respondents that could skew the results of the questionnaire – for example, a large percentage of doctors aged over 50 who may have outdated child abuse knowledge.

All major metropolitan public hospitals with child accident and emergency facilities were contacted, including the Royal Childrens Hospital. A wide spread of community health centres and general practice clinics covering metropolitan Melbourne were also surveyed.

Discussion summary

The demographic characteristics of the survey population indicated that a reasonably representative sample of doctors working in metropolitan Melbourne provided an extensive amount of information for this research.

Despite other research indications, and some of the doctors' own comments about lacking the time to complete the questionnaires, the response rate of 74% was unusually high. This response, along with the voluminous information given by doctors in their questionnaires, and their historical involvement in defining the child abuse issue, indicated doctors' genuine concern in the area of child abuse.

Consequently, doctors' under-reporting of child abuse does not seem to be related to any lack of concern about child abuse as an issue per se. However, training and education for doctors in dealing with child abuse and reporting procedures did appear to play a key role in their capacity, or rather lack of capacity, to fulfil the aims and objectives of the mandatory reporting legislation.

The fact that 23% of doctors stated that they had no training in the detection and management of child abuse, and 50.7% had no training in mandatory reporting, appeared to impede their ability to report abuse. What training and education doctors did receive was largely via their university education. Little evidence was found of the alleged extensive mandatory reporting training of doctors, despite repeated public information stating that mandated notifiers were well trained and prepared for their duties.

The minimal training and education that doctors received regarding child abuse and mandatory reporting, may have contributed to the following findings:

- only 25.7% of doctors correctly identified the currently accepted definitions of child abuse, i.e. physical, sexual, emotional/psychological and neglect;
- Even when allowing for changes over time in terminology and child protection department name changes, 37.8% of doctors still gave inappropriate or incorrect answers as to which agency they should report cases of abuse, or they could not nominate any agency to report to;
- 83% of doctors incorrectly indicated which types of abuse they were mandated to report;
- 13% of doctors incorrectly indicated or did not know whether proof of abuse was required before making a notification to the authorities. It is not;
- 95.3% of doctors incorrectly indicated which professional groups were mandated to report abuse;
- 32.4% of doctors stated that they either would not, or did not know if they would, report all cases of suspected or actual child sexual and/or physical abuse that came to their professional attention. By law, they must do so. A key rationale behind the mandatory reporting legislation was the removal of "choice" in the reporting dilemma;
- 29.7% of doctors either did not

know or believed that their Code of Medical Ethics overrides their reporting obligations under mandatory reporting law. It does not;

- 26.3% of doctors feared being sued if a notification they made proved to be unsubstantiated. This was despite legal protection enshrined in mandatory reporting legislation to prevent this from ever occurring; and
- 23.7% of doctors stated that they either would not, or did not know whether they would, report a case of suspected sexual and/or physical abuse if the perpetrator was a client of theirs and willing to seek help, despite mandatory reporting laws making it compulsory for them to do so.

Other factors too, appeared to contribute to the above findings, particularly in the area of decision making in reporting abuse. Confusion and uncertainty regarding the abuse actually occurring, and confusion surrounding abuse definitions, accounted for 46% of the reasons why doctors in the questionnaire stated that they would not report all cases of sexual and/or physical abuse.

Other reasons doctors gave as to why they would not report all cases of abuse included:

- concern about the impact that reporting would have on the family;
- a preference in working with the family themselves by handling the matter internally or discussing the case with colleagues;
- doubts about the effectiveness of the system that they would be reporting to;
- a preference in working with a perpetrator rather than reporting;
- cultural differences in the standards and definitions of abuse;
- a belief that another professional would report; and
- concerns regarding confidentiality.

In addition, 29.7% of doctors felt that knowing a child patient or their family for a significant period of time would also influence their decision to report, and 48.6% stated that they were unwilling to become involved in legal/court proceedings regarding an abuse case that they had reported.

Doctors were evenly divided as to whether mandatory reporting legislation had been effective in compelling doctors to report abuse.

Although 79.7% of doctors felt that the cultural background or socioeconomic status of a client or their family would not influence their decision to report, much research has documented that it does.

Interestingly, although 66.2% of doctors did not believe that their colleagues would report all cases, only 19.6% actually stated that they would not report all suspected or actual cases of child sexual and/or physical abuse as required by mandatory reporting laws. Although this percentage is significant in terms of the legal requirement to report, it does not match doctors' expectations as to their colleagues' unwillingness to report. On the issue of whether doctors felt that they should or should not report all cases of suspected or actual cases of sexual and/or physical abuse to the authorities, 20.3% stated that they should not. It appears there is some correlation between doctors' views as to their own reporting behaviour and their view as to whether they should be mandated to report abuse.

Doctors were evenly divided as to whether mandatory reporting legislation had been effective in compelling doctors to report abuse – 35.8% said they did not know, 35.1% said it had, and 29.1% said it had not. In fact, figures show that despite a lift in reporting rates (as has occurred with all mandated and non-mandated professionals), doctors still remain a low-reporting professional group (Victorian Auditor-General's Office 1996, p.33). Interestingly, the highest rise in notifications since the introduction of mandatory reporting has come from non-mandated people such as friends, family and neighbours (Victorian Auditor-General's Office 1996, p.33).

The doctors in the current study were just as unsure as many welfare professionals, academics, researchers, the government and the community, as to whether mandatory reporting had been effective in reducing child abuse in the community. Nearly half the respondents (45.9%) stated that they did not know whether it had been effective. Over one-third of doctors (36.5%) felt that it had not.

Research has indicated that doctors' past experience in reporting abuse may influence their future reporting decisions (Warner & Hansen 1994, p.22). Fortunately, the levels of past reporting experience did not bias the information in the questionnaire as 57% of doctors did not have previous experience in reporting while 41.9% did have some previous experience.

Doctors who did have past experience in reporting, rated this past experience as being:

- negative (48.4%);
- both positive and negative (24.2%);
- positive (17.8%);
- neither positive nor negative (6.4%); or
- not sure (3.2%).

The fact that a relatively high percentage of doctors rated their past reporting experience as being negative

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It is gradually becoming accepted that no single theory can explain or remedy child abuse.

appears to have implications for child protection authorities.

When asked how this past reporting experience influenced their decision to report, significant comments by doctors included:

- it does not influence (32.3%);
- it made them hesitant to report, and delayed their decision (22.6%);
- they would still report, but lacked faith in the system they were reporting to (14.5%);
- it facilitated their reporting decision (9.7%); and
- they would not or may not now report (4.8%).

Doctors were also asked about their own recommendations to help address the issue of child abuse and mandatory reporting. Despite high numbers of doctors making major fundamental flaws in the knowledge sections of the questionnaire, 33.1% of respondents said that they needed no further training regarding the detection, management and reporting of abuse. This appears to be of concern, given that doctors may not be aware of their own lack of knowledge regarding child abuse and mandatory reporting.

Doctors who did state that they require further training regarding abuse and reporting overwhelmingly nominated seminars, workshops, conferences and lectures with medico/legal and child protection speakers as their preferred training options.

With regard to facilitating reporting, 93.2% of doctors stated that they would like feedback from child protection authorities regarding a child abuse notification that they had made. This factor would appear to be one of great significance for doctors and may have the potential to be an influential strategy in promoting a positive experience for doctors who report abuse. Appropriate feedback and information regarding the safety of a child may also encourage doctors to report other cases of abuse in the future.

Among a range of information given by doctors regarding the facilitation of reporting, the following suggestions were put forward:

- better understanding, training, awareness and experience in child abuse detection, management, reporting and legislative procedures;
- a better quality and resourced child protection service delivery system;
- support for mandated professionals by authorities;
- a changed and improved reporting system;
- a changed and improved legal system;
- the involvement of mandated reporters in case management/case assessment;
- more continuity of practice location; and
- anonymity(!)

This last point again demonstrates doctors' lack of knowledge regarding reporting laws – notifications cannot be divulged, unless with the written consent of the notifier.

In response to what they believed would help reduce child abuse in the community, doctors regarded education, training, support, awareness and prevention programs that targeted parents, families, the community and victim/child groups as important in helping to reduce child abuse. These strategies were cited by 62.8% of doctors.

Conclusions and recommendations

Legislative intervention has been a key tool used to try to prevent and lessen the effects of the abuse of children. Mandatory reporting is one of many laws used to reflect society's general social and moral values. To be regarded as effective, such laws should be:

- acceptable – i.e. regarded as appropriate by members of society;
- familiar and accessible – i.e. well known, easily accessed and publicised;
- clear and easily understood – i.e. written in such a way that the community can see what the law means and what application it has to them; and
- enforceable – i.e. able to be enforced through the courts, and enforcement must be seen to occur (Beazer 1995, p.16; Short 1991, p.3).

The results of the current study indicate that mandatory reporting legislation may not be fulfilling all the criteria for an effective law. The scope of this research, however, was not to rate the effectiveness of mandatory reporting legislation as a child abuse panacea. It was to gain some insight into doctors' attitudes to and knowledge of reporting laws, and the impact of these reporting laws on their reporting behaviour. Some writers

have argued that the impact would be clear-cut:

> *Mandatory notification should be seen as a positive development in the area of child sexual assault, rather than an odious obligation. It relieves the dilemma (which many helping professionals face) of whether or not to notify and ensures that protection of the children remains a top priority.* (Thompson 1988, p.15).

Our results indicate that mandatory reporting may not have "relieved the dilemma" faced by many doctors when considering reporting child abuse.

Literature surveys and research studies, including this one, seem to indicate that despite a legal mandate to report abuse, a significant number of doctors may still not be reporting many suspected or actual child abuse cases. Their decision and ability to report abuse is influenced by numerous factors other than the legal mandate to report. These include:

- a lack of training and education in child abuse;
- a lack of training and education regarding mandatory reporting;
- uncertainty regarding the need for the positive proof of abuse;
- confusion and uncertainty regarding abuse definitions, including cultural differences in definitions and standards of abuse;
- concern regarding the impact that reporting would have on the family;
- a preference for working with the family themselves;
- a preference for handling abuse cases internally within their own professional work domain or peer network;
- doubts about the effectiveness of the system that they would be reporting to;
- a preference for working with a perpetrator rather than reporting;
- a belief that another professional would report;
- concerns regarding confidentiality and privacy;
- a lack of knowledge about who they should report cases of abuse to;
- a belief that their Code of Medical Ethics overrides their reporting obligations;
- a fear of being sued or becoming involved in the legal system;
- previous negative experience in reporting, or previous poor responses from relevant authorities; and
- a fear of damaging the therapeutic relationship with a family/client, especially for patients who had been involved with the doctor for a significant period of time.

A number of recommendations to enhance the ability of mandatory reporting to achieve its goals stem from the analysis of these findings. If implemented, such recommendations may well address some of the factors that are preventing doctors from reporting.

Recommendations

- Child abuse and mandatory reporting education for doctors while at university and in their general ongoing professional training should be enhanced, updated and extended.
- Child protection authorities should review and improve the methods for disseminating information on child abuse and reporting procedures to doctors.
- Child protection authorities should recognise that feedback to doctors regarding abuse notifications that they have made is crucial in encouraging the ongoing support of doctors with regard to future reporting.
- Research should be carried out to explore the impact and influence of mandatory reporting legislation on Victorian country doctors.
- In line with many other researchers' recommendations (Mitchell 1996, p.90; Crime Prevention Committee 1995, p.xiv; Munir 1993, p.119; National Child Protection Council 1993, p.5; Sinclair & Ginn 1989, p.54), a national approach in dealing with child abuse laws, definitions, policy and interventions should be developed.
  Uniform laws, definitions and policy may provide some clarity for professionals faced with shifting and/or complex child abuse and reporting information between States.
- Further Victorian and Australian research on child abuse and mandatory reporting should be encouraged to extend knowledge in this area.

Summary

Throughout history, various governments, professional groups and disciplines, including doctors, have influenced the understanding of, and responses to, child abuse. Since the "re-discovery" of child abuse in the 1950s, a range of theoretical perspectives have attempted to explain the causes of, and promote solutions to, the problem of child abuse. It is gradually becoming accepted, however, that no single theory can explain or remedy child abuse. To effectively understand, prevent and treat abuse, strategies that are ecological in nature should take into account the complexity of abuse and consider:

- the behaviour, personality and developmental history of the parent/s and/or carer;
- the characteristics of the child; and
- the familial, community and societal contexts in which the child, parent/s and/or carer are embedded (Belsky, Lerner & Spanier 1984, p.179).

Leading Australian child welfare researcher Dorothy Scott, summarises these views:

> *The history of child welfare, both here and elsewhere, teaches us to beware of prophets, preaching new*

gospels and accusing those who have come before to be worshippers of false faiths. The history of child welfare has so often been the history of seeking simple solutions to complex problems. (Scott 1994, p.20).

Mandatory reporting should be one strategy in a range of multifaceted strategies that attempts to alleviate the tragedy of child abuse. Unfortunately, this research indicates that the mandating of doctors to report abuse has fallen short of its goals. With a child welfare history characterised by reactionary intervention without adequate planning and evaluation, should we be surprised?

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