Clinician Mandatory Reporting and Maintenance of the Therapeutic Alliance

By

Lea Tufford

A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy

Factor-Inwentash Faculty of Social Work
University of Toronto

© Copyright by Lea Tufford, 2012
Clinician Mandatory Reporting and Maintenance of the Therapeutic Alliance

Lea Tufford

Doctor of Philosophy, 2012
Factor-Inwentash Faculty of Social Work
University of Toronto

Abstract

The objectives of this study are two-fold: (a) to delineate the factors that guide Ontario social workers’ decision-making when rendering judgments on the mandatory reporting of child maltreatment and (b) to understand how social workers maintain the therapeutic alliance with children and families following the decision to report suspected child maltreatment. The study is informed by two distinct bodies of literature: the decision-making theoretical literature within the fields of medicine, psychology, social work, and marriage and family therapy and the therapeutic alliance theoretical literature.

Harnessing the advantages of online survey technology, the study surveyed registered members (n = 480) of the Ontario Association of Social Workers who provide direct service to children and families. Participants responded to prepared vignettes of suspected child maltreatment followed by Likert-scale questions (strongly agree to strongly disagree) and open-ended questions on strategies to maintain the alliance. Open-ended questions allowed respondents to offer further commentary regarding their opinions on mandatory reporting and on maintaining the therapeutic alliance. These comments added a rich source of information to the quantitative data.

Multiple logistic regression analyses showed that social workers’ ethical responsibility to the College of Social Workers and Social Service Workers, their legal responsibility to the provincial mandatory reporting laws of Ontario, and consultation with peers or eliciting direction from a supervisor comprised the main factors in their decision-making around reporting suspected child maltreatment to the Children’s Aid Society. Qualitative analyses showed that social workers employ a plethora of strategies to repair the alliance following a disclosure of child maltreatment including
reporting strategies, information strategies, affect regulation strategies, advocacy strategies, and resource strategies.

The major limitation of the research design was the use of vignette research, which in proscribed circumstances may not reflect what the social worker does in actual practice. Design features that compensate for this limitation include (1) use of a 5-point Likert-item response of strongly agree to strongly disagree to allow respondents a range of responses; and (2) use of open-ended questions to allow respondents the opportunity to express their opinions on the issues.
Acknowledgements

The completion of my PhD was not possible without my Creator God and the support of many people. I would first like to thank my dear husband Doug who provided continuous love, patience, and friendship during my years of study. Your confidence that I could complete my studies always propelled me forward. I would also like to thank my two wonderful sons, David and Matthew. When I witness you striving for growth and learning it is an inspiration in my own journey of learning. Your smiles, hugs, and laughter have sustained me during many life challenges. I love you more than you will ever know. My mother Marie Tufford and my late father Robert Tufford have been constant sources of support in my educational endeavours and have instilled in me a strong work ethic.

I am extremely thankful to my doctoral committee for their supervision and contributions. Professor Marion Bogo, my doctoral supervisor and committee members, Professor Cheryl Regehr, Professor Tahany Gadalla, and Professor Nick Coady all shared their unique expertise with me and I am grateful for their diligence, thoroughness, and mentorship. My external examiner Professor Carol Stalker and internal examiner Professor Rob MacFadden provided careful attention to the dissertation.

During my PhD studies I had the opportunity to work as a research assistant with Professor Faye Mishna and Professor Charmaine Williams. I am extremely grateful for these experiences and for their willingness to share their knowledge and guidance of the research and publishing processes.

I extend a warm thank you to the Society for Social Work Research Doctoral Fellows Award which provided me with funding to conduct this research. Finally, my doctoral work could not have been completed without the assistance of the Ontario Association of Social Workers and the contribution of the hundreds of social workers across Ontario who willingly gave up their time and energy to complete the web-based survey.
TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION

• Aim ................................................................................................................................1
• Child Maltreatment ........................................................................................................1
• Mandatory Reporting Legislation ..................................................................................4
• Relevance of the Problem for Social Work ...................................................................7
• Overview of Subsequent Chapters ...............................................................................9

CHAPTER TWO: DECISION-MAKING AND THERAPEUTIC ALLIANCE THEORETICAL LITERATURES

• Introduction ..................................................................................................................11
• Medical Decision-making ...........................................................................................12
  o Sources of Uncertainty in Medical Decision-making .............................................12
  o Evidence-Based Medicine .......................................................................................15
  o Cognition versus Emotion in Medical Decision-making .....................................16
  o Biased Decision-making ......................................................................................16
  o Vigilant versus Hypervigilant Decision-making ...............................................18
  o Statistical Decision-making ..................................................................................19
  o Summary ..............................................................................................................20
• Decision-making in Psychology ..................................................................................21
  o The Role of Emotions in Decision-making .........................................................21
  o Mindful Decision-making ......................................................................................22
  o Intuitive versus Critical-Evaluative Decision-making .......................................23
  o Summary ..............................................................................................................27
• Social Work Decision-making ....................................................................................27
• Biased Decision-making..................................................................................27

• Evidence-Based Practice Decision-making...................................................29

• Actuarial Models of Clinical Decision-making..............................................31

• Summary........................................................................................................31

• Marriage and Family Therapy Decision-making...........................................32

• Decision-making Based on an Ethic of Care.................................................32

• Decision Bases...............................................................................................33

• Internal versus Conversational Decision-making.........................................33

• Triangulated Decision-making.......................................................................35

• Summary........................................................................................................35

• Decision-making and Child Maltreatment.....................................................36

Therapeutic Alliance Theoretical Literature......................................................38

• Historical Overview of Alliance Formation................................................39

• Perspectives of the Alliance...........................................................................39

  o Psychodynamic Perspective.........................................................................40

  o Humanistic Perspective..............................................................................40

  o Cognitive Behavioural Perspective............................................................41

  o Postmodern Perspective............................................................................42

• Therapeutic Alliance Ruptures ......................................................................43

• Therapeutic Alliance and Child Maltreatment..............................................46

• Decision-making and Therapeutic Alliance Theoretical Literatures:
  Implications for Understanding the Mandatory Reporting of Child Maltreatment....46

• Summary........................................................................................................47
CHAPTER THREE: CHILD MALTREATMENT EMPIRICAL LITERATURE AND CONCEPTUAL FRAMEWORK

• Introduction ........................................................................................................................................49

• Decision-making Theory and Mandatory Reporting of Child Maltreatment .............................49

• Factors Influencing Clinicians’ Reporting Decisions: Contributions of Empirical Studies .........................................................51

• Alliance Theory and Mandatory Reporting of Child Maltreatment .......................................53

• Confidentiality within the Counselling Relationship .................................................................54

• Alliance Research in Cases of Suspected Child Maltreatment .............................................57

• Summary ..........................................................................................................................................59

• A Conceptual Model of Clinician Mandatory Reporting: Contributions of Empirical Studies .........................................................................................................................60

• Model Limitations .........................................................................................................................67

• Expanded Conceptual Framework ...............................................................................................68

• Summary ..........................................................................................................................................78

CHAPTER FOUR: METHODOLOGY

• Introduction ........................................................................................................................................79

• Research Design and Questions .................................................................................................79

• Sampling Procedures ..................................................................................................................80

• Survey Design ................................................................................................................................82

• Stage One: The Initial Design .......................................................................................................84

• Stage Two: Content Testing ........................................................................................................86

• Stage Three: The Final Survey .....................................................................................................86

• Qualitative Questions ...................................................................................................................94
• Demographic Questions...............................................................................................95
• Compensation ..............................................................................................................95
• Data Collection ............................................................................................................96
• Summary......................................................................................................................97

CHAPTER FIVE: QUANTITATIVE DATA: ANALYSIS AND FINDINGS
• Introduction..................................................................................................................98
• Overall Numerical Results...........................................................................................98
• Preparing the Data for Analysis...................................................................................98
• Demographic Analysis Results....................................................................................99
• Scale Reliability Results ............................................................................................103
• Descriptive Statistics of the Likelihood of Reporting Suspected Child Maltreatment by Vignette and Group ..................................................................................104
• Descriptive Statistics of Respondents’ Top Three Decision-making Factors to Report Suspected Child Maltreatment ...............................................................................107
• Chi-Square and Correlation Analyses Results...........................................................110
• Multiple Logistic Regression Analyses Results (Decision-making) .........................112
• Interaction Effects......................................................................................................121
• Interaction Effects Results.........................................................................................123
• Therapeutic Alliance Descriptive Statistics Results .....................................................123
• Multiple Logistic Regression Analysis Results (Therapeutic Alliance) .......................127
• Summary....................................................................................................................151

CHAPTER SIX: QUALITATIVE DATA: ANALYSIS AND FINDINGS
• Introduction..................................................................................................................152
• Use of Qualitative Questions within Survey Methodology........................................152
• Data Collection and Analysis ................................................................. 153
• Assessing for Rigour and Trustworthiness of the Data ..................... 154
• Assessing for Validity of the Data ...................................................... 155
• Qualitative Data Interpretation ........................................................... 156
• Summary ............................................................................................ 174

CHAPTER SEVEN: INTERPRETATIONS AND IMPLICATIONS OF THE FINDINGS

• Introduction ......................................................................................... 175
• Research Questions and Discussion .................................................. 175
• Revised Conceptual Framework ......................................................... 190
• Implications for Social Work Practice ............................................... 192
• Limitations ......................................................................................... 195
• Implications for Future Research ...................................................... 196
• Concluding Thoughts ......................................................................... 198

REFERENCES ..................................................................................... 201
LIST OF TABLES

Table 1: OASW Membership Status and Number.................................................................81
Table 2: Variable Manipulation.............................................................................................87
Table 3: Descriptive Statistics of Respondent Characteristics ...........................................100
Table 4: Content Analysis of the Training in Child Maltreatment – Other Category........102
Table 5: Scale Reliability Results (Pearson correlations) for the Predictors: Regulatory Body Requirements and Consultation / Supervision.................................................................104
Table 6: Descriptive Statistics of the Likelihood of Reporting Suspected Child Maltreatment by Vignette and Group.........................................................105
Table 7: Descriptive Statistics (Numbers and Percentages) of Regulatory Body Requirements by Vignette and Group.....................................................106
Table 8: Descriptive Statistics (Numbers and Percentages) of Consultation / Supervision by Vignette and Group.................................................................106
Table 9: Descriptive Statistics of Respondents’ Top Three Decision-Making Factors to Report Suspected Child Maltreatment.........................................................108
Table 10: Content Analysis of Respondents’ Top Three Decision-Making Factors – Other Category.................................................................109
Table 11: Chi-square and Correlation Analyses Results of Factors that Predict a Social Worker’s Tendency to Report Suspected Child Maltreatment.................................................111
Table 12: Descriptive Statistics for Variable - Current Area of Practice.........................................................112
Table 13: Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker’s Tendency to Report or Not Report Suspected Child Maltreatment (Vignette 1) (Group 1) ...............113

Table 14: Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker’s Tendency to Report or Not Report Suspected Child Maltreatment (Vignette 1) (Group 2) ...............114

Table 15: Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker’s Tendency to Report or Not Report Suspected Child Maltreatment (Vignette 2) (Group 1) ...............116

Table 16: Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker’s Tendency to Report or Not Report Suspected Child Maltreatment (Vignette 2) (Group 2) ...............116

Table 17: Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker’s Tendency to Report or Not Report Suspected Child Maltreatment (Vignette 3) (Group 1) ...............118

Table 18: Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker’s Tendency to Report or Not Report Suspected Child Maltreatment (Vignette 3) (Group 2) ...........................118

Table 19: Summary of Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker’s Tendency to Report or Not Report Suspected Child Maltreatment ..............................................120

Table 20: Descriptive Statistics to Explore Respondents’ Steps and Actions to Maintain the Therapeutic Alliance after Reporting Suspected Child Maltreatment .................................................................124

Table 21: Content Analysis of Steps to Maintain the Therapeutic Alliance –
Other Category ........................................................................................................ 126

Table 22: Content Analysis of Actions to Maintain the Therapeutic Alliance – Other Category ........................................................................................................ 126

Table 23: Multiple Logistic Regression Analysis of Steps to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Offer Additional Sessions ........................................... 128

Table 24: Multiple Logistic Regression Analysis of Steps to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Speak to Clients via Telephone ...................................... 130

Table 25: Multiple Logistic Regression Analysis of Steps to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Meet Clients in their Home .................................................. 132

Table 26: Summary of Multiple Logistic Regression Analyses of the Steps to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment ................................................................. 135

Table 27: Multiple Logistic Regression Analysis of Actions to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Validate Clients Emotions ........................................ 137

Table 28: Multiple Logistic Regression Analysis of Actions to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Explain Your Reasons for Reporting Numerous Times ............................................................................................................................. 139

Table 29: Multiple Logistic Regression Analysis of Actions to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Help Clients Prepare for the CAS Visit .................. 141
Table 30: Multiple Logistic Regression Analysis of Actions to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Explain the Reasons behind Mandatory Reporting .................................................................................................144

Table 31: Multiple Logistic Regression Analysis of Actions to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Apologize for the Impact of Reporting .............146

Table 32: Summary of Multiple Logistic Regression Analyses of the Actions to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment ..................................................149

Table 33: Themes and Categories of the Impact of Reporting Suspected Child Maltreatment ..................................................................................................................156

Table 34: Themes and Categories of the Strategies to Maintain the Therapeutic Alliance ..........................................................................................................................162

Table 35: Positive and Negative Factors which Impact Respondents’ Decision-making .................................................................................................................................170
LIST OF FIGURES

Figure 1: Model of Clinicians’ Willingness to Report Child Abuse
(Brosig & Kalichman, 1992) .................................................................62

Figure 2: Expanded Conceptual Framework (Decision-making) .................69

Figure 3: Revised Conceptual Framework for Clinician Decision-Making
And Maintenance of the Therapeutic Alliance ....................................191
LIST OF APPENDICES

Appendix 1: Summary of Canadian and American Mandatory Reporting Laws Pertaining to Child Maltreatment ........................................233

Appendix 2: Survey ..................................................................................................................261

Appendix 3: Pilot Testing Feedback Form ........................................................................278

Appendix 4: Information Letter ..........................................................................................280

Appendix 5: Email Invitation ...............................................................................................283

Appendix 6: Email Reminder to Participate in Web-Survey ...............................................285
CHAPTER ONE: INTRODUCTION

Aim

The sheer number of maltreated children coupled with both immediate and future deleterious effects of maltreatment has led Canada and the United States to view this problem as a serious public health concern. The individual and societal effects of maltreatment have garnered a staggering annual financial investment for its treatment; however, to date, the existence of child maltreatment has not been eradicated. Social workers are often occupationally situated closest to the child or family in need and as such, hold both the power and obligation to determine if referral to the Children’s Aid Society is warranted. As child maltreatment constitutes a major public health concern and social work plays a significant role in its management, elucidating the factors that encompass social workers’ decision-making becomes imperative.

The aims of this study are to delineate the factors that guide Ontario social workers’ decision-making when rendering decisions on the mandatory reporting of child maltreatment and to understand how social workers maintain the therapeutic alliance with children and families following the decision to report suspected child maltreatment. Decision-making theory and alliance theory will inform each of these processes that will lead to a conceptual model to inform the practice of future social workers.

Child Maltreatment

Legislation differs across provinces, territories, and states in the definition of maltreatment. As an illustration, Health Canada (1997) stipulates that “child abuse occurs when a parent, guardian or caregiver mistreats or neglects a child, resulting in injury, or significant emotional or psychological harm, or serious risk of harm to the child.” Given the Ontario based context of this study, the Child and Family Services Act, R.S.O. (1990), Chapter C. 11 defines child maltreatment as “inflicting abuse on the child or failing to care for and provide for or supervise and protect the child adequately.”
While some forms of maltreatment involve definitive actions such as shaking, pushing, and hitting, as in physical maltreatment, or penetration, as in sexual maltreatment (Trocme et al., 2010), other forms such as emotional maltreatment and neglect tend towards vague definitions given the absence of visible injury while becoming apparent over time. These latter forms of maltreatment tend to be characterized by belittling, defamation or failing to provide for a child’s basic needs (i.e., food, clothing, health care) (Trocme et al., 2010). Exposure to domestic violence was added to the mandatory reporting legislation in some Canadian provinces and territories and involves a child either directly witnessing violence between caregivers or indirectly witnessing violence such as through seeing the physical injuries on the caregiver or overhearing the violence.

Child maltreatment exists throughout the world and crosses all socio-economic statuses, ethnicities, and parental genders. Child maltreatment may occur both between adults and children as well as between children. The discipline of children occurs along a continuum of practices deemed acceptable, questionable, or clearly inappropriate while the line between legally, socially sanctioned discipline and illegal maltreatment is often ambiguous and ill-defined (Ashton, 1999).

According to the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2008), there was an estimated 235,842 child maltreatment investigations conducted in Canada in 2008 (Trocme et al., 2010). Within Ontario alone, The Ontario Incidence Study of Reported Child Abuse and Neglect (OIS-2003) estimated that 128,108 investigations of child maltreatment were conducted in Ontario (Fallon et al., 2005). In the United States, there were 3.7 million children who were the subject of abuse investigations (U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, 2008). These figures from the Canadian Incidence Study, the Ontario Incidence Study, and the U.S. Department of Health and Human Services point to the sheer number of children referred to child protection services across North America who are in danger of various forms of maltreatment. The societal cost of investigating potential child maltreatment cases is high. The Ontario provincial government alone will spend more than $1.4 billion dollars in the fiscal year 2010 - 2011 on

The physical, emotional and psychological effects of child maltreatment may be felt for decades and pose a cost to society in terms of healthcare expenditures and loss of occupational productivity (Felitti et al., 1998). Studies have shown that maltreated children are at heightened risk for behavioural problems, including increased aggressiveness and later psychopathology (Cicchetti & Olsen, 1990; U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2008). Specifically, physical abuse may result in scars and disfigurement, which may impact children’s self-concept as well as their ability to engage socially with peers along with other health consequences such as allergies, arthritis, asthma, bronchitis, high blood pressure, and ulcers (Springer, Sheridan, Kuo, & Carnes, 2007). Emotional abuse and neglect may hinder children’s ability to form an attachment to parental figures which, in turn, contributes to poor well-being (Bala, 2004).

Studies have found that children who are exposed to domestic violence may experience internalizing behaviour problems (depression, anxiety, social withdrawal), externalizing behavioural problems (hyperactivity, aggression), and physical symptoms such as headaches and stomach aches (Edleson, 1999; U.S. Department of Health and Human Services, Administration for Children & Families, 2009; Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). Sexual maltreatment may interfere with children’s emotional and physical development and often sexually victimized children are subject to feelings of guilt and shame from the experience (Lau, Krase, & Morse, 2009). At the extreme end of the child maltreatment spectrum lies the harsh reality of child mortality (King, Kiesel, & Simon, 2006; WHO, 2006). In 2006, 1,490 children died in the United States as a result of child maltreatment (U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2006), while in Canada, consistently over the past 30 years, an average of 35 children per year under the age of 13 are killed as a result of child maltreatment (Dauvergne & Li, 2006).
The deleterious effects of maltreatment during childhood may be felt in adolescence. Children who are dually exposed to domestic violence and physical maltreatment are found to be less attached to parents in adolescence (Sousa et al., 2011). A history of physical abuse and neglect is positively associated with depressive symptoms, whereas sexual abuse and neglect is related to delinquency (Tyler & Melander, 2010). The effects of child maltreatment may carry into adulthood as parents with a history of maltreatment now attempt to parent their own offspring. Women with a history of childhood sexual abuse coupled with an unsatisfactory intimate relationship are found to be more likely to engage in parent-child role reversal (Alexander, Teti, & Anderson, 2000). Another disturbing finding concerns maternal histories of physical and sexual abuse leading to substance abuse problems and then to offspring victimization (Appleyard, Berlin, Rosanbalm, & Dodge, 2011). Sexual abuse in particular may negatively impact one’s ability to form a healthy, intimate adult relationship (American Psychological Association, 2012; Feinauer, Callahan, & Hilton, 1996). Even partners to adult survivors of childhood sexual abuse may experience what has been coined a “trauma contagion” which is characterized by stress, and a loss of faith in a just world (Maltas & Shay, 1995).

Mandatory Reporting Legislation

The origins of child maltreatment reporting legislation in the United States started with the medical recognition in the 1940s and 1950s of the intentional infliction of trauma on infants (Hutchison, 1993) and the development of the term “battered child syndrome” (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). Between 1963 and 1967 mandatory reporting legislation for child maltreatment was introduced in all states (Hutchison, 1993). In Canada, child welfare legislation originated with the Latin concept of parens patriae, translated as “protector” or “father of the country,” whereby the court may substitute a benevolent parent on behalf of the state (Bala & Clarke, 1981). The parens patriae framework served to inform subsequent Canadian law including Ontario’s Act for the Prevention of Cruelty to and Better Protection of Children 1893 (enacted) and the Federal Juvenile Delinquents Act 1908 (enacted) (MacIntyre, 1993). In the 1960s, provinces began introducing
mandatory reporting legislation (Mathews & Kenny, 2008) and since 1980, every province and
territory has enacted some form of this legislation (Walters, 1995) (see Appendix 1 for a detailed list of
mandatory reporting laws in Canada and the United States).

Given the medical origins of mandatory reporting legislation within the United States, initially
legislation charged only emergency room personnel to report serious physical and non-accidental
injuries (Besharov, 1986); however, in the 1970s the laws were expanded to incorporate a broader
array of professions. Currently, in both Canada and the United States there are numerous professional
groups who are considered mandatory reporters such as medical personnel, mental health
professionals, educational personnel, members of the clergy, employees of the justice system, and
occupations specific to children / youth depending on the specific legislation (see Appendix 1 for a
more detailed list of current mandatory reporters).

Professionals in most jurisdictions are required to disclose a “reasonable suspicion” of
maltreatment without the need for firm evidence and without the necessity of investigating or
substantiating maltreatment. Professionals practicing in Canada and the United States have legal
immunity from civil suit and criminal prosecution provided the report is made “in good faith” (Brown
& Strozier, 2004); however, a failure to report may result in criminal liability (Gladding, Remley, &
Huber, 2001).

Mandatory reporting legislation reflects society’s interest in bringing an end to child
maltreatment and imposes a limitation on the constitutional rights of parents in order to protect the
welfare of children (Bala & Cruickshank, 1986) through the creation of provincial, territorial and state
intervention in situations where caretakers are unable or unwilling to provide a minimum standard of
care to their children (Wilson & Tomlinson, 1986). Professionals have fallen on either side of the
debate on the efficacy of mandatory reporting laws. Those critical of mandatory reporting laws note
the subjectivity of reporting thresholds (Finlayson & Koocher, 1991; Gilbert et al., 2009; Jones et al.,
2008; Levi & Brown, 2005; Vullimay & Sullivan, 2000), the lack of specificity within the laws as to
what constitutes a suspicion of child maltreatment (Besharov, 2005; Deisz, Doueck, George, & Levine, 1996; Finkelhor, 2005; Kavanaugh, 1988; Wiklund, 2006), the invasion of privacy for the family (Faller, 1985), the openness of the laws to interpretation (Gilbert et al., 2009), the low proportion of children investigated who have maltreatment substantiated (Gilbert et al., 2009; U.S. Department of Health and Human Services, 2008), the imbued power imbalance between clinician and client (Solnit, 1982), the belief that parents would cease to bring their children for medical attention and the resulting deterioration of children’s physical health (Martz, 1995), the overloading of child-protection services (Lonne, Parton, & Thomson, 2008), the inhibition of self-referrals by children and parents due to fear of what will happen (Melton, 2005), and the discrimination towards vulnerable populations who are over-reported (Ainsworth & Hansen, 2006). Ainsworth (2002) asserts that mandatory reporting legislation produces a plethora of unsubstantiated reports that, in turn, increases the workload of child protection workers, wastes resources, and reduces the quality of services to needy children and families. Other critics contend that jurisdictions with mandatory reporting legislation should revise their current systems in favour of a voluntary assistance program whereby families who are concerned about their parenting practices would seek assistance of their own volition (Melton, 2005). Critics of this proposal point to the lack of evidence to justify the formation of a voluntary system of assistance (Sedlak & Broadhurst, 1996) and favour instead the co-existence of voluntary assistance-seeking in conjunction with a system of mandatory reporting (Mathews & Bross, 2008).

Those professionals favouring mandatory reporting laws point to their necessity given that mandatory reporting reflects a social and governmental commitment towards respecting and protecting the rights of all family members (Harries & Clare, 2002; Haverkamp & Daniluk, 1993), is effective in revealing maltreatment (Drake, Jonson-Reid, & Sapokaite, 2006; Mathews & Bross, 2008), encourages early notification to protect children (Harries & Clare, 2002), leads to increased reporting to child-protection agencies (Harries & Clare, 2002), and communicates to the family the social worker’s unwillingness to collude in the ongoing maltreatment of children (Courtois, 1988). Proponents of
mandatory reporting assert that society has a responsibility to those who are unable to help themselves and to support victimized children (Glancy, Regehr, & Bryant, 1998). To abolish mandatory reporting would undermine the safety of children and increase their vulnerability to harm (Mathews & Bross, 2008).

The presence of mandatory reporting legislation and the ongoing, contentious debates over the benefits and weaknesses of the legislation place clinicians in an unenviable position of observing and interpreting the legislation when working with families. This leads to a process of decision-making whereby clinicians take into account not only the presence of the legislation but case-based and personal contextual factors in their decision to report or not report suspected child maltreatment (Brosig & Kalichman, 1992). It is the combination of mandatory reporting legislation and these additional case and contextual factors that will be explored through this study. Examining these pertinent factors that influence clinicians in their decision-making is paramount, as reporting inappropriate cases causes unnecessary and unwarranted intrusion into the lives of families while non-reporting appropriate cases endangers the welfare of children and increases the liability of the clinician (Regehr & Kanani, 2006).

Relevance of the Problem for Social Work

The existence of mandatory reporting legislation directly impacts the profession of social work. First, the treatment of children and families constitute a core social work specialization. Social workers, with their understanding of and expertise in developmental, systemic, and attachment perspectives, are ideally positioned to intervene with families in crisis or families with long-lasting challenges. Attention to the problems of children and their families is congruent with the traditional mission and values of social work (Barsky, 2010; Reamer, 1994a; Reamer 1994b), particularly Value 1: Respect for the Inherent Dignity and Worth of Persons (CASW, 2005). Social workers extend the rights of dignity and worth to include children in need of assistance.
Many of the settings where social work is practiced, such as hospitals, community mental health centres, and schools, are heavily populated with children and families and as such, social workers may be the first mental health professionals to be privy to potential cases of child maltreatment and to determine the need for reporting to the Children’s Aid Society (CAS). However, the complexity arises in the legal mandate placed on social workers to disclose a “reasonable suspicion” of maltreatment without the need for firm evidence and without investigating or substantiating maltreatment (Brosig & Kalichman, 1992). Indeed, social workers’ individual perspectives on what constitutes maltreatment become a crucial factor in their decision-making. A clinical situation that may be serious enough for one social worker to report to the CAS may not be serious enough for another social worker.

From a statistical viewpoint, the mandatory reporting of child maltreatment greatly impacts the field of social work. In 2002, professionals made slightly more than half of the 1.8 million reports to Child Protective Services in the United States (McDaniel, 2005). Social service workers, including social workers, made 10% of all reports received by Child Protective Services in 2005 (U. S. Department of Health and Human Services, 2007). In Canada, professionals made 75 percent of the 103,298 substantiated reports to Children’s Aid Societies (Trocme et al., 2010). In Ontario alone, there was a 180% increase in the cases referred by professionals from 15,903 substantiated cases in 1998 to 45,233 substantiated cases in 2003 (Fallon et al., 2005).

A closer examination of the rates of unsubstantiated cases in Canada reveals interesting findings regarding mandatory reporting. The rates for unsubstantiated cases are variable and range from 16% - 64% (16% exposure to domestic violence, 34% emotional maltreatment, 48% neglect, and

1 Given the Ontario based context of this study, the term “Children’s Aid Society” will be used to refer to child protection and investigation. This is the most commonly used term although some jurisdictions in Ontario use the term “Family and Child Services.” In other Canadian provinces and in the United States child protection may be described by other terms.
64% sexual maltreatment). These figures indicate that at least 50% or more of the cases of neglect and sexual maltreatment reported to the CAS are not being substantiated, thus underscoring the need to examine the factors social workers take into account when referring suspected child maltreatment cases.

Finally, mandatory reporting of child maltreatment has significant implications for the maintenance of the therapeutic alliance between social worker and client. The social work profession views the relationship between social worker and client as integral to professional practice while the relationship is considered a central feature of many postmodern treatment modalities (Anderson, 1987; Miehls, 2011; White & Epston, 1988). Historically, social work authors have characterized the relationship as the “soul” (Biestek, 1957), the “heart” (Perlman, 1957), and the “major determinant” (Hollis, 1970) of social work intervention. Mandatory reporting of child maltreatment tests the bonds of this hard won relationship to their fullest. Some social workers err on the side of maintaining the alliance by choosing to not report, while others report and attempt to moderate the consequent effects. Given that social workers are therapeutically oriented, as opposed to punitively oriented, many social workers view interfering with the therapeutic relationship to report child maltreatment as having more damaging than helpful consequences. Despite social worker commitment and attempts to work collaboratively with clients, the therapeutic relationship is essentially hierarchical and social workers are subject to reporting laws. This renders social workers caught between reporting a suspicion and potentially losing the client.

Overview of Subsequent Chapters

This thesis is divided into seven chapters. In this first chapter the historical origins of mandatory reporting legislation were outlined along with the proponents and critics of this legislation as well as the relevance of the legislation for social work practice. The forms of child maltreatment were explored along with the deleterious effects of maltreatment during childhood, adolescence, and into adulthood. Chapter two examines the theoretical literature related to decision-making within the
disciplines of medicine, psychology, social work and marriage and family therapy along with the implications for decision making in reporting child maltreatment. This chapter also examines the theoretical literature related to the therapeutic alliance and to alliance ruptures. The implications for the alliance in reporting child maltreatment are introduced. The chapter concludes with an overall commentary on these two bodies of literature within the context of reporting suspected child maltreatment. Chapter three first explores the empirical literatures of decision-making and therapeutic alliance as they relate to child maltreatment. What follows is a presentation of the conceptual framework of Brosig and Kalichman (1992), and an examination of the model’s strengths and limitations. Based on a critical analysis of the literature, an expanded conceptual framework is developed. This framework forms the basis for this thesis research.

Chapter four outlines the research design, research questions, and methodology of this study including the sampling procedures, survey design, data collection, and data analysis procedures. Chapter five reports the quantitative results, including descriptive statistics of respondents and multiple logistic regression analyses of the decision making factors and types of steps and actions to maintain the therapeutic alliance. Chapter six reports the qualitative findings of the impact of reporting suspected child maltreatment on their alliance with families, the strategies to maintain the therapeutic alliance and their experiences with specific Children’s Aid Societies and workers. Chapter seven offers a discussion of the results including their implication for future research and social work practice, as well as the limitations of the study. A conceptual framework based on the findings is presented and discussed.
CHAPTER TWO: DECISION-MAKING AND THERAPEUTIC ALLIANCE THEORETICAL LITERATURES

Introduction

This chapter will examine the decision-making theoretical literature within the fields of medicine, psychology, social work and marriage and family therapy and the respective contributions of each field. The chapter will also explore the therapeutic alliance theoretical literature with specific focus on the psychodynamic, humanistic, cognitive behavioural and postmodern models. These two bodies of literature are foundational to an examination of how social workers conceptualize reporting suspected child maltreatment to the CAS and how social workers maintain the therapeutic alliance with the client.

The components and processes of decision-making have been intensely debated in the medical, psychology, social work, and to a lesser extent, marriage and family therapy literatures. The terms “decision” and “judgment” are often used interchangeably in the literature and it is unclear which emanates from or evolves into the other. However, Yates, Veinott, and Patalano (2003) define a decision as a commitment to a course of action and a judgment as an assessment or belief about a given situation based on the available information. Quality of professional judgment can distinguish one skilled clinician from another and while it may be difficult to accurately define what constitutes good judgment, it becomes apparent when good judgment is lacking or inappropriate (Cushing, 1982).

As much of the theoretical literature on decision-making originated within medicine and this field has taken a leading role in attempting to explicate the decision-making strategies of physicians (Kassirer & Kopelman, 1991), this chapter begins with a discussion of decision-making in medicine. Each discipline offers distinct viewpoints on the processes and complexities related to decision-making, thus contributing to an examination of decision-making within suspected child maltreatment.
Medical Decision-making

Sources of Uncertainty in Medical Decision-making

This section will explore three features of medical decision-making: uncertainty; cognitive and emotional processes; and bias, as well as two patterns of decision-making: vigilant and hypervigilant decision-making and statistical approaches to decision-making. As uncertainty is an endemic feature across all branches of medicine, authors writing in the areas of cognition, emotion and biased decision-making explore how physicians cope with this important feature.

Uncertainty is a characteristic feature of medical decision-making and Montgomery (2006) theorizes that at the heart of the quest for certainty is a longing for control. However, the need for control is disguised as a need for knowledge since ultimate control does not exist in medical diagnosis. No treatment is ever entirely certain in its effect. Complexity and uncertainty are woven into the physician’s effort to understand the particulars of a patient’s condition or illness in light of general rules and then the focus shifts back to the individual patient for confirmation (Montgomery, 2006).

Thus, the exercise of clinical judgment lies at the intersection of a body of scientific knowledge along with a collection of well-practiced skills. This enables physicians to fit their knowledge and experience to the circumstances of each patient (Pellegrino & Thomasma, 1993).

Beresford (1991) identifies three sources of uncertainty in medical decision-making: technical, personal and conceptual. These sources of medical uncertainty were identified from 25 qualitative interviews conducted with physicians in a variety of health care settings in Quebec and Ontario and are thus not generalizable outside the sample. Despite this limitation, the findings are relevant to the current study as social workers experience personal and conceptual forms of uncertainty when rendering decisions regarding child maltreatment. Technical uncertainty concerns the lack of data to “predict the effects of certain factors in the progress of a disease or the outcomes of certain interventions” (Beresford, 1991, p. 7). The proliferation of medical information makes it impossible for a single practitioner to be certain they have all the facts necessary for any given case.
Paradoxically, each new piece of medical information becomes itself a source of more questions to be answered to truly understand the situation in question or render a decision on the preferred course of treatment. Advances in medical technology will not eliminate the need for clinical judgment but may exacerbate this need.

Personal uncertainty is rooted in the physician-patient relationship and is characterized by two areas: the first concerns the patient’s inability to make his or her wishes known to the doctor, either through a form of incompetence or where the patient is in a semi-conscious state (Beresford, 1991). When the prognosis is less than positive, the lack of knowledge of a patient’s values and wishes gives rise to difficult problems in treatment. In cases where the family is speaking on behalf of the patient, problems can arise when the physician is uncertain that the family is acting in the best interests of the patient or are requesting more or less treatment than the patient himself or herself would have in a conscious state. A second source of uncertainty relates to the sense of attachment which can grow between physician and patient through frequent or extended treatments and raises the question if emotionally detached or attached medical personnel can truly render accurate clinical judgment (Beresford, 1991).

Beresford’s third type of uncertainty, conceptual, arises from two sources: patients who require access to the same resources such as personnel or equipment and the application of universal parameters to specific situations. In the former situation, physicians may be uncertain as to which patient’s situation is more severe and thus should have access to potentially scarce resources. In the words of one radiologist “it’s very hard to prioritize two different pathologies that are both serious” (Beresford, 1991, p. 8). The challenging nature of this decision is made all the more poignant in light of Canada’s publically funded health care system that seeks equal access to services across patients. The latter scenario, the application of universal parameters to specific situations, may also lead to uncertainty given that illness rarely presents as a textbook case and physicians may be uncertain if a patient’s situation fits within pre-determined guidelines leading to a specific mode of treatment.
Compounding the confusion, physicians may conclude that the guidelines or parameters to be applied are inadequate or the patient exhibits symptoms not included in the guidelines but which are important to treatment.

Katz’s comments (1988 as cited in Elstein & Dowie) precede the research of Beresford (1991) but underscore the reality of uncertainty by noting that physicians may not acknowledge the high degree of uncertainty in medicine and specifically in medical treatments. The denial of uncertainty has both adaptive and maladaptive components. In terms of adaptive components the denial of uncertainty can make the selection of treatment options clearer and more certain, thus action becomes possible. However, denying uncertainty through action, often at the behest of patients, can be maladaptive in that it can lead to unnecessary surgeries and medication. Katz also notes the denial of uncertainty may be maladaptive in that it can render a physician captive to performing one treatment such as radical surgery for breast cancer when other treatments may be equally beneficial to patients. Finally, Katz posits that denying uncertainty is maladaptive in that it maintains professional power and control over the medical decision making process. Projecting a sense of certainty through a mask of infallibility makes it difficult for physicians to explore doubts and uncertainties. As opposed to denying uncertainty, Katz (1988) encourages physicians to maintain an awareness of uncertainty and, somewhat more challenging and humbling, acknowledge that uncertainty to patients.

One branch of medicine with a high need for accuracy and dire implications for uncertainty is radiology. Potchen (2006) conducted a study comparing 20 radiologists with an accuracy rate of 95 percent to the bottom 20 radiologists with an accuracy rate of only 75 percent and found that the radiologists who were inaccurate were also very confident in their perceived accuracy when, in fact, they were wrong. Potchen (2006) noted that the effort to manage uncertainty when making a diagnosis often lies in whether the radiologist is a risk taker or is risk averse. Risk takers have high false-positive errors and tend to call a normal finding abnormal whereas radiologists who are risk averse have high false-negative errors and tend to classify an abnormal reading as normal.
Evidence-Based Medicine

The latter half of the 20th century witnessed a movement within medical practice characterized by several overarching trends: “increasing complexity of health care, importance of better value from health care, pressing need for evidence development, need for more practice-based research, shift to a culture that learns, and a new model of patient-provider partnership” (McClellan, McGinnis, Nabel, & Olsen, 2008). In response to these shifting trends, evidence-based medicine was launched at McMaster University (Howick, 2011).

Evidence-based medicine de-emphasizes the use of intuition or unsystematic clinical experience while stressing the examination of evidence from clinical research (Evidence Based Medicine Working Group, 1992). With the aim of improving medicine and health care, evidence-based medicine is concerned with finding the best source of medical evidence, the best method to gain medical evidence, the best medical result to be achieved, and the best expert to make medical decisions (Vos, Houtepeh, & Horstman, 2005). Proponents of the broader term Evidence-Based Health Care (EBHC) purport that “anyone who makes decisions about groups of patients or populations will have to practice evidence-based decision-making” (Muir Gray, 1997, p. 1). Those favouring EBHC extend the responsibility for sound decision-making based on empirical support beyond occupations involved in primary health care to include other disciplines such as social work.

Evidence-based medicine has not advanced without criticism. Detractors contend that evidence-based medicine ignores clinical experience and intuition and that understanding of basic investigation and pathophysiology are not given proper weight (Howick, 2011). Proponents of evidence-based medicine purport that attention is given to exceptional physicians who imbue their practices with intuitive diagnosis and excellent judgement. As these physicians can articulate the process by which they arrive at diagnoses, this benefits those learning the practice of medicine. Those in favour of evidence-based medicine point to the necessity of understanding pathophysiology both in the absence of adequate evidence and for the interpretation of evidence (Howick, 2011).
Cognition versus Emotion in Medical Decision-making

Groopman (2007) notes a paucity of research on the effect of emotion on a physician’s decision-making, as well as a general lack of emphasis on physicians’ emotions during medical school. Yet a physician’s internal state can strongly influence his or her clinical judgment and actions. By example, patients thought to display a psychological disorder may not receive the same level of attention from internists, surgeons and gynaecologists (Groopman, 2007). On the one hand, in order to treat patients with traumatic injuries or young patients with life threatening diseases, a level of emotional detachment is required. To become immune to one’s emotions is impossible but also inadvisable since a lack of emotion diminishes the humanistic role of the physician (Groopman, 2007). On the other hand, if physicians are overcome by emotion, this can impair decision-making which is ultimately in the disservice of the patient.

Emotionality in decision-making impacts patient care as well. Elstein (1976) notes that affective sensitivity and an adherence to patient values form integral aspects of clinical decision-making such as when a physician is sensitive to the emotional and value needs of the patient as well as to the attendant psychological and social problems that occur when a patient faces a serious illness. For example, many physicians offer patients free samples of medications in recognition of financial hardship or will advocate for specific medical or psychological resources to assist patients with varying needs.

Biased Decision-making

Based on the work of Tversky and Kahneman, conducted in the 1970s with psychology students, Klein (2005) posits five decision-making biases to which physicians may fall suspect: the representativeness heuristic, the availability heuristic, overconfidence, confirmatory bias, and illusory correlation. These decision-making biases may represent an attempt on the part of the physician to cope with the uncertainty characteristic of many medical decisions. The representativeness heuristic refers to how much a particular patient’s circumstances / symptoms represent the stereotype of a
category while ignoring the likelihood of falling into each category. The availability heuristic refers to how judgments are influenced by the amount of publicity the problem has received. Physicians may be overconfident in the accuracy of their decisions while not recognizing their lack of knowledge within a certain area. This bias is also endorsed by Redelmeier, Ferris, Tu, Hux, and Schull (2001) who describe overconfidence as representing three of nine causes of fallibility. Physicians also tend to search for data that confirm rather than disprove their hypotheses. Finally, physicians may fall subject to the illusory correlation and emphasize only the positive cases leading them to believe in the effectiveness of their treatments. These psychological biases are present in most areas of human judgment to a greater or lesser degree. Klein’s (2005) suggestions for avoiding these biases include developing awareness of one’s shortcomings, of the factors that affect decision-making, and of the likelihood of particular events.

Klein’s theories have come under scrutiny in a number of different respects. First, Eva and Regehr (2005) point out that Klein does not take into account that highly performing individuals can just as easily be under-confident in their abilities, as poorly performing individuals can be overconfident. Second, the advice Klein offers to avoid these decision-making biases, namely increased awareness, has been criticized for failing to take into account the complexity of the cognitive mechanisms whence the biases arise (Eva & Norman, 2005) and liken the process of reducing bias to that of a light switch whereby the individual turns from remembering salient experiences to recalling hard to remember experiences. Eva and Norman (2005) note that mental activity often occurs outside of conscious awareness, thus nullifying Klein’s suggestion of raised awareness. Third, Klein also fails to take into account Tversky and Kahneman’s (1974) discussion of anchoring biases in medical decision-making and patient estimates of health risk. Tversky and Kahneman (1974) hypothesize that physicians and patients will consider an anchor, such as one’s perceived risk for developing influenza, which, in turn, biases the judgment in the direction of the anchor and leads one to seek immunization.
Tversky and Kahneman (1973) also identified a number of cognitive errors which have been applied to medical decision-making. The “availability error” refers to the tendency to judge the likelihood of an event by the availability of ready examples. A physician who has recently seen numerous cases of a particular illness is more likely to ascribe the illness to a new patient when, in fact, this may not be the case for that particular patient. In addition, physicians may fall subject to “distorted pattern recognition” whereby a physician may focus on limited features of a patient’s illness while disregarding other features. This form of selective choice, also termed “confirmatory bias” is a fallacy whereby a physician confirms what they expect to find by accepting or ignoring information. The physician, in effect “anchors” onto a specific diagnosis that fails to consider multiple possibilities. A final cognitive error is termed “diagnosis momentum” and occurs when a diagnosis becomes fixed in one physician’s mind and despite incomplete evidence pointing to this diagnosis, he or she passes the diagnosis onto peers and/or subordinates.

Vigilant versus Hypervigilant Decision-making

Decision-making patterns may fall between vigilant and hypervigilant decision-making. The vigilant decision-making pattern is characterized by an organized, thorough information search, consideration of alternatives, time to evaluate each alternative, and finally, re-examination and review prior to making a decision (Janis & Mann, 1977). This ideal pattern of decision-making generally results in high quality decisions. Those critical of the vigilant decision-making process point to the difficulty of its application given that medical assessments are often performed under time constraints or with ambiguous or contradictory information (Zsambok & Klein, 1996). In addition, the inclusion of multiple players in the decision-making process can hinder reaching a satisfactory decision.

In contrast to the vigilant decision-making pattern, hypervigilant decision-making is characterized by an information search which is non-systematic in nature, involves a consideration of limited alternatives arising from this search, rapid evaluation, and selection without extensive review or reappraisal. Janis and Mann (1977) also note that this pattern of decision-making is more impulsive
and disorganized, resulting in poorer decisions. The assumption behind the debate between vigilant
and hypervigilant decision-making posits that one can reach a rational decision through this
comprehensive process of option generation and evaluation (Keinan, 1987). Medical scholars have
suggested that what occurs within medical decision-making is often a process of “pattern recognition”
whereby the cues to a patient’s problems, from the medical history, physical examination, x-ray studies
or laboratory tests, form a pattern that the physician identifies as a specific condition or disease.
Groopman (2007) identified this process as occurring instantaneously, without conscious analysis and
derives from the physician’s visual and aural appraisal of the patient’s concerns. Unlike vigilant
decision-making, these cues are pulled from all directions and do not occur in a linear process.

In contrast to Janis and Mann (1977), Johnston, Driskell, and Salas (1997) note the
characteristics of hypervigilant decision-making, specifically information filtering and use of heuristics
to speed information processing and quick closure; may be a more effectual response to the demands
of naturalistic decision-making. Payne, Bettman, and Johnson (1988) outline the contingent nature of
decision-making and posit that when operating under time constraints, adopting a less analytical
decision-making strategy may be adaptive and result in a better outcome than using a vigilant pattern
of decision-making. Klein (1996) argues that in naturalistic settings, decision makers rely on previous
experience to identify options and heuristics to select a course of action before selecting a reasonable
solution. When viewed from this aspect, hypervigilant decision-making may represent an adaptive
response based on the decision-making task and not cognitive inefficiency and disruption.

*Statistical Decision-making*

A statistical approach to decision-making involves the use of numerical methods such as
sensitivity analysis and chronic disease modelling to render judgments regarding the treatment of
patients (Parmigiani, 2002). One advantage of using numerical methodology in the decision-making
process is that it renders judgments unequivocal and offers objective comparison with actual results
(Poses, Cebul, & Centor, 1988). However, this assumption is problematic in that it assumes the
original judgments are correct and free of error. A second advantage of the statistical approach concerns the queries of patients who often pose medical questions around diagnoses, prognoses, and responses to treatment in quantifiable terms: “what are the chances it is cancer?” or “what are the chances the treatment will cure me?” Probability questions place the medical practitioner in the role of the quantitative judge (Poses et al., 1988).

Schwartz (2000) describes the use of support theory as a framework to guide probability judgments. Descriptions of competing events are evaluated by assessing the relative support for each description, thus, whether a broken hip is the result of a fall or a non-fall. Poses et al. (1988) note two studies (Christensen-Szalanski & Bushyhead, 1981; Tierney, Fitzgerald, & McHenry, 1986) that have shown that statistical estimates of disease probability may be strongly predictive of physicians’ actual management decisions although these relationships do not necessarily imply cause and effect. Poses et al. (1988) describe the use of various methods of probability judgments including calibration curves and covariance graphs to inform medical decision-making processes regarding when a physician initiates testing or treatment of specific diseases. Other statistical methods used in medical decision-making include frequency formats (Gigerenzer, 1996), decision trees (Schwartz, Gorry, Kassirer, & Essig, 1973) and linear models (Wigton, 1988). Critics of employing a solely statistical methodology to medical decision-making note the increasing amounts of medical information available and the tendency to fit all clinical problems into a model, thus slighting important aspects of a problem (Elstein, 1976). Critics also warn that patients have come to expect the most current and sophisticated medical technologies despite the cost and the potential uncertainty of the outcome (Eddy, 1996). Elsewhere, critics point to the need for an overall cost reduction in medical care (Clark & Cohen, 2010; Malach & Baumoi, 2010)

Summary

Uncertainty is a prime feature within all aspects of medical decision-making and includes various forms such as personal, technical, and conceptual. Given the proliferation of medical
technology, modern day physicians are inundated with an overabundance of medical information that may lead to uncertainty regarding the appropriate treatment. However, within many helping professions, the inverse is true, and these professionals, facing a paucity of information by which to base decisions, must make the best decision with the available evidence. Whether due to an overabundance or paucity of information, professionals across disciplines are faced with decision-making in the throes of uncertainty.

Evidence-based medicine, statistical decision-making, and hypervigilant decision-making comprise rigorous and methodologically precise decision-making strategies designed to manage the uncertainty of medical decision-making and shift thinking processes away from biased decision-making, intuition, or use of heuristics. As discussed later in the chapter, decision-making from an evidence-based perspective has grown beyond medicine to other helping professions and advocates decision-making based on evidence from studies with rigorous methodologies.

Finally, the management of patients’ and physicians’ emotions in the face of uncertainty can render physicians potentially anxious and distressed and thus, affect their decision-making. The helping professions by their very nature comprise work with distressed clients who may experience difficulty managing their own emotions. Thus, helping professionals are charged with managing the emotions of their clients as well as making sound decisions amidst the upheaval of their own emotions.

Decision-making in Psychology

The Role of Emotions in Decision-making

Researchers within the fields of clinical and physiological psychology note that decision-making does not occur in an emotional vacuum and that emotion is an important factor to consider (Finucane, Peters, & Slovic, 2003; Loewenstein, Weber, Hsee, & Welch, 2001). Zajonc (1980) posits that affective reactions to stimuli precede cognitive reactions and thus no cognitive appraisal is needed. For example, individuals believe they are making rational decisions by weighing all the positives and negatives when in reality, one’s choices are determined by simple likes and dislikes of articles such as
the house or car one purchases. After the choice is made, individuals will then find various reasons to justify their choice. Emotions such as fear, judgment, anxiety, or compassion can affect the decision-making process either positively or negatively by changing priorities, distorting thinking, or providing the motivation to think carefully about the situation (O’Sullivan, 1999).

Lazarus (1991) distinguished between three different aspects of emotions: the physiological reaction, the expression of emotion, and the action tendency. Although clinicians cannot halt their physiological reaction to a situation as this is prompted by the meaning the situation holds for them, they can control how they act once aroused. How the emotion is displayed has less impact on decision-making than the action tendency triggered (Lazarus, 1991). For example, an individual experiencing anger can have a tendency to retaliate whereas if an individual feels compassion, the action tendency may be to help the person in need. The action tendencies of emotions can have a significant impact on the decision-making around situations and thus, need to be managed else they may be acted upon in a mindless fashion. Ways to cope with emotions may involve reappraising the personal meaning of the situation (O’Sullivan, 1999), distancing oneself from the situation and the people within it (Satyamurti, 1981) or avoiding the aspect of the decision situation that evokes the emotion (O’Sullivan, 1999). It is essential that clinicians demonstrate awareness of how they make decisions and be reflective of the emotions they experience as well as the impact of these emotions on their decision-making processes for decisions based on too much or too little emotion may not serve the situation or the individuals involved.

Mindful Decision-making

A mindful approach to decision-making involves attention to reflection and self-awareness on the part of the decision maker (Bruce, Manber, Shapiro, & Constantino, 2010). A mindful clinician refines his or her capacity for attention and insight through self-examination of one’s own experience (Segal, Williams, & Teasdale, 2002). Westberg and Jason (1994) note that mindfulness enhances professionals’ ability for self-reflection, including the ability to solve problems, make decisions, and
maintain cognizance of their own values in addition to those of their clients. Mindfulness is an extension of reflective practice (Hewson, 1991) whereby the decision maker develops awareness of one’s mental process, listens attentively, and recognizes bias and judgments (Epstein, 1999). A mindful approach fosters awareness of the correct course of action in a problematic scenario but also of the factors that obscure the decision-making process, thus preparing the decision maker when next faced with a similar scenario. Described as a state of what “could be,” the mindful decision maker welcomes uncertainty rather than adopting a stance of avoidance. Mindfulness as an extension of reflective practice harkens back to Schon (1983) who introduced the notion of reflection into the decision-making process by postulating that professional practice is not totally reliant on the application of theoretical knowledge but a form of tacit knowledge referred to as reflection-in-action or reflection-on-action.

Clinical judgment is thought to be based on a combination of explicit knowledge that is formally taught, quantified and can translate into evidence based practice and tacit knowledge that is learned through observation and practice (Epstein, Cole, Gawinski, Piotrowski-Lee, & Ruddy, 1998). Under the rubric of reflection, professionals manage ill defined or ambiguous problems by re-framing or re-naming them in order to address them more readily. Following this, Gambrill (2005) describes successful problem solvers as those who examine their thinking processes, assumptions, and reasoning, thus engaging in a process of reflection.

*Intuitive versus Critical-Evaluative Decision-making*

Drawing from the work of Hare (1981), Kitchener’s (1984) highly acclaimed, ground breaking work distinguished between two levels of decision-making when faced with deciding the most ethical course of action: the intuitive level of moral reasoning and the critical-evaluative level. The intuitive level involves the beliefs, knowledge and assumptions found in professional ethical codes of conduct. When faced with an ethical dilemma, psychologists “have an immediate, prereflective response to most ethical situations based on the sum of their prior ethical knowledge and experience. This response
forms the basis of their ethical actions” (Kitchener, 1984, p. 44). The intuitive level of moral reasoning guides clinicians faced with unanticipated ethical dilemmas, time constraints that require imminent action, and ethical dilemmas on which professional codes of conduct are silent. In the face of these specific challenges a clinician may fall back on their moral values (Corey, Corey, & Callanan, 1979). However, the intuitive level of moral reasoning is insufficient as a solitary form of decision-making as it may fail to guide clinicians in atypical ethical situations. In addition, the ability to exercise moral reasoning leading to sound ethical decisions can vary from clinician to clinician, thus it is not possible to trust all clinicians in this regard.

The critical-evaluative level of moral reasoning becomes necessary “to guide, refine, and evaluate ordinary moral judgment” (Hare, 1981). This level of moral reasoning promotes reflection on ordinary moral judgment and redefines the bases for clinicians’ actions (Kitchener, 1984). The critical-evaluative level is hierarchically comprised of three tiers: professional codes or laws comprise the first tier, six general ethical principles: autonomy; fidelity; justice; beneficence; nonmaleficence; self-interest form the second tier, and finally ethical theory encompass the third. The first tier, professional codes, is the ethical rules by which the behaviour of a professional group is judged by the members. Reading one’s ethical codes along with case applications can guide clinicians in the interpretation and application of specific ethical codes when faced with ethical dilemmas. Their utility in this regard is without question. However, ethical codes may be either contradictory or ambiguous in certain ethical areas. In addition, clinicians who belong to several professional bodies are thus subject to numerous and at times, competing codes of conduct (Drane, 1982). Finally, several authors have noted that the impetus for the formation of ethical codes was a means to protect professions from outside regulation and to police one’s own membership. Thus, ethical codes of conduct may protect the membership more than the consumer and may omit issues of ethical concern (Rosenbaum, 1982). Ethical codes tend to be conservative in nature and reflect the collective behaviour of the membership as opposed to individual behaviour.
Because ethical codes may be either too broad or too narrow in focus, the second tier of the critical-evaluative level of moral reasoning (Hare, 1981) distinguishes 6 ethical principles that are more general and fundamental as opposed to ethical codes. Autonomy is the first ethical principle and pertains to how individuals choose to conduct their life. Autonomous persons accept responsibility for their behaviour and decision-making and are charged with respecting the rights of others to make autonomous choices (Kitchener, 1984). Autonomy is closely tied to the concept of competence that assumes that an individual has the capacity to make competent and rational decisions. When viewed from this perspective, infants, children or those with diminished cognitive capacity (e.g., a person suffering with advanced Alzheimer’s disease), would be unable to make rational decisions while individuals who are incarcerated would be unable to act on a rational decision. Thus, there are cognitive and behavioural limits to autonomy. Elements within the therapy session that are relevant to achieving autonomy include informed consent, privacy, and not using coercion.

Fidelity, the second ethical principle, involves loyalty, faithfulness, and promise keeping, maintenance of confidentiality and doing no harm to the client. Fidelity arises when individuals (clinician – client) enter into a voluntary relationship; an ethical commitment with obligations for both parties. The informed consent process, established at the beginning of the relationship, forms both the nature and requirements of the relationship and is essentially a statement of fidelity. Justice, the third ethical principal, historically has been suggested to mean “fairness” (Benn, 1967, p. 298) and extends to the fair distribution of benefits and burdens (Beauchamp & Childress, 1979). In a society with limited goods and services, rules and procedures are implemented in order to distribute goods and services in a just and fair manner, such as whom in the family receives services and if these services are comparable to services received by other family members.

Beneficence, or doing good for others, underlies the fourth ethical principle, and includes the actions of the helping professional. Beneficence involves contributing to the health and welfare of clients and to meeting clients’ expectation that they will benefit from professional contact (Kitchener,
The fifth principle, nonmaleficence, implies not causing harm to others and is historically rooted in medical practice, “above all do no harm” (Brown, 1982). Not doing harm involves neither inflicting intentional harm nor engaging in actions that risk harming others with the stronger obligation being to avoid harm.

Many believe that the fifth ethical principle, nonmaleficence, or not causing harm to others, overrides beneficence. The difficulty lies in determining, from an ethical standpoint, just how much discomfort is justifiable in clinical treatment. If a client enters treatment voluntarily, is fully informed of the risks, and experiences temporary discomfort during treatment, it is likely this situation would not be considered an example of nonmaleficence; however, when the client’s autonomous choice is limited by age (child) or circumstance (institution), it becomes more difficult to justify treatment discomfort (Kitchener, 1984).

Despite the clinical relevance of the concepts of beneficence and nonmaleficence, Kitchener does not clearly define these concepts and thus, they rest on a matter of perspective. What one client perceives as beneficent behaviour on the part of the clinician may be perceived as maleficent by another client. By example, the action of a clinician who decides to report a suspicion of child maltreatment to the CAS may be viewed by one client as beneficent and stemming from the clinician’s care and concern of the child / family. However, another client may view the action as maleficent and stemming from the clinician’s desire to be punitive and authoritative.

Finally, self-interest, the sixth ethical principle, is reflected in self-knowledge, self-improvement, self-protection, and self-care of the clinician. When a clinician is unaware of these elements, their needs and values may interfere with treatment decisions. When faced with a challenging ethical dilemma and after exhausting the first two tiers of the critical-evaluative level, ethical rules and principles, a clinician can turn to ethical theory, the most abstract tier. This final tier may involve determining an overarching utilitarian principle such as finding the greatest balance of good over evil.
Summary

Psychology has advanced the field of decision-making by examining the role emotions play when rendering decisions. This focus is in contrast to the field of medicine that has largely ignored the role of physician emotion in medical decision-making focusing instead on pattern recognition, question formation and the avoidance of cognitive error (Groopman, 2007). However, cognition and emotion are inseparable and it stands to reason that within the helping professions a clinician’s emotional experience and subsequent physiological reaction plays a significant role in one’s decision-making ability. A clinician being swayed by too much or too little emotion can act in a manner that is not in the best interests of the client. Moreover, the helping professions imply a second person in the dyad, thus the role of the client’s emotion comes into play as well.

The practice of mindfulness meditation, with origins rooted in Buddhist tradition, is a way of “being” and “seeing” in the world (Dalai Lama, 2005) which can assist clinicians with being consciously aware of body, speech, feelings and thoughts (Bruce et al. 2010). The practice has implications for clinician decision-making given that one is afforded the mental space to observe their thoughts and feelings without being subsumed by them.

With regards to the intuitive and critical evaluative forms of decision-making, Kitchener has put forth a reasoned argument for a tiered approach to decision-making. She is sound in her judgment that the intuitive level of decision-making is insufficient to capture the breadth and depth of decision-making required in clinical practice. Furthermore, she is wise to include the maintenance of confidentiality with the autonomy of informed consent.

Social Work Decision-making

Biased Decision-making

Similar to the literature reviewed on decision-making in medicine, Gambrill and Shlonsky (2000) note that decision-making around risk assessment in child protection is often made in the throes of uncertainty, with limited relevant material, and will impact future client and service outcomes.
They identify a host of personal and environmental factors that influence decisions, such as limited knowledge, limited ability to process information, and difficulty in making predictions under considerable uncertainty. Gibbs and Gambrill (1999) note social workers can cognitively analyze a limited number of possibilities at one time. Thus, decision makers tend to use selective perception (not seeing what is present), a sequential (rather than contextual) processing of information, and a reliance on heuristics or shortcuts to decision-making. Other decision-making concerns involve faulty memories, lack of knowledge or a decision to not use available knowledge, the influence of preconceptions on judgement, mood fluctuations that vary from one day to the next and searching for client deficiencies while neglecting assets (Gambrill & Shlonsky, 2000). Social workers may also respond to more impactful events while ignoring less impactful data. What social workers see and hear first may figure more prominently in their judgement, thus dulling them to new and perhaps contrary evidence. Finally, social workers may be subject to wishful thinking (belief that an outcome will occur), to the illusion of control (certainty that predictions may come true) or to a need to appear decisive while compromising the quality of one’s decision (Gambrill & Shlonsky, 2000).

Social workers are not trained to formulate decisions based on statistical data but to use a combination of experience, intuition and individual heuristics. Robyn Dawes, a noted authority on clinical decision-making in psychology, deplores the lack of scientific basis in which clinical decision-making occurs. Specifically, he criticizes the use of previous experience as a basis for clinical decision-making (Dawes, as cited in Gambrill, 2002). Instead, he promotes the science of scepticism, the comparison of clinical problems, the need for evidence, and the ability to test ideas and to develop hypotheses. Dawes (as cited in Gambrill, 2002) posits that beyond scientific rigour, clinicians have an ethical imperative to make decisions in this manner.

Finally, social workers may be hampered by environmentally based factors that could influence decision-making. Decisions may be impacted by the values and policies of agencies and the broader community in which the social worker practices (Ashton, 2007; Margolin, 1997). Social workers may
be also hampered by time pressures, distractions, and the development of a mechanical approach to
decision-making that is devoid of reflection. Social workers operating in an agency environment may
feel pressure to conform to “group think,” which neglects alternate views (Forsyth, 2006; Janis, 1982)
and may be reluctant to criticize the decision-making of clinician-friends within case conferences
(Meehl, 1973) or those with more power in the hierarchy.

Evidence-Based Practice Decision-making

In reaction to the plethora of above-noted biases hampering clinical decision-making within
social work as well as a reaction to authority-based decision-making that relies on non-empirical
elements such as consensus, status, anecdotal experience, faith, trust, good intention or tradition to
make decisions (Gambrill, 2001, 2005), evidence-base practice, with origins in medicine as noted
earlier, was ushered into the field of social work. Gibbs (2003), a major proponent of evidence-based
practice within social work, provides the following definition of its application to clinical decision-
making: “evidence-based practitioners adopt a process of lifelong learning that involves continuously
posing specific questions of direct practical importance to clients, searching objectively … for the
current best evidence … and taking appropriate action guided by evidence” (p. 6).

Another major proponent of the adoption of evidence-based practice within social work,
Gambrill (2001) asserts that the practice emphasizes critical appraisal along with client involvement.
She distinguishes empirical based social work practice, based on an authoritarian stance (i.e.,
consensus, status), along with a justification approach (i.e., confirming views rather than falsifying
them through rigorous testing), from evidence-based practice, the hallmarks of which include
developing answerable questions, conducting a methodological search for evidence, critically
appraising evidence, including clients’ values and expectations, and evaluating the outcome. The
adoption and utilization of evidence-based practice is in tandem with The National Association of
Social Workers Code of Ethics (2008) that exhorts social workers to base practice on recognized,
empirically based knowledge. Similarly, the Canadian Association of Social Workers Guidelines for
Ethical Practice (2005) advises social workers to “inform their practice from a recognized social work knowledge base” (p. 22).

Arguments in favour of the adoption of evidence-based practice in the field of social work point to the improvement in social worker decision-making, the ability to manage voluminous research knowledge, the incorporation of clients’ values and preferences, the emphasis on social worker learning, and the encouragement of practice-relevant research (Mullen, Shlonsky, Bledsoe, & Bellamy, 2005). A failure to integrate evidence into the decision-making process is postulated to lead to the utilization of ineffective interventions or interventions that do more harm than good as well as a failure to use interventions that do more good than harm (Gray, 2001). Five steps to evidence based practice include developing answerable questions; searching for evidence by which to answer the questions; appraising the evidence in terms of validity; impact and applicability; applying the results to practice / policy decisions; and evaluating the effectiveness of the outcome (Sackett, Rosenberg, Gray, Haynes, & Richardson, 2000). The double goal of evidence-based practice is to produce clinicians who are effective, efficient, and humane in addressing clients’ concerns as well as clinicians who commit to learning in the process (Barrows, 1994).

Evidence-based practice is not without its criticisms. While offering a formal, structured, means by which to analyze decision-making, Straus and McAlister (2000) purport a host of objections to evidence-based practice. Specifically, they maintain that it ignores clinical expertise as well as client values and preferences, is a cook book approach as well as a cost-cutting tool, is limited to clinical research, and rests solely within academia. Webb (2001) advances further limitations such as that the practice ignores the processes of deliberation and choice involved in decision-making, that the randomized controlled trial is the only admissible evidence, and that effectiveness is a matter of interpretation. In response to these assertions, Gibbs and Gambrill (2002) offer a detailed counterargument against these claims while upholding the value of evidence-based practice as a rigorous and efficacious decision-making process.
Actuarial Models of Clinical Decision-making

Actuarial models of clinical decision-making that are based on empirical relationships between predicted variables and outcomes of interest have been designed specifically for decision-making in child protection investigations (Gambrill & Shlonsky, 2000). The advent of sophisticated client tracking techniques, developments in computer technology, and advanced empirical methods have led to actuarial models of assess risk (Gambrill & Shlonsky, 2000). Studies in the use of actuarial based models show them to be superior to clinical prediction (Dawes, Faust, & Meehl, 1989; Falco & Salovitz, 1997; Grove & Meehl, 1996; Johnson, 1992), thus improving the reliability of decisions.

However, actuarial models are limited by vague definitions of outcome measures (Zuravin, 1999), use of previously constructed measures which may lack reliability and validity (English & Graham, 2000), the absence of base rate data (Wald & Woolverton, 1990), the difficulty of individual prediction given the wide variation among individuals (Gambrill & Shlonsky, 2000), and unacceptable levels of sensitivity and specificity (Gambrill & Shlonsky, 2000).

Actuarial models and measures of risk assessment for child maltreatment are most commonly used by child protection workers conducting investigations with the hope of accurately identifying children at risk for harm (Regehr, LeBlanc, Shlonsky, & Bogo, 2010). Social workers in general practice settings do not normally have access to actuarial models of clinical decision-making to assess risk. Hence, the absence of empirical models to assess risk highlights the need to understand the factors social workers employ in their clinical decision-making.

Summary

Social work scholars have identified both personal and environmental impediments to effective and efficacious decision-making in social work. These impediments reflect the ecological system or person-in-environment theoretical basis upon which social work is predicated and may address personal and environmentally based biases. Despite its critics, evidence-based practice is proposed as a move away from authority based practices, as a means of honouring ethical obligations, fostering
accountability regarding what can be done and to what effect, systematically integrating ethical, evidentiary, and application issues, and promoting knowledge dissemination (Gambrill, 2006).

**Marriage and Family Therapy Decision-making**

Despite the extensive theoretical examinations of decision-making reviewed above in medicine, psychology and social work, these disciplines have come under criticism for conceptualizing decision-making as a linear, sequential, and internal processing of external information while failing to consider the role of context and interactional factors (Ivey, Scheel, & Jankowski, 1999; Jankowski & Ivey, 2001). The systemic orientation of marriage and family therapy contributes to the discussion on decision-making by focusing on the context in which decisions are made. Marriage and family therapy views clinical decision-making as residing within larger decision-making processes and is multidimensional in scope. Given the emphasis on couple and family systems in treatment, marriage and family therapists balance the welfare and rights of the individual versus those of the family or couple system (Woody, 1990). Thus, a decision that benefits the individual may have dire consequences for the couple or family system in which the individual resides.

**Decision-making Based on an Ethic of Care**

One of the first conceptualizations of decision-making within the field of marriage and family therapy was put forth by Gilligan (1977, 1982) and Gilligan and Attanucci (1988) who developed an ethic of care model of decision-making. The model that focuses on relationships views moral requirements as arising from the particular needs of others as well as the particulars of the situation (Flanagan & Jackson, 1987; Gilligan, 1982). A therapist working from an ethic of care perspective considers the consequences of a decision for the client(s) such as how the decision would affect the relationship, the context, the need to avoid hurt, and issues of altruism (Friedman, Robinson, & Friedman, 1987; Lyons, 1990). This model views responsibilities as evolving out of relationships with others. The concern for individual rights is replaced by concern for responsibility toward interdependent relationships (Gilligan, 1982). Terms important to the care model are connectedness,
relationship, responsibility, interdependence, preventing harm, sacrifice, caring, and context (Lyons, 1983).

**Decision Bases**

Woody (1990) proposes a model of decision-making within the field of marriage and family therapy that can be used for resolving ethical concerns and derives from the assumption that therapists draw from diverse bases when rendering a decision. The five bases include: (1) theories of ethics; (2) professional codes of ethics; (3) professional theoretical premises; (4) sociolegal context; and (5) therapist’s personal / professional identity. Theories of ethics offers the marriage and family therapist a logical method for ethical decision-making based on universal principles of intuitive thinking (promoting principles of justice regarding client welfare, dignity, liberty, and self-determination) and critical thinking (based on utilitarian theory, i.e., the greatest good for the greatest number of persons involved). Professional codes of ethics guide marriage and family therapists and include rules, norms and principles in which the therapist should be well-versed.

Professional theoretical premises, such as the tenets of family systems, cognitive-behavioural therapy, structural family therapy, and strategic family therapy offer differing assumptions about human nature, behaviour, pathology, health and the factors that promote client welfare. The sociolegal context, that includes sociocultural values, public policy, and organizational context in which marriage and family therapists operate, impact how therapy is conducted and the responsibilities of the therapist. The therapist’s personal / professional identity forms the final basis of decision-making. The “person” is present in the helping relationship, conducts intuitive and critical thinking, and identifies and weighs information from the previous four decision bases. The therapist’s ethical “character” along with his or her values, knowledge and skills form an integrated personal and professional identity.

**Internal versus Conversational Decision-making**

Jankowski and Ivey (2001) offer a current conceptualization of decision-making whereby they distinguish between two “meta” problem definition processes: internal and conversational decision-
making approaches. An internal approach to decision-making rests solely on one’s own sense-making process and is comprised of three elements: therapist-specific factors, contextual factors, and therapist-client interaction factors. The therapist-specific factors include the therapists’ assumptions about therapy and people, ideas about the clients and their situation prior to commencing treatment, knowledge gained through training and educational experiences, therapists’ perceptions of their professional role, and therapists’ perceptions of the referral (Jankowski & Ivey, 2001). The contextual factors include the larger systems or context in which the therapy took place: school or mental health agency; physical location and aesthetics of the therapy session; referral incident; referral process; referral source; and expectations for therapy that accompanied the referral. The therapist-client interaction factors include those of the therapist (previous experiences with other clients, therapist perception of the reason for coming to therapy, therapist concerns about the client’s perception of him or her as the therapist), therapist observations (reading the client’s reactions to questions, comments, and observing the client’s behaviour), therapist self-perceptions (experience of self, emotional growth during the session, professional growth issues, personalizing of client experiences) and change (therapist desire for change in the client).

In sum, formulating a problem definition involves three elements: the therapist comparing and contrasting pre-existing knowledge with current information obtained from the client during the session; developing an understanding of how contextual factors impact both the therapist and the client’s experiences during the session; and how considering experiences resulting from interaction with the client during session fit the therapist’s previous experiences with other clients.

A conversational decision-making approach involves reflecting on the therapist’s problem definition of therapist-specific factors, context, and interactional factors and incorporating these reflections into the therapeutic conversation. Sharing these internal constructions permits clients to use the ideas in ways that are beneficial to them. By making the conscious decision to discuss the problem
definition with the client in a respectful fashion, the client is able to determine the helpfulness of a particular problem definition to their specific situation.

Triangulated Decision-making

In an innovative conceptualization of therapist decision-making, Brown and Strozier (2004) outline a model of decision-making based on Bowen’s concept of triangulation (1978), a basic phenomenon of any relationship system. Although couples and families may be the actual clients in treatment, therapists, due to ethical, legal, and occupational responsibilities, often have a third “client” in the room metaphorically, for example, school principals, multi-disciplinary hospital teams, Employee Assistance Program providers, insurance companies, or the CAS. Bowen (1978) posited that in periods of calm, “the triangle works as a comfortably close twosome and a less comfortable outsider” (p. 199). However, when stress arises, the family system triangulates people in from the outside. Brown and Strozier (2004) put forth that the more aligned the therapist becomes with the 3rd “client,” the attending client becomes the outsider in the triangle of the therapist-client-3rd client apparatus, possibly affecting the continuation of treatment. Thus, therapists who consciously or unconsciously decide to “move closer” to the 3rd “client” risk losing the attending client.

Summary

The field of marriage and family therapy has made an important contribution to the understanding and conceptualization of clinical decision-making based on its key tenets. The processes of triangulated and conversational decision-making are predicated on Bowen’s concept of family triangulation and systems theory respectively. By linking discipline specific theoretical concepts and decision-making processes, marriage and family therapists deepen the cognitive understanding of decision-making. In addition, by examining the contextual factors in which therapy occurs (location, referral, and expectation of outcome) as well as the macro systems in which clients live, this promotes decision-making from a systemic perspective.
Decision-making and Child Maltreatment

The preceding sections provided an overview of decision-making from the medicine, psychology, social work, and marriage and family therapy literatures. Each discipline offers insights and contributions to the complex decisions physicians and social workers must make on a daily basis to assess and treat in a comprehensive and safe manner for patient and client alike. In this section, selected and key concepts from the literature reviewed on decision-making in the four disciplines will be examined within the context of the mandatory reporting of child maltreatment.

Medicine has rightly identified uncertainty in the face of complexity due to a lack of sufficient information by which to render a sound decision. Similarly this dilemma can occur within the context of reporting child maltreatment. Social workers rarely have all the facts of the case and often must rely on the verbal accounts of the clients, thus basing their decision-making on limited information. Medicine has also concluded that applying universal parameters to specific situations is equally problematic and this holds true for decision-making within child maltreatment. Given that child maltreatment legislation is jurisdictional, universal parameters regarding what constitutes maltreatment do not exist. Moreover, specific client situations may include other variables such as poverty, housing and medical issues, thus confounding any available universal parameter. Medicine has further identified various types of biased decision-making, one such bias being over-confidence in one’s decisions. Social workers are not immune from this type of bias and may not recognize their lack of knowledge concerning a particular type of child maltreatment or knowledge of disciplinary practices within a specific culture.

Within psychology, researchers have also come to understand and appreciate the role that emotions play in decision-making. Lazarus (1991) distinguished between the physiological reaction, the expression of emotion, and action tendencies of emotion. For social workers, mandatory reporting of child maltreatment may raise a plethora of emotions including anger, fear, sadness, worry, and frustration. Emotions that are not understood or managed well may impact social workers and lead to
an over-reaction on their part. The literature in psychology also suggests the importance of mindfulness in decision-making. Social workers who are attuned to their emotions and who are able to recognize and manage the impact of their emotions may render more sound decisions.

Within the field of social work Gambrill (2005) aptly notes that decision-making constitutes a high degree of uncertainty, as there is often insufficient information to have full confidence in one’s decisions. This is often the case when social workers make decisions concerning child maltreatment as the allegation may come via a second or third party or the evidence of maltreatment may not be visually apparent. Furthermore, decision-making in the social sciences relies on general principles that rarely allow a decision maker to accurately make a prediction about an individual (Dawes, 1994).

Social work has also identified a host of personal and environmental biases that can impinge on decision-making. What a social worker sees and hears first may figure more prominently and overshadow new and contrary evidence such as when a parent works hard to change their disciplinary practices. Social workers may also engage in wishful thinking, for example, the belief that if they continue working with a family the maltreatment may cease, which may not always take place.

Environmental factors such as time pressures can impinge on social workers’ decision-making, particularly if they have a full roster of clients expecting service that day.

Finally, the field of marriage and family therapy has identified an internal versus conversational approach to decision-making, the latter involving the inclusion of the client in the decision-making. Many social workers choose to discuss their decision to report suspected child maltreatment with the client prior to the report to maintain the clinical relationship, gain the perspectives of the client, and inform the client of the process that will unfold. However, many social workers also discuss this important decision with their colleagues, supervisor, or anonymously with the CAS prior to reporting and engage in a conversational approach to decision-making with other professionals. Marriage and family therapy has also identified decision-making based on an ethic of care model that centres on relationships and how the decision would affect the clinical relationship. For many social workers
operating within an ethic of care model, the loss of the clinical relationship is paramount as it may involve a disruption or termination of service and a possible continuation or worsening of the reported maltreatment. For these social workers, reporting child maltreatment may not be worth the loss of the clinical relationship. The ethic of care model underscores the value of therapeutic alliance which is the focus of the following section.

*Therapeutic Alliance Theoretical Literature*

The processes of decision-making and maintenance of the alliance are inter-related, for a decision to which the client objects may affect the alliance, whereas a focus on maintaining the alliance may force the clinician into alternate decisions that he or she ultimately believes is not within the best interest of the client. Mary Richmond’s conceptualization of the friendly visitor is presented before moving onto an examination of the alliance from psychodynamic, humanistic, cognitive behavioural, and postmodern perspectives. Finally, Safran and Muran’s (1996, 1998, 2000, 2006) groundbreaking work on alliance ruptures will be discussed.

The therapeutic alliance has been described as bidirectional between patient and therapist (Bordin, 1979). Elsewhere, Safran and Muran (2000) argue that the concept of the alliance “highlights the fact that at a fundamental level the patient’s ability to trust, hope and have faith in the therapist’s ability to help always plays a central role in the change process” (p. 13). Thomas, Werner-Wilson and Murphy (2005) position the therapeutic alliance as the “extent to which a client and therapist work collaboratively and purposefully and connect emotionally” (p. 19). In separate meta-analyses, Lambert and Barley (2001) note that the therapeutic alliance accounts for 30% of treatment outcome, while Horvath (2001) postulates that the alliance accounts for at least 50% of the favourable effects of therapy. The therapeutic alliance is integral across treatment modalities and is a powerful predictor of outcome independent of clinician adherence to specific therapeutic approaches (Bickman, Andrade, Lambert, & Doucette, 2004; Chatoor & Krupnick, 2001; Horvath & Bedi, 2002; Karver, Handelsman,
Fields, & Bickman, 2006; Luborsky, 2000; Martin, Garske, & Davis, 2000; Sexton, Littauer, Sexton, & Tommeras, 2005).

**Historical Overview of Alliance Formation**

The concept of alliance for social work practice finds its roots in Mary Richmond’s (1899) non-dynamic conceptualization: “friendly visiting means intimate and continuous knowledge of and sympathy with a poor family’s jobs, sorrows, opinions, feelings and entire outlook upon life” (p. 180). According to her early view, the relationship was akin to a friendship and the assessment process was seen as encompassing the client’s familial, social, and occupational network. For Richmond, intimate knowledge of clients and their social environments was the precursor to change, reflected in Brandell and Ringel’s (2004) statement “social work practice arose from a tradition in that the idea of alliance and alliance building is almost inextricable from conceptions of treatment” (p. 551). In 1922, Richmond reflected on the nature of direct practice in *What is Social Case Work* and drew the connection between the effectiveness of service and how workers related to their clients. She identified honesty, affectionate acceptance, and imaginative sympathy as factors in relationships that support change.

**Perspectives of the Alliance**

Although Greenson (1965) first coined the term *working alliance* to delineate the positive collaboration between client and therapist as an essential component for success in therapy, Bordin is credited with the commonly used term *therapeutic alliance*. Bordin (1979) postulated the existence of three integral components of the alliance: bond, goals, and tasks. The emotional bond refers to the quality of the relationship in that the client feels understood, respected, and valued. The agreement on the goals refers to the degree of agreement about the purpose of meeting together whereas the agreement on tasks includes the individual roles and means by which change will take place (Bordin, 1979). The therapeutic alliance plays an integral role in the interactions between therapist and client and is one of the most consistent and strongest predictors of treatment success (Horvath, 2001; Horvath
& Symonds, 1991; Lambert & Barley, 2001; Martin et al., 2000) as well as being a common factor across treatment modalities (Lambert, 1992).

Psychodynamic Perspective

Historically, Freud emphasized the importance of rapport between analyst and patient to complete the work essential to successful psychoanalytic treatment (Freud, 1912) with this collaboration serving as a precondition for interpretations leading to insight. Recent psychodynamic therapies place greater emphasis on the therapeutic relationship including aspects of collaboration and worker empathy (Coady, 2008). Models such as interpersonal psychoanalysis (Sullivan, 1953), object relations theories (Winnicott, 1965), self psychology (Kohut, 1977), attachment theory (Bowlby, 1980), and relational theory (Aron, 1996) utilize Alexander and French’s (1946) conceptualization of the “corrective emotional experience.” By means of a healthy relationship with a caring therapist, clients can develop “more positive internal images of self, other, and relationship, which in turn could lead to a healthier sense of self and more adaptive interpersonal functioning” (Coady, 2008, p. 51). The therapeutic relationship is viewed as central to the treatment process, emphasizing the experiential, reparative, and facilitating aspects of the relationship between the therapist and the client (Berzoff, Flanagan, & Hertz, 2011; Borden, 2000; Goldstein, Miehls, & Ringel, 2009; Miehls, 2011).

Humanistic Perspective

Rogers’ seminal book, Client-Centered Therapy (1951) bestowed the relationship with a healing and restorative function. He proposed that the value of the relationship crosses all modes of therapy and conferred on the clinician the ultimate responsibility of fostering the relationship. Rogers believed that he had identified the necessary and sufficient conditions to promote change and that to facilitate client growth, it was necessary to provide a particular kind of relationship based on congruence, acceptance, and empathy.

Although Roger’s theory continues to be viewed as a cornerstone for understanding and engaging in the helping relationship, aspects of Rogers’ theory have engendered criticism. Bordin
(1979) challenged Rogers’ conceptualization of the relationship as one-dimensional. His view saw the relationship as bi-directional, between client and clinician, where both are equally responsible for providing the environment to facilitate change. In addition, studies of Rogers’ work have revealed that a good therapeutic relationship correlates positively with outcome; however, it is the client’s subjective evaluation of the relationship, including qualities of empathy, congruence and unconditional regard, rather than the clinician’s actual behaviour, which has the most impact on therapy outcome (Horvath, 2000).

Another criticism concerns Rogers’ emphasis that the relationship constitutes the only necessary and sufficient condition for change. Many disciplines including social work have contended that while the relationship is a necessary component to produce change, it is not a sufficient component in itself given the complexity of client situations (Bachelor & Horvath, 1999). Finally, Rogers’ emphasis on relationship building and assisting the client to explore the meaning of his or her situation may overlook sources of oppression in the client’s environment such as hunger or exposure to maltreatment by a partner or parent (Rothery & Tutty, 2008). For clients experiencing oppressive or dangerous life situations, relief or protection with concrete interventions, in addition to a meaningful helping relationship, may constitute the necessary and sufficient conditions for change.

Cognitive Behavioural Perspective

During the development of behaviour therapy in the 1950s and 1960s there was little empirical support for the effectiveness of relationship variables outside of the Rogerian constructs of empathy, warmth, and genuineness (Castonguay, Constantino, McAlavey, & Goldfried, 2010). The foundation of Cognitive Behavior Therapy (CBT), with emphasis on learning, conditioning, reducing psychopathological symptoms, and providing coping skills, is the main reason why the therapeutic relationship went for years as an under recognized factor (Castonguay, Newman, Borkovec, Grosse Holtforth, & Maramba, 2005). However, later cognitive behavioural scholars came to recognize the value of the therapeutic relationship. Goldfried and Davison (1976) noted that “the truly skilful
behavior therapist … interacts in a warm and empathic manner with his client (p. 56) while Beck, Rush, Shaw, and Emery (1979) asserted that “cognitive and behavioral therapists probably require the same subtle therapeutic atmosphere that has been described explicitly in the context of psychodynamic therapy” (p. 50) in addition to emphasizing relationship variables such as basic trust and rapport. These descriptions of the therapeutic relationship were characteristic of how the relationship was viewed by early behavioural therapists, that of a warm relationship without explicit elaboration or specification (Castonguay et al., 2010).

The alliance in CBT differs in some respects from the types of alliances formed in other therapeutic orientations whereby a CBT alliance emphasizes teamwork more than other therapies (Raue & Goldfried, 1994). The model of “collaborative empiricism” (Beck et al., 1979, p. 6) is still central to cognitive therapy (Young, Rygh, Weinberger, & Beck, 2008). The collaborative relationship involves clients and therapists working together to identify problems and solving client concerns. This sense of collaboration is akin to two scientists working together, one providing the raw data while the other guides the research questions (Beck et al., 1979).

Another important distinction between how CBT and other orientations have treated the alliance underscores the role that this treatment factor is assumed to play in the change process. CBT is primarily concerned with specific techniques which can produce change (Castonguay et al., 2010). Thus, the alliance is treated as a factor that facilitates the use of techniques and as a vehicle for promoting therapeutic change and not as a change mechanism itself (Castonguay et al., 2010). Put another way, cognitive and behavioural therapists have viewed the alliance as a necessary, but not sufficient, therapeutic change factor (Beck et al., 1979; DeRubeis, Brotman, & Gibbons, 2005; Friedberg & Gorman, 2007).

**Postmodern Perspective**

An approach to alliance formation, based on constructivist ideas, emphasizes a relationship based on collaboration and mutual respect (Anderson, 1987; Richert, 2010; White & Epston, 1988)
whereby the client is both invited to co-construct new meanings and behaviours (Sexton & Whiston, 1994) and is viewed as the expert on his or her life and concerns. The emphasis on mutuality and collaboration serves to redefine the relationship by positing that people derive meaning through the power of social interaction, culture, beliefs, and language of a society. Gergen (1991), a proponent of social constructionism, purports that humans are not autonomous individuals, holding independent beliefs, but instead our beliefs change radically with changes in our social context. According to this perspective, clients are influenced by and require connection to others. A social constructionist framework can enhance the relationship by identifying new constructions of clients’ problems that opens space for problem resolution (Anderson & Goolishian, 1988; Freedman & Combs, 1996; Manfrida, 2011).

Postmodern perspectives have come under criticism from such figures as Salvador Minuchin (1991), a leading theorist in family therapy. Minuchin noted that an emphasis on the social construction of reality may, in fact, interfere with helping clients cope with the reality of their social injustices such as poverty and homelessness. In the face of these oppressions, a client’s situation is not simply a social construction but their personal reality. However, Buckman, Kinney, and Reese (2008) note that Minuchin’s critique has been refuted for resting on the assumption that only realists imbued with an objective view of reality can help clients cope with real problems and for failing to recognize that narratives can harden into reality.

**Therapeutic Alliance Ruptures**

Safran and Muran have been at the vanguard in the examination of alliance ruptures, also known as empathic failure, resistance and transference-countertransference enactments. Definitional variations of alliance ruptures include “deteriorations in the relationship between therapist and client” (Safran & Muran, 1996, p. 447), “a breakdown in the collaborative process, period of poor quality of relatedness between patient and therapist, a deterioration in the communicative situation, or a failure to develop a collaborative process from the outset” (Safran & Muran, 2006, p. 288). Although Rogers
viewed the relationship as unidirectional, Safran and Muran (1996) note that alliance ruptures emerge from both therapist and client contributions. Clients may demonstrate behaviours or communications requiring exploration in session while therapists may become caught in maladaptive interpersonal cycles similar to clients’ other interpersonal interactions, that serves to confirm clients’ generalized representations of self-other interactions (Safran, 1990).

Alliance ruptures may waver in intensity, duration, and frequency and may go undetected by either therapist or client; however, their negotiation rests at the core of the change process (Safran & Muran, 2000). Intense alliance ruptures can lead to a weakened alliance, thus resulting in dropout or treatment failure (Samstag, Batchelder, Muran, Safran, & Winston, 1998; Tryon & Kane, 1990, 1993, 1995). However, when a therapist manages an alliance rupture well, it can serve as the basis for therapeutic change and provide clients with a “new constructive interpersonal experience that will modify their maladaptive interpersonal schemas” (Safran, 1993). Given that clients may be neither willing nor able to voice their concern regarding a lack of comfort or disagreement with their therapist, it thus becomes critical for the therapist to recognize when the alliance is in jeopardy and address the rupture in a sensitive fashion to allow exploration and a minimum of client anxiety (Safran, Samstag, Muran, & Stevens, 2001). This is often easier said than done for both novice and experienced therapists may have difficulty recognizing when the alliance is in trouble (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996; Hill, Thompson, Cogar, & Denman, 1993; Regan & Hill, 1992; Rhodes, Hill, Thompson, & Elliott, 1994) and may have difficulty addressing alliance ruptures in a manner that improves treatment outcome (Fuller & Hill, 1985; Martin, Martin, Meyer, & Slemon, 1986; Martin, Martin, Meyer, & Slemon, 1987). A number of studies have shown that when therapists can respond to clients in a non-defensive fashion, adjust their behaviour accordingly, and address ruptures as they arise, the alliance may improve (Foreman & Marmar, 1985; Lansford, 1986; Rhodes et al., 1994).

Safran, Crocker, McMain, and Murray (1990) have developed a model for addressing alliance ruptures. This four stage model is predicated on the importance of identifying recurring states and
patterns in the psychotherapy process (Safran & Muran, 1996). Drawing from intensive observations of 15 psychotherapy sessions in which alliance ruptures had reached a degree of resolution, a four-stage model was developed which includes four patient states and four therapist interventions. In Stage 1 (Attending to the Rupture Marker), the client’s verbalizations or actions indicate the presence of a rupture in the alliance. Safran et al. (1990) dichotomized rupture markers into either those of withdrawal or confrontation (Harper 1989a, 1989b). In withdrawal rupture markers, the client withdraws or partially disengages from the therapist, his or her own emotions, or an aspect of the therapeutic process. In confrontation rupture markers, the client directly indicates anger, resentment, or dissatisfaction with the therapist or therapeutic process. The first therapist intervention facilitates the exploration of the rupture by directing the client’s attention to the immediacy of the therapeutic relationship or his or her experience (e.g., “What are you experiencing” or “I have a sense of you withdrawing from me”) (Safran & Muran, 1996).

In Stage 2 (Exploration of Rupture Experience), the client expresses negative feelings mixed with the rupture marker. This takes two major forms: one in which the client begins to express negative sentiments followed by qualifying the statement or taking it back (e.g., “I’m frustrated, but it’s more with the situation than you”), or the client expresses his or her feelings in a blaming or belittling fashion, as opposed to taking ownership of them (e.g., I’m sick and tired of you holding out on me”). The therapist now facilitates self-assertion by acknowledging his or her own contribution to the interaction and by refocusing on the here and now of the therapeutic relationship.

In Stage 3 (Exploration of Avoidance), the client typically gives some indication of anxiety or block and the therapist explores the interpersonal expectations, beliefs or fears that block the exploration of the feelings associated with the rupture. Safran and Muran (1996) note that a client who believes that angry feelings will result in retaliation will have difficulty acknowledging and expressing his or her angry feelings. In this stage the therapist probes for fears or expectations (e.g., “what do you imagine would happen if you expressed your angry feelings”). This exploration facilitates the client’s
ability to acknowledge and express feelings and thoughts associated with the rupture experience. The process of articulating interpersonal expectations that are often tacit in nature helps the client acknowledge and express negative feelings that are avoided because of these expectations (Safran & Muran, 1996).

In Stage 4, the final client state, (Self-Assertion), the client directly expresses his or her feelings or needs toward the therapist in a manner that involves the acceptance of responsibility for them (e.g., “I really want your help or “I’m angry at you” rather than “You’re not helping me” or “You make me angry”). Self-assertive statements imply a degree of autonomy or individuation not characteristic of statements that are demanding, blaming, pleading or apologetic. The therapist in turn intervenes by validating or empathizing with the client’s experience.

Therapeutic Alliance and Child Maltreatment

All modern theoretical perspectives place great emphasis on the therapeutic alliance and a strong alliance can facilitate clients disclosing their child rearing struggles to a clinician with the intent of seeking assistance. These perspectives to a greater or lesser degree view the client and clinician functioning as collaborators in the therapy process and developing a shared understanding of how the client conceptualizes discipline within the context of his or her beliefs, culture, and language. This shared understanding may lead to a reconsideration of a client’s disciplinary practices; however, during the shifting of parental perspectives, a clinician may find himself or herself debating the necessity of contacting the CAS.

Decision-making and Therapeutic Alliance Theoretical Literatures: Implications for Understanding the Mandatory Reporting of Child Maltreatment

The fields of medicine, psychology, social work, and marriage and family therapy all comprise various helping disciplines with different foci, theories, and approaches to patient or client care. Despite this divergence in scope, decision-making cuts across these disciplines and uncertainty surfaces as a core feature. Uncertainty as a clinical aspect of decision-making is highly complex and
comprised of multiple factors: personal, situational, ethical, legal, and circumstantial. Helping professionals must balance these factors to render decisions that are ultimately in the best interests of the client. The mandatory reporting of child maltreatment is arguably one of the most significant decisions a clinician can make for it concerns one of society’s most vulnerable populations. Failure to render a sound decision can have dire implications for the child, thus highlighting the ever-present reality of decision error.

This study argues that decision-making theory and alliance theory contribute to understanding the decision to report or not report suspected child maltreatment. What are unclear are the factors that social workers in particular take into account when making this decision and how the alliance is maintained following the decision to report. The expanded conceptual framework found on page 69 is a visual representation of these two theories.

Summary

This chapter explored the uncertainty inherent in clinical decision-making from the perspectives of medicine, psychology, social work, and marriage and family therapy. Each discipline proffers insights into the management of uncertainty, ranging from the utilization of evidence-based practices to including the perspectives of colleagues and clients. Reporting child maltreatment is an area of clinical concern rife with uncertainty and decision-making based on partial information. Social work carries the weight of decision-making around a most vulnerable population and the task of balanced decision-making while avoiding a too broad or too narrow focus.

The clinical relationship is the crucible that forms the basis of social work intervention. A clinical decision to report maltreatment, rendered in the throes of uncertainty, can lead to consequences that may foster or impede the relationship. This may lead some social workers to question the value and worth of their reporting actions.

The following chapter furthers this discussion by examining the empirical literature related to decision-making and therapeutic alliance in the context of reporting child maltreatment. A conceptual
framework by Brosig and Kalichman (1992) outlining decision-making within suspected child maltreatment is presented and critiqued. What follows is an expanded conceptual framework based on an integration of the theoretical and empirical literatures reviewed. This expanded framework provides the basis for this study.
CHAPTER THREE: CHILD MALTREATMENT EMPIRICAL LITERATURE AND CONCEPTUAL FRAMEWORK

Introduction

This chapter examines the existing empirical literatures of decision-making and alliance theory as they pertain to the mandatory reporting of child maltreatment. The discussion initially centres on the complexity of whether to report the often circumstantial evidence around a suspicion of child maltreatment. The empirical alliance literature on the mandatory reporting of child maltreatment is then explored and situated within the context of professional confidentiality. Finally, a conceptual framework by Brosig and Kalichman (1992) outlining decision-making within suspected child maltreatment is presented and critiqued before discussing an expanded conceptual framework that forms the basis of this study.

Decision-making Theory and Mandatory Reporting of Child Maltreatment

As reviewed earlier, Gambrill (2005) aptly notes that decision-making in the helping professions constitutes a high degree of uncertainty, as there is often insufficient information to have full confidence in one’s decisions. This is often the case when social workers make decisions concerning child maltreatment where the evidence may not be readily observable. Decision-making is also subject to factors such as doubtful evidence, questionable premises, suppressed evidence, vacuous guarantees, evading, overlooking or distorting facts that may compromise social workers’ decision-making process and have significant relevance to decisions around mandatory reporting (Gambrill, 2005).

Decision-making may also be hampered by constraining factors imposed on the decision maker such as ambiguous legislative wording or time constraints. In a qualitative study on the effects of child exposure to domestic violence, respondents from the health care sector explained that legislative amendments have had deleterious effects for physicians who are uncertain if they are to call the CAS, perceiving the legislation as ambiguous in the definition of exposure. In addition, if physicians, who
already experience burdens of patient volume and limited time, ask patients about domestic violence and receive an affirmative response, they set into motion additional responsibilities for themselves that further disrupt the flow of their workday (Alaggia, Jenney, Mazzuca, & Redmond, 2007).

Many individuals who seek the services of social workers exhibit multi-faceted and complex personal dilemmas such as health and mental health issues, violence committed towards their person, and loss of loved ones, often of an unexpected and traumatic nature. Client difficulties are often ambiguous and compounded by clients frequently asking social workers questions of a legal nature (Regehr & Kanani, 2006), hoping to clarify their situations or obtain information on a legal course of action. At the same time, social workers are compelled to act ethically and to comply with provincial, federal, and state laws. Child maltreatment, at heart, encompasses the intersection of law and social work for it is through legal mechanisms that children’s situations are reported, investigated, and in some cases, children are apprehended. Though not acting in the role of a lawyer, the profession of social work applies child-care law to human situations (Conti, 2011; Grace, 1994) and balances individual interests against the interests of society. The practice of professional social work is regulated by a variety of provincial, territorial, and state legislation that may have notable differences, thus the actions of a social worker may vary from province to province and state to state (Regehr & Kanani, 2006).

As an example, depending on the age of majority, a social worker in one province may need to report a situation to the CAS whereas a social worker in another province may not face this obligation (see Appendix 1 for a detailed summary of Canadian and American mandatory reporting laws). Thus, it falls to social workers to stay abreast of legislation within their jurisdiction and to familiarize themselves with new legislation should they move to another province or state as this will impact their decision-making processes regarding the reporting of child maltreatment.
Factors Influencing Clinicians’ Reporting Decisions: Contributions of Empirical Studies

Extant research has focused on identifying the factors that influence clinicians’ decisions to report child maltreatment. Reasons for reporting include the legal obligation to report and need to protect the child (Beck & Ogloff, 1995), the expectation that the report would have a positive effect on treatment (Kalichman et al., 1989), fear of malpractice (Cruickshanks & Skellern, 2007; Haines & Turton, 2008; Hansen et al., 1997), the clinicians’ personal history of maltreatment (Hansen et al., 1997), and the perception of perpetrator behaviour such as when a father admits to child maltreatment (Kalichman et al., 1989) or is non-compliant in admitting culpability (Kalichman & Craig, 1991).

Despite the long-term existence of mandatory reporting laws, studies of specific occupational samples have found variable rates for non-reporting child maltreatment including 12% of psychologists (Beck & Ogloff, 1995; Kalichman, Craig, & Follingstad, 1988), 21% of psychologists (Pope & Bajt, 1988), 25% of psychologists (Haas, Malouf, & Mayerson, 1988), 32% of family therapists (Green & Hansen, 1989), 34% of psychologists (Kalichman et al., 1989), 37% of psychologists (Kalichman & Craig, 1991), 51% of social workers (Zellman, 1990a), and 63% of psychologists (Swoboda, Elwork, Sales, & Levine, 1978). James, Womack, and Stauss (1978), in a survey of general practitioners and paediatricians, found these physicians would not report suspected child maltreatment unless the family concurred in the decision to report. In the same survey, 42% responded that they would report any case of sexual maltreatment. Saulsbury and Campbell (1985) found that 60% of the 252 physicians in their survey would report a suspected case of neglect. The implication of these statistics is considerable, given that the children in these non-reported cases are not afforded the opportunity for intervention and protection. As evidenced by the dates of these studies, specific occupational disciplines have historically shown varying degrees of reluctance to report child maltreatment. In the years following these studies both mandatory reporting legislation and professional discourse around mandatory reporting has shifted, for example, as noted in chapter one, in some Canadian provinces and territories, child witness to domestic violence has now been included in mandatory reporting legislation. Given
these legislative and professional discourse shifts it becomes imperative to examine the factors social 
workers take into account when rendering decisions concerning child maltreatment.

In critiquing these studies, it should be noted that the large majority focus on surveys directed 
specifically at licensed psychologists practicing within the United States, with the exception of the 
Beck and Ogloff study that focused on psychologists within Canada. The samples may not be 
representative of all licensed psychologists and the response rates across studies are variable and may 
influence generalizability. The determination of reporting or not reporting in these studies fell within 
broader research questions and was generally based on hypothetical vignette cases that may not reflect 
what these clinicians may actually do in practice. The studies also do not take into account that 
clinicians will have various levels in training regarding reporting of child maltreatment.

As demonstrated above, the existence of mandatory reporting laws does not guarantee 
compliance with reporting. Explanations for the lack of compliance include the following: concerns 
over disruption of the therapeutic relationship (Ansel & Ross, 1990; Harper & Irvin, 1985; Horwath, 
2007; Kalichman, 1993; Kalichman et al., 1989; Miller & Winstock, 1987; Muehleman & Kimmons, 
1981; Pope, Tabachnick, & Keith-Spiegel, 1987; Swoboda et al., 1978; Tower, 1992; Watson & 
Levine, 1989); uncertainty and discomfort of identifying and reporting child maltreatment (Beck & 
Ogloff, 1995; Camblin & Prout, 1983; Green & Hansen, 1989; Kalichman & Craig, 1991; Kalichman 
et al., 1989; Kenny & McEachern, 2002; Stein, 1984; Tower, 1992; Wilson & Gettinger, 1989; 
Zellman, 1990a); ambiguous mandatory reporting laws (Jones & Welch, 1989; Weisberg & Wald, 
1984); negative experiences with the child protection organization (Beck & Ogloff, 1995; Kalichman 
& Brosig, 1993; Kenny, 2001; Mathews & Kenny, 2008; Saulsbury & Campbell, 1985); potential legal 
and physical ramifications of reporting (Badger, 1989; Baily, 1982); unsupportive agency policies 
around reporting child maltreatment (Kenny, 2001; Kenny & McEachern, 2002); effects of reporting 
on the child and family (Tilden et al., 1994); and family and reporter characteristics (Barksdale, 1989; 
Eckenrode, Powers, Doris, Munsch, & Bolger, 1988; Haas et al., 1988; Newberger 1983; Nightingale
& Walker, 1986). Alpert and Green (1992) note that uncertainty concerning legal requirements, loss of the therapeutic alliance, fear of retaliation against the child, and lack of faith in the adequacy of the CAS were the most significant factors in electing to not report suspected child maltreatment.

Alliance Theory and Mandatory Reporting of Child Maltreatment

One of the most significant and potentially profound ruptures that can occur in a therapeutic relationship involves the social worker’s response to a disclosure of child maltreatment, potentially triggering a report to the CAS. In this context, social workers find themselves triangulated between maintaining the therapeutic alliance with the client and acting in an ethically and legally responsible manner (Brown & Strozier, 2004). Peterson (1992) describes the societal barriers that hinder the development of a relationship where healing can occur and amongst them is the legal apparatus that forces social workers to consider their professional responsibility at the expense of the relationship. Some social workers err on the side of maintaining the alliance by choosing to not report, while others report and attempt to moderate the consequent effects (Steinberg, Levine, & Doueck, 1997). Given that social workers are therapeutically oriented, as opposed to punitively oriented, many social workers view interfering with the therapeutic relationship to report child maltreatment as having more damaging than helping consequences. Despite social workers’ commitment and attempts to work collaboratively with clients, the therapeutic relationship is essentially hierarchical and social workers are subject to reporting laws.

Within the Canadian context of social work, the Canadian Association of Social Workers (2005) Code of Ethics requires that “social workers respect the importance of the trust and confidence placed in the professional relationship by clients and members of the public” (p. 7). Social workers within Canada are also subject to federal privacy laws (Regehr & Kanani, 2006) as well as provincial statutes governing confidentiality within education, child and family services, hospitals, and mental health (Solomon & Visser, 2005).
Mandated reporting tests the bonds of the therapeutic alliance to their fullest. In this context, Weinstock and Weinstock (1988) aptly write, “therapists are placed into the disquieting position of masquerading as empathic clinicians who become undercover police agents by betraying patient confidences” (p. 421). Heymann (1986) echoes these sentiments by stating “the client is still the same person, but there has been a sudden and drastic switch in social roles, whereby the therapist exits and the informer bursts in at the door” (p. 152). These words underscore the inherent tension and dilemma between providing empathy and abrogating the therapeutic role to act in accord with codes of ethics and laws. The introduction and expansion of mandatory reporting legislation places a higher value on the protection of children than on confidentiality between social worker and client (Steinberg et al., 1997). Thompson (1990) suggests that behaviour may be ethical and yet illegal (choosing to not report child maltreatment because of potential physical risk to the child), unethical and illegal (not reporting suspected child maltreatment because of a lack of knowledge regarding reporting procedures), or unethical and outside of legal jurisdiction (working with families where maltreatment has occurred without appropriate training or supervision). In cases where law and ethics compete, the social worker must decide between these conflicting, albeit legitimate, loyalties.

Confidentiality within the Counselling Relationship

Mandatory reporting necessitates a breach of confidentiality, which can erode the client’s trust in the social worker, cause a significant rupture in the therapeutic alliance (Safran & Muran, 2000) and endanger the therapeutic alliance (Agatstein, 1989; Berlin, Malin, & Dean, 1991; Chanmugam, 2009; Uchill, 1978; Zellman, 1990a). In essence, mandatory reporting laws lie in conflict with ethical standards for confidentiality that social workers are required to uphold (Kalichman et al., 1989) and place the actions of the social worker between the two earlier reviewed ethical principles of beneficence and nonmaleficence (Jordan & Meara, 1990; Kitchener, 1984). In a review of the psychotherapy literature, Graybar and Leonard (2005) note that the confidentiality and utter privacy that grounds the ethics of psychotherapy is cited as promoting healing. Elsewhere, confidentiality has
been regarded as the cornerstone of the therapeutic relationship (Jagim, Wittman, & Noll, 1978; Keith-Spiegel & Koocher, 1985).

Freud (1959) first underscored the need for absolute confidentiality in the psychoanalytic method when he noted “the whole undertaking becomes lost labor if a single concession is made to secrecy” (as cited in Everstine et al., 1980). More recently, Bollas and Sundelson (1995), in writing on the fundamental features of the psychoanalytic relationship, cite the necessity for unconditional therapeutic confidentiality for “absolute confidentiality permits the patient to harm the objects of his internal world and in doing so express fully in the presence of the analyst the precise nature of his mental conflict” (p. 77). Mandatory reporting legislation becomes punitive in light of the need for absolute confidentiality. Undergirding the notion of confidentiality is an individual’s right to privacy. Within the Canadian context, privacy is considered a basic human right and “reflects the right of an individual to control how much of his or her thoughts, feelings, or other personal information can be shared with others” (Keith-Spiegel, 1985, as cited in Cram & Dobson, 1993). Section 7 of the Canadian Charter of Rights and Freedoms (1982) states “everyone has the right to life, liberty, and security of the person and the right not to be deprived of fundamental justice” (p. 260).

Given that confidentiality is a central component in the therapeutic relationship (CASW, 2005; Corey & Corey, 1993; Cormier & Cormier, 1991) and is both an implicit and explicit standard (American Psychological Association, 1990), filing a report places the social worker in a difficult position. Failure to report may place the child at risk or in an unsafe position and place the social worker in an unethical position whereas reporting will breach confidentiality and may damage the therapeutic alliance, perhaps irrevocably (Bersoff, 1975; Chanmugam, 2009).

Informed consent undergirds the limits to confidentiality and mandated reporting. Although the ethical guidelines of most regulatory bodies emphasize the responsibility to inform clients of the limits of confidentiality, consent forms are either not provided or often do not contain information specific to confidentiality limits (Burkemper, 2004; Handelsman, Kemper, Kesson-Craig, McLain, & Johnrud,
56

Weinstein, Levine, Kogan, Harkavy-Friedman, & Miller (2000), in a survey of 258 social workers, psychologists and physicians of which 50% of the sample were social workers, it was found that 40% did not inform the client about the limits of confidentiality until reportable material was disclosed. Baird and Rupert (1987), in a survey of psychologists, found that only half the sample informed clients of confidentiality limits during the first therapy session whereas Otto, Ogloff, and Small (1991) found more than 90% of their sample addressed the issue of confidentiality with their clients. Nicolai and Scott (1994), in a survey of 204 practicing psychologists, found that four fifths of respondents provided specific information around suspected child maltreatment; however, almost 20% of the sample indicated that they sometimes, rarely, or never provided the information to clients and more than 5% informed clients that all disclosures are confidential. This last statistic is problematic for the novice client will assume that all disclosures, regardless of content, will be kept confidential.

The principle of informed consent centres on the standard that clients have the right to information that affects their decisions about what to disclose or not disclose to the social worker. There are three aspects to informed consent: comprehension of presented information, capacity to make rational decisions, and freedom from coercion (Bray, Shepherd, & Hays, 1985). In a study on the effect of information provided during in-session behaviours, Taube and Elwork (1990) found that clients who were made aware of the limits of confidentiality did not disclose as many child punishment and neglect behaviours as clients who were not informed of the limits of confidentiality. The authors believed that self-disclosure of issues around child maltreatment centred on two factors: how well the client understood mandatory reporting law and how relevant the child maltreatment law was to the personal situation in question. In examining this scenario from another perspective, does the provision of this information or lack thereof by the social worker alter in some fashion the actions of the clinician in the event of a disclosure?
Alliance Research in Cases of Suspected Child Maltreatment

Despite the plethora of studies on the therapeutic alliance between social worker and client, there are few studies conducted on the outcome of the therapeutic alliance following mandated reporting. Harper and Irvin (1985) undertook a retrospective study of 49 cases of medical neglect admitted to hospital and assessed the effect of the report on the parental alliance. In 2 of 49 cases parents discontinued treatment following the report, in 12 cases there was no stated change to the alliance, and in 35 cases the effect of reporting was positive or very positive. Researchers hypothesized that when the report takes place concurrently with treatment, the risk of premature termination is not likely to occur. They further surmised that the act of reporting contributes to the clinical work by orienting parents to the reality of their child’s situation and that parents may respond with relief to the report.

Watson and Levine (1989) also undertook a retrospective study of the written records in 59 cases where a mandated child abuse report was made or where the therapist suspected child abuse or neglect and communicated this concern to the client but did not file a report. Twenty-four percent of cases were classified as having a negative outcome with regards to the alliance (e.g., termination, missed appointments, lateness, client expressed anger, or threatened violence during session). Researchers found that reports or considerations of reports were more likely to have negative consequences when they were made about a client presently in treatment as opposed to a third party not in treatment. Of the 29 clients who were in treatment and who were the subject of a report, 31% had negative outcomes and only 6.9% had positive outcomes (e.g., client remained in treatment, showed increased self-disclosure or cooperation after the report). Of the 30 cases involving reports on third parties not in treatment, half as many (16.7%) were associated with negative outcomes and 33.3% showed positive outcomes. Watson and Levine (1989) hypothesized that this last finding is due to the greater breach of confidentiality felt by clients who are actually in treatment.
Steinberg et al. (1997) conducted a survey with psychologists (n=907) requesting them to describe a case involving reporting and the subsequent impact reporting had on treatment. Survey respondents reported that 27% of clients withdrew from treatment immediately or shortly after the report and the respondents attributed these premature terminations as resulting from their having filed the report. Similar to the Watson and Levine (1989) finding, Steinberg et al. found that when the perpetrator identified was not someone directly engaged in treatment, there was greater client retention than when the client was the alleged perpetrator.

Steinberg et al. (1997) also found that the more reports to CAS a therapist had made in the past, the less likely the client was retained in treatment following the report. Thus, a greater reporting history led to a decrease in the alliance following the report. The Steinberg et al. finding has not been replicated and currently remains unexplained. However, in the previous discussion on triangulated decision-making, Brown and Strozier (2004) purport, from a systemic viewpoint, the existence of a triangle between the therapist, family, and CAS, predicated on Bowen’s (1978) concept of triangulation. They put forth the hypothesis that a strong alignment between the therapist and the CAS, possibly forged on many previous reports to CAS, may lead to a distancing between therapist and family and thus, less likelihood that the client will be retained in treatment following the report.

Weinstein et al. (2000) undertook a survey of mental health professionals including psychiatrists, psychologists and social workers (n=258) where they asked professionals to describe their most recently reported case and the impact of reporting on the relationship with the client. In terms of outcome, in 72.7% of cases, there was a positive outcome (e.g., client expressed relief and increased self-disclosure), or no change outcome (e.g., the alliance remained unaffected). However, in 27.3% of cases, there was a negative outcome (e.g. client remained in treatment but with decreased disclosure or client terminated treatment). In a minority of cases (4%), clients made threats or attempted to harm the therapist following the report.
Studies have reported three factors which improve the therapeutic alliance in instances of mandatory reporting. First, the presence of a strong therapeutic alliance prior to reporting made the greatest contribution towards predicting outcome, with a stronger alliance associated with positive outcome (Harper & Irvin, 1985; Levine et al., 1995; Steinberg et al., 1997; Weinstein et al., 2001). This finding appears robust as it has been found across studies. Second, clients with a longer period of time in treatment at the time of the report tended to have more positive outcomes (Levine et al., 1995; Weinstein et al., 2001). Most clients were in treatment for about three months prior to the revelation of maltreatment. It is possible that the association of longer periods of time in treatment could reflect the strength of the alliance or may help clients overcome their reluctance at discussing maltreatment. Third, the more explicit the therapist was about the procedures for informed consent, the more positive the client’s response after the report (Steinberg et al., 1997). Previous research has shown that a discussion of confidentiality and its limits is important and useful to the therapeutic process (Bromley & Riolo, 1988; Crenshaw & Lichtenberg, 1993; Nicolai & Scott, 1994).

Summary

An examination of the empirical studies on decision-making and alliance within the context of mandatory reporting highlights the complexity of this clinical issue and sheds light on factors not previously considered. This examination also surfaces several limitations in previous studies: low response rates, small sample sizes, surveys restricted to one geographic area or to one mental health discipline that limits generalizability, recall bias, as well as surveys that sample frequent reporters versus sporadic reporters. In addition, studies utilizing prepared vignettes may be problematic in that the vignettes may not represent the contextual reality of actual practice. The expanded conceptual framework presented on page 69 is an attempt to provide a more comprehensive explanation of the factors clinicians consider when rendering decisions concerning suspected child maltreatment.
Brosig and Kalichman (1992) developed a conceptual model of the factors involved in clinician’s decision-making in cases of mandatory reporting. Their current model builds upon an earlier model of police decision-making around child maltreatment reporting as developed by Willis and Wells (1988). This earlier model suggested that a variety of factors influence child maltreatment reporting decisions, including: legal factors, characteristics of the officers, situational factors, organizational factors, and officers’ attitudes and experiences concerning reporting maltreatment. Viewing this model as applicable to clinicians, Brosig and Kalichman adapted Willis and Wells’ model to practising psychologists’ child maltreatment reporting decisions. The model is empirically based on the individual and collective works of Brosig and Kalichman as well as the work of other researchers in the field of mandatory reporting.

In this model, they outline three factors that affect the tendency to report: legal factors, clinician characteristics, and situational factors. It is unclear as to why organizational factors and attitudes and experiences of psychologists (rather than officers) concerning reporting maltreatment were not included in this model. These factors are believed to interact as the clinician weighs the decision to report (Herzberger, 1988). The following sections offer a summary and critique of the empirical evidence used by Brosig and Kalichman to build this conceptual model.

Legal Factors

Knowledge of the Law

Amongst the legal factors that affect clinicians’ decision to report child maltreatment, knowledge of mandatory reporting laws, interpretations of these laws, and legal requirements all impact whether a clinician reports or not. Swoboda et al. (1978) found that 32% of psychologists in their survey were not familiar with reporting laws and thus, were noncompliant in reporting suspected cases of maltreatment. As noted earlier, knowledge of mandatory reporting legislation does not guarantee compliance (Green & Hansen, 1989; Kalichman et al., 1989; Swoboda et al., 1978) despite
legal consequences for failing to report suspected maltreatment (Gray, 1987) and knowledge of the law has been found to be less important than clinicians’ interpretations of statutory wording and legal requirements (Brosig & Kalichman, 1992).

Statutory Wording

Statutory wording of mandatory reporting laws has been found to be a cause for concern, with vaguely worded statements potentially leading to underreporting (Finkelhor, 2005; Jones & Welch, 1989) or over reporting of maltreatment (Besharov, 2005; Solnit, 1982). Ambiguous legislative language such as “reasonable suspicion,” “cause to believe,” and “reasonable cause to know and suspect” are listed as potential reporting requirements and terms such as “maltreatment” and “neglect,” that lack precision in their definitions, confuse mandated reporters as to what constitutes reportable behaviour and leave much discretion to the reporter (Levi, Brown, & Erb, 2006; Levi & Loeben, 2004). Wording of this nature may lead mental health professionals to make decisions guided by factors of a personal or subjective nature that may have no relevance to the situation in question (Ashton, 1999).

The Levi et al. (2006) survey (n=42) focused specifically on paediatric residents’ understanding and interpretation of reasonable suspicion of child maltreatment and found wide variation in the thresholds set by medical residents. However, residents were not asked about their breadth of experience in reporting child maltreatment, thus the variability may be affected by increased experience with reporting. The Ashton (1999) survey focused on a convenience sample (n=86) of first year graduate students majoring in social work. The students examined 12 vignettes to test the hypothesis that age, gender, marital status, parenthood, and the worker’s personal perception of the seriousness of a given parental behaviour are related to the propensity to report. The study found that the sample considered all the incidents serious but age, gender, marital status and parenthood were not related to whether or not an individual would report. However, the mainly female composition of the sample may have obscured a relationship between worker characteristics and reporting behaviour.
Figure 1.

Model of Clinicians’ Willingness to Report Child Abuse (Brosig & Kalichman, 1992) (Reproduced with permission)
Legal Requirements

In addition, the legal requirements for reporting vary from province to province and state to state and definitions of maltreatment range from broad and general to narrow and specific (Jones & Welch, 1989), thus contributing to the confusion around reporting. Zellman (1990b) conducted an American study of mandated reporters including family practitioners, paediatricians, child psychiatrists, clinical psychologists, social workers, public school principals, and child care providers and found that clarity of understanding concerning legal requirements was most strongly related to the likelihood of reporting. When clinicians were clear as to when a report of child maltreatment was legally required, they were more likely to report. The Zellman (1990b) study focused on physicians, psychiatrists, clinical psychologists, social workers, public school principals, and childcare workers (n=1196). Respondents were asked to examine five vignettes describing possible child maltreatment with abuse-relevant judgments (characteristics of the alleged maltreatment, defined as abuse or neglect, and requirements of the law) being strongly related to reporting intentions. Sexual abuse was rated the most serious while physical abuse was rated the least serious.

Clinician Characteristics

Years of Experience

Brosig and Kalichman (1992) suggest that individual differences between clinicians are one source of the variability in reporting decisions. One such characteristic is the amount and extent of professional experience. Barksdale (1989) interviewed 10 psychotherapists and found that those professionals with more work experience were more likely to report a case of suspected child maltreatment and were less concerned with the potential negative consequences. Less experienced therapists were more concerned with potential negative attitudes toward reporting and thus, were less likely to report. Nightingale and Walker (1986) obtained similar results in a study with Head Start workers who offer family based services. When presented with a hypothetical case of child maltreatment, respondents with more work experience were more likely to report. Haas et al. (1988), in
a study of psychologists, found that psychologists with more years of experience (17.12 years) chose to report a hypothetical case of maltreatment less often than those psychologists with fewer years of experience (11.46 years). They hypothesized that the psychologists with greater years of experience may be more cynical about their ability to intervene successfully in a case of suspected child maltreatment.

It is important to examine these contradictory findings in light of the differing samples, methodologies, and definition of clinician experience. All three studies sampled varying categories of mental health professionals: psychotherapists, family workers, and psychologists. Methodologically, the Barksdale study utilized face-to-face interviews while the remaining two studies used anonymous questionnaires. Subjects may have provided different responses in interviews than in an anonymous questionnaire. Finally, the Barksdale study defined “experience” based on number of years practiced while the Nightingale and Walker study defined “experience” based on level of education.

Training

A second characteristic of clinicians that may impact reporting decisions is training in the recognition of child maltreatment. Nightingale and Walker (1986) surveyed 143 Head Start workers to determine the tendency to report based on having specific training in child maltreatment. The study found that clinicians with prior training in maltreatment identification were more likely to report suspected maltreatment. However, Kalichman and Brosig (1993), in a study with 297 licensed psychologists, found that those psychologists who had received continuing education in maltreatment identification were less likely to report suspected maltreatment than those who had not received such training.

Clinicians’ history of reporting may also affect their current reporting tendencies. Kalichman and Craig (1991) conducted a study of 328 licensed psychologists and used vignettes to test the limits of their hesitation to report. They found that psychologists who had previously failed to report were less likely to report a hypothetical case of abuse, whereas those who had reported in the past were
more likely to report a hypothetical case. This suggests that clinicians display a consistency in their reporting behaviours and may present biases for or against reporting. In separate surveys of practicing psychologists, Kalichman et al. (1989) and Kalichman and Craig (1991) found that 42% and 31% respectively indicated they believed reporting child maltreatment would adversely affect the process of family therapy. When presented with a case where the expected outcome of reporting was positive, psychologists were more likely to report than if the expected outcome was negative (Kalichman, et al., 1989). Similarly, Muehleman and Kimmons (1981) found that reporting hinged on what clinicians predicted as the consequences to the child and family.

**Attitudes and Experience**

Clinicians’ attitudes and beliefs about child maltreatment reporting laws are likely affected in turn by the consequences of their reporting experiences. Reporting maltreatment that results in the cessation of maltreatment or facilitation of therapy may increase the likelihood of future reporting whereas negative reporting experiences are likely to result in the decreased tendency of future reporting. Failure to report that is met by disruptions in therapy or litigation against the therapist will most likely increase future reporting, thus, “the effects of reporting on subsequent reporting decisions directly relate to the consequences of the decisions rather than the decisions themselves” (Brosig & Kalichman, 1992).

**Situational Factors**

**Victim Attributes**

The final factors that influence clinicians’ child maltreatment reporting decisions are those of a situational nature. Victim characteristics constitute the first factor. The victim’s gender has not been found to be a significant reporting factor (Kalichman et al., 1989); however, age was shown to be a factor when clinicians were presented with vignettes outlining a case of abuse of younger victims (age 7) as opposed to older victims (age 16) with clinicians more likely to report younger victims (Kalichman & Craig, 1991). Race and social class were also considered important. Newberger (1983)
found underreporting of maltreatment when clients were white and affluent whereas Jensen and Nichols (1984) found that maltreated children with an abusive father who was socially unattractive, meaning that he exhibited poor personal hygiene and was of a lower social class, were more likely to be reported than cases involving socially attractive persons.

Type and Severity of Abuse

Type of abuse constitutes the second factor and several studies have shown that sexual maltreatment is more likely to be reported than neglect or emotional maltreatment (Nightingale & Walker, 1986; Wilson & Gettinger, 1989; Zellman, 1990b). The severity and timing of maltreatment is also important as Green and Hansen (1989) found that psychologists would be less likely to report if suspected maltreatment was not severe and Wilson and Gettinger (1989) found that maltreatment described as presently happening was more likely to be reported than maltreatment described as occurring in the past. These results indicate concern over how clinicians formulate their reporting decisions; these decisions hinge on the clinician’s subjective judgment of what constitutes severe and current maltreatment.

Availability of Evidence

The last situational factor concerns the clinicians’ level of certainty that maltreatment has, in fact, occurred. This may depend on the amount of evidence that is presented (Watson & Levine, 1989). Kalichman et al. (1989) and Kalichman and Craig (1991) found that cases where the child provided a verbal accounting of maltreatment were more likely to be reported. This is a significant finding for many maltreated children remain silent due to the fear of aversive consequences of disclosing maltreatment (Pierce & Pierce, 1985). This last finding is based on an analysis of 205 substantiated cases of childhood sexual abuse.

Reporting also increases when the child has physical signs of maltreatment or a parent admits to being abusive (Kalichman et al., 1989). These cases demonstrate that increased evidence correlates with increased certainty of maltreatment that, in turn, correlates with a greater likelihood of reporting
(Kalichman et al., 1989). However, increased evidence may imply more serious maltreatment (Zellman, 1990a). Thus, noncompliance with mandatory reporting laws may relate to the uncertainty of the validity of their suspicions and lead clinicians to seek further evidence prior to reporting. This could be problematic for when clinicians act as investigators, role confusion is often the result (Melton & Limber, 1989). In addition, clinicians’ dependency on evidence for certainty in their decisions may be a direct result of vague statutory wording.

**Model Limitations**

Brosig and Kalichman (1992) have presented a foundational model of decision-making in mandatory reporting that includes the impact of legal factors, clinician characteristics and situational factors. However, their category of victim attributes is limited to age, race, and social class only. As well, regarding parenting, they do not operationalize the contextual factors of culture, religion, and immigration on parenting practices and discipline. Also, the model does not take into account a family’s previous involvement with child protection agencies that has been shown to be a factor in reporting decisions (Eckenrode et al., 1988; Katz, Hampton, Newberger, Bowles, & Snyder, 1986). The model does not examine how the social location of the clinician could impact decision-making as will be argued in the expanded and revised model.

The model does not take into account the intersectionality of the legal, characteristic, and situational factors but displays each factor as independent entities. With the exception of the clinician characteristics, the arrows flow in a unidirectional fashion from each factor to the decision to report suspected maltreatment. In all likelihood, these factors are not distinct entities. The arrow from clinician characteristics to the decision to report suspected maltreatment is bi-directional, thus implying that clinicians will further reflect or be influenced by their own characteristics in a case of suspected child maltreatment.

Brosig and Kalichman (1992) view the decision to report suspected child maltreatment as residing solely within the clinician and do not take into account consultation with colleagues,
supervisory processes, and anonymous telephone contact with child protective services, or accessing the legal resources of a clinician’s regulatory body within the model. This is surprising given that a year following the publication of their model, Kalichman and Brosig (1993) found that 80% of practicing psychologists discussed cases of suspected maltreatment prior to reporting.

Brosig and Kalichman do not consider the clinicians’ experience of reporting child abuse as playing a factor in their decision-making. This experience is important to examine as the view held by the clinician of his or her respective CAS can either promote or impede whether the clinician reports or not. The power held by the CAS in terms of investigation, protection, and removal should make it a factor to be considered. Finally, the proposed factors in the Brosig and Kalichman model rest on studies that contain various methodological limitations: surveys which sample a solitary mental health discipline and small sample sizes.

Expanded Conceptual Framework

The conceptual framework on page 69 expands Brosig and Kalichman’s legal, clinician, and situational factors to include elements not articulated in their original model, namely professional factors. The expanded conceptual framework outlines the complexity social workers face when presented with a suspicion of child maltreatment. The elements to be investigated in the present study are highlighted in grey. The following sections outline the theoretical and research literatures supporting the inclusion of these additional factors.
Figure 2.

Expanded Conceptual Framework (Decision-making)

- **LEGAL FACTORS**
  - Knowledge of the Law
  - Statutory Wording
  - Legal Requirements

- **CLINICIAN FACTORS**
  - Personal Disciplinary History
  - Comfort with Conflict
  - Personal Experience with CAS
  - Gender
  - Parenthood
  - Attitude Towards the Children's Aid Society

- **SITUATIONAL FACTORS**
  - Victim Attributes
  - Type of Abuse
  - Severity of Abuse
  - Availability of Evidence
  - Circumstances Around Disclosure (recantation / confirmation of abuse, person disclosing abuse)
  - Culture, Religion & Ethnicity

- **PROFESSIONAL FACTORS**
  - Years of Experience
  - Training
  - Attitudes and Experience
  - Reporting History
  - Consultation / Supervision
  - Field of Practice

- **RELATIONSHIP FACTORS**
  - Relationship with the Client
  - Concerns about the Impact on the Relationship

---

**DECISION MAKING PROCESS**

- **REPORT**
  - STEPS TAKEN TO AVOID / REPAIR RUPTURE IN RELATIONSHIP
    - Telephone contact
    - Additional sessions
    - Validate emotions
    - Home visit

- **NOT REPORT**
  - RELATIONSHIP WITH THE CLIENT AND CONCERNS ABOUT THE IMPACT ON THE RELATIONSHIP
**Legal Factors**

*Regulatory Body Requirements*

Regulatory body requirements constitute a factor in a social worker’s decision to report in addition to knowledge of the law, statutory wording, and legal requirements. Increasingly, clinicians in various health and mental health services are required to be members in good standing of their regulatory body in order to secure and maintain employment. Codes of ethics and standards of practice within regulatory bodies provide guidelines with regards to issues of confidentiality, informed consent, and mandatory reporting of child maltreatment and may differ from profession to profession (AAMFT, 2001; CASW, 2005; NASW, 2008).

**Clinician Factors**

*Personal Disciplinary History*

Personal disciplinary history was not considered in the previous model and concerns the personal discipline the social worker received during his or her formative years. The experience of hearing a child or adult recount a discipline experience within a professional capacity is likely to generate reflection and possible emotional response regarding one’s own disciplinary history (Baginsky, 2003; Buckley, 2000). The relationship between how adults were disciplined during their formative years and their beliefs about discipline and maltreatment is complex; for example, a social worker who experienced a type of punishment as a child is more likely to feel that this type of punishment is appropriate and approve of its use unless his or her appraisal of the experience is negative (Ashton, 2001; Bower & Knutson, 1996; Buntain-Ricklefs, Kemper, Bell, & Babonis, 1994; Hemenway, Solnick, & Carter, 1994). Negative appraisals generally include feelings of rejection, unfairness, harshness or abuse and thus, lead to a decreased likelihood of endorsing this form of punishment as normative (Kelder, McNamara, Carlson, &
Lynn, 1991; Schenck, Lyman, & Bodin, 2000). This is very much an individual value judgment for parental behaviour considered to be serious by one social worker may not be viewed as serious by another social worker. Social workers who assessed their childhood experiences of discipline as abusive were more likely to suspect potential or questionable abuse (Hansen et al., 1997; Nuttall & Jackson, 1994). Conversely, punishment not appraised to be abusive or harsh is or was more likely to be evaluated as appropriate, which may be legislatively problematic as mandated reporters may be required to report behaviours they experienced and labelled as appropriate forms of discipline.

Comprehending Conflict

A social worker’s comfort with conflict comprises the second clinician factor. Previous studies found clinicians were concerned with the reaction of parents to a report to the CAS (Badger, 1989; Vullimay & Sullivan, 2000). A social worker who experiences difficulty managing conflict and who perceives that a client will become angry or upset may be more hesitant to inform parents that a report will be made despite having the best of intentions to maintain the therapeutic alliance following the report.

Personal Experience with CAS

Social workers who were involved with the CAS during their formative years may be impacted either positively or negatively by this involvement now that they are acting in the role of a professional. A previous positive experience with the society may engender a willingness to involve the society whereas those social workers with an unfavourable experience may be reluctant to utilize their services. Although this aspect of the decision-making equation has not been the focus of investigation in previous studies, the American Psychological Association asserted “psychologists recognize that personal problems and conflicts may interfere with
professional effectiveness. Accordingly, they refrain from undertaking any activity in which their personal problems are likely to lead to inadequate performance” (p. 2). Thus, for psychologists with a personal history of abuse or neglect, these experiences may render their decision-making around reporting child maltreatment additionally complex (American Psychological Association, 1990).

**Gender**

Gender may also factor into the decision-making process; however, the evidence is contradictory. Attias and Goodwin (1985) found differences in the reporting behaviour of male and female clinicians with regards to sexual abuse with 79% of female clinicians indicating they would report incest despite recantation by the child as compared to 62% of male clinicians. Other studies have also found gender to be a factor in reporting decisions (Broussard, Wagner, & Kazelskis, 1991; Dukes & Kean, 1989). Despite these findings, however, Kalichman et al. (1989) found no gender differences in psychologists’ reporting behaviour in either physical or sexual maltreatment. Ashton (2004) also found gender was not related to the likelihood of reporting.

**Parenthood**

A factor not included in the previous model and one that has received scant attention in the literature, concerns the social worker’s status as parent. This could have implications given that the social worker himself or herself is not simply hearing about parental discipline from the client but is currently in the role of disciplinarian to a minor child. Parenting one’s own child may surface discipline issues previously unconsidered and may foster opinions about what constitutes acceptable or unacceptable parenting practices. Snyder and Newberger (1986) found that parenthood was a significant predictor (p < .05) of seriousness ratings among social workers
and psychologists evaluating child maltreatment, specifically sexual abuse. Ashton (2004), however, found that parenthood was not related to the likelihood of reporting.

Attitudes Towards the Children’s Aid Society

A social worker’s attitude towards the functioning of the child welfare system may affect his or her decision-making processes. Tilden et al. (1994) found that the primary reason why clinicians choose to not report suspected cases of child maltreatment is that doing so unleashes a series of events which unfold outside their control. Indictments of the CAS include the inadequacy of child protection workers to conduct thorough investigations given a lack of training in how to assess family violence, lack of overall funding for the society, failure by intake and investigation workers to not take reports seriously, negative responses by child protection workers towards the reporter, failure to protect other children residing in the home, and a lack of respect or failure to understand the therapeutic interventions previously undertaken by the clinician (Strozier et al., 2005). Previous reporting experiences can foster the development of certain attitudes and an opinion regarding the functioning of the CAS and may influence willingness to report (Brown & Strozier, 2004). If a social worker believes that a situation will not be investigated due to lack of resources or not taken seriously, this may affect his or her decision to report.

In addition, the CAS does not investigate all reports but screens incoming allegations and investigates cases selectively (Finklehor & Zellman, 1991; Sedlak & Broadhurst, 1996). The selective screening procedures may contribute to a divergence between mandated reporters’ expectations and the response of the CAS for social workers may assume that the CAS will respond to and investigate any and all allegations.
Situational Factors

Culture, Religion & Ethnicity

Although type of maltreatment was discussed in the previous model with regards to physical and emotional abuse, and neglect, these perspectives do not consider the diversity in parental discipline from the perspectives of culture, religion, and ethnicity. Parents immigrating to Canada and the United States may engage in child rearing practices considered non-normative or harsh compared to those deemed acceptable in Canada and the United States and may be mistaken for maltreatment (Chang, Rhee, & Weaver, 2006; Dubowitz, 1997; Fontes, 2002, 2005; Maiter, 2004). How social workers differentiate cultural parenting practices from child maltreatment while factoring in legal reporting obligations is unclear (Terao, Borrego, & Urquiza, 2001).

Circumstances Around Disclosure

Given that a disclosure of child maltreatment can take place without the child present, the dilemma for the social worker is to render a decision concerning the welfare of the child in the absence of actually seeing or interacting with the child (Agatstein, 1989). Thus, social workers are basing the reports on the accounting of the clients before them. Some clinicians do not report and instead wait for additional evidence to appear to confirm if the situation warrants reporting (Strozier et al., 2005). However, waiting for additional evidence is problematic, as the majority of legislation requires the reporting of a suspicion of child maltreatment and not evidence that it has occurred. Studies have shown that when a child disclosed maltreatment, when the father admitted to maltreating a child and when the father refused to attend treatment, the clinician was more likely to report maltreatment (Kalichman et al., 1988; Kalichman et al., 1989; Kalichman & Craig, 1991). In addition, evidence of previous maltreatment has been shown to have a
significant impact on clinicians’ decisions to report (Zellman, 1992). Zellman (1992), in a large study (n=1,196) of physicians, paediatricians, psychiatrists, clinical psychologists, social workers, public school principals, and child care workers, found that when previous maltreatment was presented in vignettes to clinicians, they perceived the law to require a report and that the report would have a salutary effect on the child and the family. Recantation has also been shown to impact clinician decisions. In the same study, Zellman (1992) found that when the victim retracted her accusation when questioned by an authority figure, this led to ratings that substantially reduced the likelihood of reporting.

**Professional Factors**

**Reporting History**

Kalichman and Craig (1991) found that clinicians who had a history of failing to report child maltreatment were less likely to report. Some clinicians may possess a bias towards reporting or not reporting. In all likelihood, the bias in reporting or not reporting lies at the intersection between their knowledge and understanding of the law, their profession’s guidelines, and their personal values (Haas et al., 1988). However, as social workers within Canada and the United States are legally obligated to report suspected cases of child maltreatment, a social worker maintaining a personal bias against reporting might actually fail to report a case of suspected child maltreatment which may result in harm to the child.

**Consultation / Supervision**

Consultation and supervision may also be a consideration within professional factors. The guidelines for Canadian psychologists include consultation with colleagues who could serve as advisors in challenging cases (Finlayson & Koocher, 1991), thus recognizing the value in obtaining differing perspectives when making complex decisions. Elsewhere, teams are
considered to be an appropriate form of peer supervision within the field of marriage and family therapy to assist the clinician with blind spots or biases (Haverkamp & Daniluk, 1993), as well as to assist arriving at a determination to make a report to the CAS (Flaherty et al., 2008; Strozier et al., 2005). Reporting child maltreatment directly to the CAS may not necessarily be the first action taken and some institutional policies mandate prior notification of supervisory personnel about suspected maltreatment prior to reporting (King, Reece, Bendel, & Patel, 1998). Finally, Weinstein et al. (2000), in a survey of social workers, psychologists, and physicians, found that almost 92% of the respondents consulted with at least one source prior to reporting and these sources included supervisors, colleagues, and the CAS intake line. The high percentage of clinicians who engaged in a process of consultation suggests the need for both clarification and support for the decision prior to making the report. In situations where a case involves parental discipline practices based on cultural norms but deemed questionable in the eyes of the social worker, it may be advisable to seek consultation to better inform the decision to report suspected child maltreatment (Terao et al., 2001).

Field of Practice

There is a paucity of research on how a social worker’s field of practice impacts one’s decision to report suspected child maltreatment. The majority of existing studies focus on the distinctions between mental health professionals such as social workers, psychiatrists, and psychologists; however, they fail to delineate fields of practice within each profession. One study by Delaronde, King, Bendel, and Reece (2000) did examine social workers, physicians, and physician assistants employed within four primary work settings: individual practice, group practice, hospital-based, and social service / school to determine their preference for an existing child maltreatment reporting policy or an alternative reporting policy. This latter category refers
to reporting only certain types of suspected maltreatment while reserving less severe cases for consultation with a specialist functioning independently from the CAS. The study found that those individuals who worked in individual practice were significantly (p < 0.05) more likely to favour the alternative policy than those in group practice or in a hospital setting.

**Relationship Factors**

**Relationship with the Client**

A social worker’s relationship with the client may factor into the decision to report to the CAS. Given that some clients regularly attend treatment for months or years, frequent sessions and working through challenging personal issues contribute to the formation of a strong, clinical relationship. Weinstein et al. (2000) found that clients had been in treatment for roughly 3 months prior to the disclosure of reportable child maltreatment material. Thus, clinicians in the Weinstein et al. study had potentially formed powerful, therapeutic relationships with their clients. Although not within the field of social work, Vullimay and Sullivan (2000) found that 44% of paediatricians chose to not report for fear of jeopardizing the relationship with the parents and Morris, Johnson and Clausen (1985), found that familiarity of the reporter with the family was a consideration in the decision to report.

**Concerns about the Impact on the Relationship**

Closely related to the concern over the relationship with the client is the concern over the impact of reporting on the relationship (Ansel & Ross, 1990; Harper & Irvin, 1985; Horwath, 2007; Kalichman, 1993; Kalichman et al., 1989; Miller & Winstock, 1987; Muehleman & Kimmons, 1981; Pope et al., 1987; Swoboda et al., 1978; Tower, 1992; Watson & Levine, 1989). Indeed, alliance outcome studies in cases of mandatory reporting have consistently shown that roughly one-quarter of cases were classified as having a negative outcome with regards to the
alliance (e.g., termination, missed appointments, lateness, client expressed anger, or threatened violence during session) (Steinberg et al., 1997; Watson & Levine, 1989; Weinstein et al., 2000).

The synthesis of the conceptual and research literatures of the 10 identified factors that contribute to social worker decision-making in suspected child maltreatment, render apparent the divergent and, at times, contradictory findings. The expanded model, based on the conceptual and research literatures, attempts to contextualize the factors that contribute to the decision-making of social workers, and incorporates professional and CAS factors while meeting the expected demands of mandatory reporting laws.

Summary

Decision-making within the context of mandatory reporting is often made in the throes of ambiguity and uncertainty and for social workers, is imbued with the need to balance individual interests with collective interests. Despite the existence of mandatory reporting laws, the empirical evidence surfaces a plethora of factors that influence the decision to report suspected child maltreatment, thus emphasizing the non-linear nature of the decision while highlighting the occurrence of non-reporting. Given this reality, it is imperative to further explore the factors which impact social workers’ decision-making. Brosig and Kalichman are commended for presenting a conceptual framework to understand some of these factors; however, the expanded conceptual framework outlined in this chapter presents a more fulsome picture of the potential factors based on the empirical literature.

Chapter 4 presents the pertinent elements of the methodology used in this study, including the sampling and data collection procedures. The survey design and rationale are explored in depth.
CHAPTER FOUR: METHODOLOGY

Introduction

This chapter introduces the research questions to be explored in the study. The chapter continues with an in-depth examination of the sampling procedures and outlines the design of specific features of the survey including the vignettes, quantitative, qualitative, and demographic questions. Finally, data collection procedures are detailed.

Research Design and Questions

The aims of this study are to delineate the factors that guide Ontario social workers’ decision-making when rendering decisions on mandatory reporting of child maltreatment and to understand how social workers maintain the therapeutic alliance with children and families following the decision to report suspected child maltreatment. An online, cross-sectional survey design using vignettes followed by Likert-type questions was used to explore these aims (see Appendix 2 for the complete survey). In addition, qualitative comments were elicited from respondents to further explore and refine the quantitative data.

Four overall research questions form the focus of this study:

1. What are the factors that predict a social worker’s decision to report or not report suspected child maltreatment?

2. What is the interaction between legal, clinician, situational, and professional factors?

3. What factors predict the likelihood of social workers undertaking specific steps and actions to maintain the therapeutic alliance once they report suspected child maltreatment?

4. What are the strategies to maintain the therapeutic alliance after social workers report suspected child maltreatment?
Sampling Procedures

The study population focused on (a) residents of Ontario; (b) who had completed a bachelor’s (BSW), master’s (MSW), or PhD degree (or any combination) in social work; (c) who were registered members of the OASW; (d) who had an active email account with the OASW; and (e) who were engaged in clinical practice that has necessitated taking various factors into account when rendering a decision concerning child maltreatment. The social worker’s engagement in clinical practice may have existed currently or within the past five years to account for those professionals who may have moved to administrative or research positions but who in the recent past worked in a clinical role. Engagement in clinical practice also included social workers working on a full-time or part-time basis. This information was stated upfront in the information letter as well as the introduction to the survey so that the potential respondents could determine their eligibility.

The sampling frame (Rubin & Babbie, 2005) was the 2010 electronic membership list of the OASW. The OASW is a voluntary, non-profit, provincial association for social workers. As a provincial branch of the Canadian Association of Social Workers (CASW), the OASW had 3,048 members with active email accounts and who were willing to receive research surveys. Approximately 747 members either did not have email accounts or did not accept ads / outside requests (R. Mascherin, OASW, personal communication, February 16, 2010). The breakdown of the OASW membership status is presented in Table 1.
Table 1.

**OASW Membership Status and Number**

<table>
<thead>
<tr>
<th>Membership Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members working full time</td>
<td>1,452</td>
</tr>
<tr>
<td>Members working part-time</td>
<td>689</td>
</tr>
<tr>
<td>Unemployed members*</td>
<td>361</td>
</tr>
<tr>
<td>Students</td>
<td>199</td>
</tr>
<tr>
<td>New graduates (1(^{st}) year)</td>
<td>153</td>
</tr>
<tr>
<td>Retired members</td>
<td>99</td>
</tr>
<tr>
<td>New graduates (2(^{nd}) year)</td>
<td>82</td>
</tr>
<tr>
<td>Non-residents</td>
<td>13</td>
</tr>
</tbody>
</table>

*includes those members on maternity leave or members who are working less than 10 hours per week

For the purposes of this study, unemployed members, students, and non-residents were excluded. Unemployed members were excluded since it could not be differentiated as to how many were not engaged in active practice and how many were practicing on a limited basis. Students were excluded as their education was not yet complete and non-residents were excluded given that the survey was specific to the Ontario context. Excluding these three categories left a total of 2,533 members who received the survey.

G*Power analysis was used to determine the statistical power (Erdfelder, Faul, & Buchner, 1996). It was determined that the responses of 335 members of the OASW were required. This figure was based on an alpha of 0.05, an effect size of 0.05, and power of 0.80 with 10 predictors. Assuming a conservative response rate of 30%, the survey needed to include 1,117 members (335 / .30).

An examination of previous surveys of mandated reporting with social workers reveals some variation in the expected response rate. Four surveys that included social workers amongst other professions, obtained response rates of between 55% - 86% specifically for the social work respondents (Delaronde et al., 2000; King et al., 1998; Tilden et al., 1994; Zellman, 1992). It should be noted that these surveys involved aggressive follow-up with respondents. To provide a
point of comparison, surveys of mandated reporting with licensed or registered psychologists obtained lower response rates of between 40% - 70% (Beck & Ogloff, 1995; Brosig & Kalichman, 1992; Finlayson & Koocher, 1991; Kalichman & Craig, 1991; Kalichman et al., 1989; Kennel & Agresti, 1995). This survey did not obtain the high response rate as in the above noted studies. The authors in the Delaronde et al. (2000) study utilized a combination of mail and telephone follow-up procedures to ensure a high response rate while the authors in the King et al. (1998) study sent a follow-up survey accompanied with a letter from the president of the state professional association of social workers. This survey relied exclusively on follow-up emails to respondents only, thus a more conservative response rate of 30% was anticipated.

The survey was intended for social workers who were in direct practice with children and families or who were engaged in direct practice within the last five years. However, the OASW did not keep records of the field of service of their membership, thus, given the wide range of occupational specializations of their membership (such as gerontology, social advocacy, community work), it was necessary to survey the entire population of 2,533 members with active email accounts and who were willing to receive research surveys.

Survey Design

The data collection instrument was a self-administered survey designed by the principal investigator consisting of vignettes, closed-ended (quantitative) statements and open-ended (qualitative) questions. The survey was written and distributed exclusively in English. According to the OASW, of the entire membership, fewer than 100 members indicated being Francophone (R. Mascherin, OASW, personal communication, June 9, 2010), thus, given the membership’s facility with the English language, limiting the survey to English did not bias the results. The survey also required a level of proficiency in reading and writing skills. However, as this survey
was directed at members who had at least one university degree in social work, it was anticipated that they had a relatively high level of reading and writing ability. The survey also required some proficiency in computer skills and typing ability; however, it was again anticipated that members of the association had sufficient technological skills to navigate the survey.

Vignette research is commonly used in surveys studying actions taken within the context of reporting suspected child maltreatment. They are constructed to examine variables related to factors around reporting child maltreatment such as age, gender, marital status, parenthood (Ashton, 1999), breadth of reporting laws (Brosig & Kalichman, 1992), reporting history, training in mandatory reporting (Compaan, Doueck, & Levine, 1997), tendency to report (Kalichman et al., 1989), and victim age, victim gender, perpetrator gender (Kennel & Agresti, 1995).

The benefits of using vignettes in studies on the reporting of suspected child maltreatment are manifold. One, as vignettes focus on the present circumstances, the methodological concern with recall bias is eliminated. Two, vignettes allow for the manipulation of variables for hypothesis testing. This is important to the present study and is also advantageous in the face of legislative amendments as to maltreatment typology which may now be reportable (i.e., child witness of domestic violence). Three, vignettes allow for the contextualization of practice. In the present study, the three contexts included a community mental health centre, a family counselling centre, and a hospital. These are common workplaces for social workers who may presently or formerly be employed in these locales. Four, vignettes allow for a more fulsome description of case details which adds richness to the case. Five, with the exception of the manipulated variable, the vignettes in the present study were standardized with respondents receiving the same vignettes. Standardization allows for more accurate
comparison between respondents. Six, studies have indicated that the use of vignettes is a valid measure for the likelihood of reporting child maltreatment (Feng & Levine, 2005; Hansen et al., 1997; Zellman & Bell, 1990). Seven, results may be combined during analysis with demographic factors relating to the decision maker (Taylor, Dempster, & Donnelly, 2007). Finally, vignette methodology has a long history of use in psychology and education (Lopez, 1989). Despite the centrality of decision-making within social work, research to date has mainly focused on qualitative methodology (ethnography, case records, interviews, focus groups, and diary methods) while quantitative methodology has received more limited attention (Taylor, 2006). This study seeks to redress this final point.

One disadvantage of vignette research is that the vignettes represent hypothetical cases with albeit rich but limited information. However, the vignettes constructed for this survey were contextualized to common social work practice settings; provide the age of the child; detail the length of time in treatment; manifest common emotions expressed during therapy such as anger or crying; and provide a brief but relatively detailed description of the concern. The inclusion of these important contextual elements serves to shift the vignettes from the hypothetical to the plausible. A second disadvantage of vignette research concerns external validity given the presence of multiple factors in the decision-making process; the respondent not treating the study as ‘real’ (Campbell, 1957; Carroll & Johnson, 1990).

The vignettes and survey questions were written by the author and the process occurred in two stages:

Stage One: The Initial Design

The first stage involved an in-depth engagement with the literature to determine how vignettes are constructed (Fowler, 2009) and to view actual examples (Ashton, 1999; Brosig &
Kalichman, 1992; Compaan et al., 1997; Kalichman et al., 1989; Kennel & Agresti, 1995). An examination of previously used vignettes in surveys within the context of mandatory reporting took place to understand their use in research. The study author then initially designed various vignettes outlining suspected maltreatment and consulted with the intake department at the Children’s Aid Society of Toronto around the appropriateness of the vignettes for use in this study. To ensure content validity, the vignettes were based on current child maltreatment legislation in Ontario given that the study was taking place in the Ontario context. The expanded conceptual framework (p. 69) was used to guide the construction of the vignettes and survey questions and included selected variables within the legal, clinician, situational, professional and relationship factors. Specifically, the study author wanted to test the following variables: Regulatory Body Requirements; Consultation / Supervision; Comfort with Conflict; Culture, Religion & Ethnicity; Circumstances Around Disclosure; Reporting History; Attitude Toward CAS; and Field of Practice. These variables were included in the case characteristics and in the survey questions following each vignette. Two additional variables, Parenthood and Gender, that are characteristics of the respondent, were included in the demographic section. A number of other variables within the legal, clinician, situational, professional, and relationship factors were not tested in this study (variables not highlighted in grey on page 69) as they were previously explored for the Brosig and Kalichman model. Although the variables Personal Disciplinary History and Personal Experience with the CAS may impact the decision to report or not report suspected child maltreatment, they were not examined in the present study. These variables pertain to respondents’ experiences during their formative years which are not the focus of this study.
Stage Two: Content Testing

Once the survey was initially prepared and to ensure face and content validity of the instrument, ten MSW post-degree social workers and one MA / PhD social worker were invited to complete the survey and respond to a feedback sheet (see Appendix 3). The 11 individuals were selected based on their previous experience in the child welfare sector or in children’s mental health settings. Of the 11 respondents, 6 provided feedback on issues of length and clarity of vignettes, instructions, and questions (Fowler, 2009). Through discussion with the pilot test respondents and examination of their feedback forms, revisions were made to the survey which involved additions to the instructions or the elimination or modification of certain questions or statements.

Stage Three: The Final Survey

Section A of the final survey contained 3 vignettes with one manipulated variable in each and 12 Likert-scale questions that examined the factors to be studied. Recantation of abuse / confirmation of abuse, the manipulated variable in Vignette 1, were included as they have not been tested within the Canadian context. Immigrant parents / Canadian born parents, the manipulated variable in Vignette 2, were included as parents immigrating to Canada may engage in child rearing practices considered non-normative or harsh compared to those deemed acceptable in Canada and may be mistaken for maltreatment (Dubowitz, 1997; Fontes, 2005). This manipulated variable helped to explore how social workers differentiate discipline practices with parents from different cultures. Parent discloses / child discloses, the manipulated variable in Vignette 3, were included as studies have shown that when a child disclosed maltreatment, when the father admitted to maltreating a child and when the father refused to attend treatment, the clinician was more likely to report maltreatment (Kalichman et al., 1988; Kalichman et al.,
Each of these manipulated variables was included to understand the role of that particular variable on social workers’ decision-making.

Vignette research on suspected child maltreatment may range from one or two vignettes (Brosig & Kalichmann, 1992; Brown & Strozier, 2004) to eight or nine vignettes (Ashton, 2004, 2007; Haas et al., 1988; Howe, Herzberger, & Tennen, 1988; Renninger, McCarthy Veach, & Bagdade, 2002) depending on the purposes of the study. Thus, three vignettes were within the range of an acceptable number of vignettes. A limit of three vignettes also reduced the possibility of respondent fatigue as well as the potential for sacrificing completion of the remaining parts of the survey.

The manipulated variable within each vignette is presented in Table 2.

Table 2.

Variable Manipulation

<table>
<thead>
<tr>
<th>Vignette 1</th>
<th>Manipulated Variable Group 1</th>
<th>Manipulated Variable Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: 13 year old girl</td>
<td>Recantation of abuse</td>
<td>Confirmation of abuse</td>
</tr>
<tr>
<td>Type of Maltreatment:</td>
<td>Physical</td>
<td></td>
</tr>
<tr>
<td>Vignette 2</td>
<td>Immigrant parents</td>
<td>Canadian born parents</td>
</tr>
<tr>
<td>Age: 3 year old boy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Maltreatment:</td>
<td>Physical</td>
<td></td>
</tr>
<tr>
<td>Vignette 3</td>
<td>Parents disclose</td>
<td>Child discloses</td>
</tr>
<tr>
<td>Age: 7 year old girl</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of Maltreatment:</td>
<td>Emotional</td>
<td></td>
</tr>
</tbody>
</table>

This next section describes the construction and rationale of each vignette.
Vignette 1 (for Group 1) *(Recantation of Abuse)*

You are a social worker at a community mental health centre. You have been seeing a mother and 13-year-old daughter regularly for the past 2 months for the daughter’s noncompliant behaviour. They are recent immigrants from Bosnia. While meeting individually with the daughter she tells you that last week, she entered her parents’ bedroom and saw her father punch her mother in the stomach. The daughter becomes very upset when relating this incident and begins to cry. You invite the mother into the session and **the daughter recants her story while the mother vehemently denies the incident.** The mother accuses you of fabricating the story to try to break up their family and the two leave the session abruptly.

Vignette 1 (for Group 2) *(Confirmation of Abuse)*

You are a social worker at a community mental health centre. You have been seeing a mother and 13-year-old daughter regularly for the past 2 months for the daughter’s noncompliant behaviour. They are recent immigrants from Bosnia. While meeting individually with the daughter she tells you that last week, she entered her parents’ bedroom and saw her father punch her mother in the stomach. The daughter becomes very upset when relating this incident and begins to cry. **You invite the mother into the session and she confirms the incident;** however, she states that this is a family matter, can be handled within the family and leaves the session with the daughter.

In this vignette the social worker is employed at a community mental health centre. This locale was chosen given the proliferation of social workers currently employed within this typical clinical setting, as well as the number of social workers who may have begun their careers at a community mental health centre but are now employed in other settings. The duration of the therapeutic relationship was a crucial decision given the survey’s focus on the therapeutic alliance. In this vignette, the social worker has been seeing the mother and daughter for the past 2 months, thus, the participant can assume the presence of a therapeutic relationship which facilitates the alliance based questions within the survey. In Canada, seven jurisdictions include exposure to domestic violence as a circumstance where a child is in need of protection (Newfoundland and Labrador, Alberta, Manitoba, the Northwest Territories, Nova Scotia, Prince Edward Island, and Saskatchewan) (Matthews & Kenny, 2008). Although exposure to domestic violence legislation does not currently exist in Ontario, witnessing violence, rather than the child...
being the recipient of abuse or neglect, may surface a level of uncertainty and promote clinical reflection in the participant to determine if the abuse warrants reporting to the CAS. In addition, the Eligibility Spectrum (the screening tool used by the Children’s Aid Societies in Ontario) interprets the Child and Family Service Act and has chosen to include child exposure to partner violence within emotional harm / exposure to conflict section (Ontario Association of Children’s Aid Societies, 2006).

The manipulated variable in Vignette 1 is recantation / confirmation of abuse. This variable was chosen for manipulation as it is a situational factor clinicians must consider when rendering a decision regarding reporting of child maltreatment. Recantation / confirmation of abuse have been shown in the past to affect clinicians’ decisions. Zellman (1992), in a large study (n=1,192) of physicians, paediatricians, psychiatrists, clinical psychologists, social workers, public school principals, and child care workers, found that when the victim retracted her accusation when questioned by an authority figure, this led to ratings that substantially reduced the likelihood of reporting. Recantation / confirmation of abuse have not been tested within the Canadian context regarding emotional maltreatment resulting from witnessing domestic violence. The confluence of these two features in Vignette 1 should have elicited the respondents’ clinical judgment when responding to the survey questions.

Vignette 2 (for Group 1) (Maltreatment from Immigrant Parents)

You are a social worker in a family counselling centre where you have been seeing a mother and her 3-year-old son regularly for the past 4 months. The father has not attended counselling. The family emigrated from Southeast Asia 4 months ago. You find the mother to have a short temper and she has become angry with you in past sessions if she perceives you as not agreeing with her opinion. While in the interview, the mother reports that her son knocked over a lamp breaking it. The father reportedly hit the son on the buttocks with his hand. You are uncertain if a mark has been left on the child and are uncertain of the child’s well-being given the mother’s temper. With the verbal permission of the mother, you speak to the father on the phone. He acknowledges hitting his son with his hand and indicates his willingness to attend counselling to
discuss the incident further. The mother, however, thinks you are overreacting and leaves the session with her son.

**Vignette 2 (for Group 2) (Maltreatment from Canadian Born Parents)**

You are a social worker in a family counselling centre where you have been seeing a mother and her 3-year-old son regularly for the past 4 months. The father has not attended counselling. **The family is 3rd generation Caucasian Canadian.** You find the mother to have a short temper and she has become angry with you in past sessions if she perceives you as not agreeing with her opinion. While in the interview, the mother reports that her son knocked over a lamp breaking it. The father reportedly hit the son on the buttocks with his hand. You are uncertain if a mark has been left on the child and are uncertain of the child’s well-being given the mother’s temper. With the verbal permission of the mother, you speak to the father on the phone. He acknowledges hitting his son with his hand and indicates his willingness to attend counselling to discuss the incident further. The mother, however, thinks you are overreacting and leaves the session with her son.

In this vignette the social worker is employed at a family counselling centre which can be thought of as similar to agencies such as Family Services or Children’s Mental Health Centres. These organizations typically employ social workers and provide services to families within their geographic area. In this vignette, the social worker has been treating the mother and son for the past 4 months, thus, indicating the presence of a therapeutic relationship. The father has chosen to not attend counselling, often a typical familial situation where seeking mental health services for family or child issues falls to the mother. This feature of the vignette contributes to its plausibility. To test the Comfort with Conflict variable, the mother is described not only as having a short temper but as displaying anger in previous sessions and she leaves this session abruptly at the conclusion of the vignette.

The selected maltreatment, hitting with the hand on the buttocks, falls within the realm of physical maltreatment and is often reported at intake of Children’s Aid Societies. The ambiguity of the vignette arises from four descriptors: the absence of a physical object in the action of hitting, the uncertainty of a mark on the body of the child, the concern over the child’s well-being given the temper of the mother, and the father’s willingness to attend counselling to
discuss the striking of his son. The inclusion of these descriptors within the vignette was expected to engender a process of reflection and clinical judgment in the respondents when responding to the survey.

The manipulated variable in Vignette 2 is immigrant status versus citizenship of the family. In Group 1 the family are newly emigrated (4 months) from Southeast Asia to Canada and in Group 2, the family have been in Canada for 3 generations, thus posing a distinction between familiarity with Canadian practices and expectations for disciplining children. The family in Group 2 is identified as being Caucasian. This particular group was selected to distinguish between Caucasian and non-Caucasian families who have been living in Canada for several generations. Given Canada’s increasingly diversified cultural mosaic and the absence of a study focusing on various standards for disciplining children within the province, it is essential to understand the role ethnicity and immigration status play in social worker’s clinical judgment.

Vignette 3 (for Group 1) (Individual Alleging Abuse – Parents)

You are a social worker in a hospital paediatric unit. Your client is a seven-year-old Caucasian girl hospitalized for the past 7 weeks due to heart problems. One day you hear the girl whining and crying in her hospital room. You notice her parents shut the door to her room, scream at her for 10 minutes and call her “good for nothing.” When the parents leave the room you ask why they screamed at her. The parents explain that this stops their daughter’s whining and is effective with their two younger children.

Vignette 3 (for Group 2) (Individual Alleging Abuse – Child)

You are a social worker in a hospital paediatric unit. Your client is a seven-year-old Caucasian girl hospitalized for the past 7 weeks due to heart problems. One day you hear the girl whining and crying in her hospital room. You notice her parents shut the door to her room, scream at her for 10 minutes and call her “good for nothing.” When the parents leave the unit you ask the daughter why her parents screamed at her. The daughter explains that it stops her whining and is effective with her two younger siblings.

This vignette takes place in a hospital, a setting familiar to many social workers. The specific locale within the hospital is the paediatric department, an often emotionally charged
environment given parents’ strain of having an ill child. The duration of the child’s hospital stay is 7 weeks, thus promoting the formation of a therapeutic alliance between the clinician, and the child and her parents. The selected parental response of screaming and name calling towards their ill child falls under the criteria of emotional maltreatment. This particular form of maltreatment, albeit rife with the destructive effects on children’s self-esteem and sense of self-worth, is often characterized by ambiguity given the lack of specificity in the incident and absence of visible injury. The vagueness surrounding emotional maltreatment often confuses whether it is necessary to report to the CAS. In the context of this study, a vignette centering on emotional maltreatment was expected to promote reflection on the part of the survey participant as to the necessary course of action. In addition, the inclusion of potential maltreatment towards two younger siblings was meant to further confound the situation and foster the promotion of clinical judgment.

The manipulated variable in this vignette was the disclosure of abuse by a parent versus the disclosure of abuse by a child. The overarching question concerned whether the identity of the person disclosing the maltreatment affected the social worker’s decision to report. This variable was chosen for manipulation as it constituted a situational factor clinicians must consider. The identity of the person disclosing maltreatment has been shown in the past to affect clinicians’ decisions, specifically, studies have shown that when a child disclosed maltreatment as opposed to a father disclosing maltreatment, the clinician was more likely to report maltreatment (Kalichman et al., 1989; Kalichman & Craig, 1991). However, the aforementioned studies surveyed licensed psychologists and did not examine social workers.

Each vignette was followed by 12 Likert-type statements; statements A2 - A9 correspond to the variables in the conceptual framework on page 69 to be tested. The first statement, I would
report this situation to the Children's Aid Society (A1), addressed the action of reporting or not reporting. The second statement, I have an ethical obligation under the College of Social Workers and Social Service Workers to report this situation (A2) and the third statement, I have a legal obligation under the Ontario provincial mandatory reporting laws to report this situation (A3), tested the variable, Regulatory Body Requirements. The fourth statement, In arriving at my decision to report or not report this case, I am comfortable discussing my concerns with these parents / caregivers (A4) tested the variable Comfort with Conflict.

The fifth statement, I would seek the advice of a colleague in deciding whether or not to report this situation (A5) and the sixth statement, I would seek the advice of a supervisor / manager whether or not to report this situation (A6) tested the variable Consultation / Supervision. The seventh statement, The cultural background of the parents would influence me in my clinical decision to report or not report this case (A7), tested the variable Culture, Religion & Ethnicity. The eighth statement, The circumstances around disclosure (who discloses maltreatment or recantation) are important to me in my clinical decision to report or not report this case (A8) tested the variable Circumstances Around Disclosure. The ninth statement, My overall previous experience in calling the Children’s Aid Society influences my decision of the current case (A9) tested the variable Reporting History. Statements A10 – A12 asked respondents about the therapeutic alliance following the decision to report. In total, Section A of the survey contained 36 Likert-scale format responses on mandatory reporting and the therapeutic alliance.

To test the variable Gender, respondents were asked in the demographic section What is your gender (C2)? To test the variable Parenthood, respondents were asked in the demographic section Do you have children (biological / adopted / step-children) of your own (C4)? To test the
variable Field of Practice, respondents were asked in the demographic section to Select your current social work area of practice (C9). To test the variable Attitude Towards CAS, respondents were asked in the demographic section What has been your overall experience in reporting or consulting to the Children’s Aid Society (C15).

The response choices for the quantitative items were uniform through questions A1 – A10 and included a five-point ordinal, Likert-scale (from strongly agree to strongly disagree) (Fink, 2003). As each question was mandatory, a sixth option, No Response, was included.

Qualitative Questions

In Section B, two qualitative questions were included on the issue of the therapeutic alliance following the decision to report suspected child maltreatment. There was ample text space to include their written narrative. There were a number of reasons for administering qualitative questions following the quantitative statements. Surveys which include open-ended questions allow the researcher to learn additional information and allow respondents to describe their true views of the subject (Fowler, 2009). In addition, the opportunity to answer questions in their own words alleviates respondent frustration at being restricted to choosing a provided response. Schaefer and Dillman (1998) note that respondents were more likely to answer open-ended questions in an electronic based survey and the responses were longer than the mail responses. Finally, Couper, Traugott and Lamias (2001) found that responses given within open ended text boxes tended to have a high degree of validity.

The two questions were:

1. What is the initial impact of reporting suspected child maltreatment on the relationship between you and the family?
2. What are the strategies you have found to be effective in maintaining the therapeutic
alliance with the family after reporting suspected child maltreatment and why do you think they are effective?

Demographic Questions

To obtain a description of selected personal and occupational characteristics of those who completed the survey, Section C entailed a demographic questionnaire. Questions in this section included age, gender, ethnicity, parenthood, completed degree, location of completed degree, length of practice as a social worker, length of practice with children and adolescents, current field of practice, former field of practice, training in mandatory reporting, number of reports to or consultations with the CAS, reasons for non-reporting to the CAS and overall experience with the CAS.

The survey was structured to elicit responses to each question in Sections A, B, and C. However, question C14, *Have you ever decided to not contact the Children’s Aid Society even though you had a suspicion of child maltreatment*, was designated as optional as respondents may not have felt comfortable answering this question.

Compensation

In Section D, the final section, those respondents who completed the survey were given the option of entering a draw for a $150.00 Chapters Indigo gift card. This gesture was to show appreciation for the time respondents took to complete the survey. In addition, the use of an honorarium is now common practice at the conclusion of online surveys (Dillman, 2007). Respondents interested in the draw were requested to enter their first name, email address, and / or daytime telephone number. Before the survey data was reviewed the researcher transferred each participant’s name and contact information to a secure file. This step was taken to ensure
that the survey responses were completely anonymous as well as confidential. The winner was contacted following the closing date of the survey.

To facilitate the draw, the study author printed a list of the respondents who completed the survey, cut out each name separately, placed them in a hat and drew the name of the winner. Finally, the pieces of paper on which the names were cut were shredded. Only the winner of the draw was notified given the high number of respondents (390) who entered the draw.

The procedures for this study received approval by the University of Toronto Research Ethics Board. The risk and benefits, confidentiality, and informed consent of participation in the survey were outlined in the information letter to respondents (see Appendix 4).

**Data Collection**

The survey was administered in online format to capture social workers employed in urban, suburban, and rural areas as well as social workers who work with children (ages 1 – 11) and adolescents (ages 12 - 16); however, respondents who elected to complete a paper copy of the survey were mailed a hardcopy form. Use of a computer-based survey involved the following assumptions regarding the population: (1) they would have some degree of computer literacy; (2) they would have access to the Internet; (3) they would believe this is an important topic and wish to respond to the survey. The pilot testing phase of the study confirmed that survey completion time was 20 minutes which is within the recommended time frame for Internet surveys (Bourgue & Felder, 2003).

The survey was formatted into Survey Wizard, a secure, online website administered through the Ontario Institute for Studies in Education at the University of Toronto. An email invitation to participate was uploaded to members of the OASW with current email addresses
through their association’s database administrator. Survey Wizard was used as the electronic platform to house the survey and to record the responses of respondents.

Group 1 members were asked to click on the following URL, https://surveys.oise.utoronto.ca/surveyviewer2/index.php?surveyID=GASCM while Group 2 members were asked to click on the following URL, https://surveys.oise.utoronto.ca/surveyviewer2/index.php?surveyID=KYLJ9 to be taken to the information letter, consent form, and survey itself. These URLs were included in any subsequent email reminders. The survey was initially distributed in mid-September 2010 and five email reminders were sent out at 1.5 week intervals to ensure an acceptable response rate (Singleton & Straits, 2005). In addition, Granello and Wheaton (2004) found that sending email reminders early in the morning or late in the day resulted in the greatest response rate. Thus, the association sent the e-mail reminders between 3:30 - 4:30 p.m.

Summary

To explore the research questions outlined in this chapter, online survey methodology using manipulated vignettes was chosen. Given the complexity and multifaceted nature of mandatory reporting and the specificity of the proposed research questions, survey methodology permits the exploration of a range of opinions and courses of action from a large number of social workers. An online survey using text based qualitative questions allowed respondents the freedom to explore their thoughts and perspectives in a more fulsome manner.

Chapter 5 presents the quantitative findings of the study including descriptive statistics of the sample and chi-square analysis of predictors to be used in the multivariate analyses.
CHAPTER FIVE: QUANTITATIVE DATA: ANALYSIS AND FINDINGS

Introduction

This chapter presents the quantitative findings from the study. It begins with initial comments concerning the total number of surveys received and how the data was prepared for analysis. What follows are descriptive statistics of the demographic data, bivariate and multivariate analysis, and results of the interaction effects. Summary tables are presented with commentary following the multiple logistic regression analyses to facilitate clarity.

Overall Numerical Results

Of the 2,533 surveys sent to OASW members, 561 surveys were submitted online and 4 surveys were submitted by hardcopy. As Survey Wizard tracks both “started” and “completed” surveys it was possible to determine how many respondents did not complete the survey. Of the 561 online surveys, 469 (84%) were completed and 92 (16%) were started but not completed. As 335 responses were required to achieve statistical power as per the calculation based on G*Power Analysis, this requirement was met.

Preparing the Data for Analysis

Prior to data analysis the surveys were uploaded onto SPSS version 19. The data were then cleaned to ensure an accurate analysis. The author maintained an accurate log of each question or case which underwent the cleaning process. The following is a summary of the steps used in the data cleaning process. In questions A1 – A10, C10, C14, C15 the categories of “no response,” “not applicable” or “I have neither reported nor consulted with the CAS” were re-coded as “missing” and were not included in the analysis. In questions A11, A12, and C11 the category of “none” was verified to ensure that those respondents who selected “none” did not select other options. In questions A11, A12, B1, C3, C6, C9, C10, and C11, the category of
“other, please specify” was verified to ensure that respondents who selected this option did specify a response. For these same questions some respondents who selected “other, please specify” had responses which could be recoded into preceding responses and responses such as these were recoded.

To obtain an understanding of the amount of missing data and in order to make decisions about eliminating respondents who did not answer most of the questions, frequency tables were run for all variables. Based on the examination of the frequency table, a decision was made to keep in further analyses only cases that had up to 2 missing or unknown responses. This resulted in a new dataset with 480 cases (85% from the original dataset). It should be noted that the greatest number of missing values occurred in questions C12 *Over the past 12 months, how many times have you contacted the CAS to report suspected child maltreatment* and C13 *Over the past 12 months, how many times have you contacted the CAS to consult with them if a case of suspected child maltreatment should be reported?* There were 110 missing responses for question C12 and 112 missing responses for question C13.

*Demographic Analysis Results*

To obtain a profile of the composition of the sample, frequencies and descriptive statistics were run for the demographic questions. The means and standard deviations are reported for continuous and normally distributed variables and quartiles are reported for skewed continuous variables. The quartiles are the $25^{th}$, the $50^{th}$, and the $75^{th}$ percentiles that indicate the values of the variable that have 25, 50, or 75 percent of the distribution below. The results are presented in Table 3.
Table 3.

*Descriptive Statistics of Respondent Characteristics*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
<td>5</td>
<td>1.0</td>
</tr>
<tr>
<td>25-29</td>
<td>25</td>
<td>5.2</td>
</tr>
<tr>
<td>30-34</td>
<td>43</td>
<td>9.0</td>
</tr>
<tr>
<td>35-39</td>
<td>45</td>
<td>9.4</td>
</tr>
<tr>
<td>40-44</td>
<td>55</td>
<td>11.5</td>
</tr>
<tr>
<td>45-49</td>
<td>66</td>
<td>13.8</td>
</tr>
<tr>
<td>50-54</td>
<td>88</td>
<td>18.3</td>
</tr>
<tr>
<td>55-59</td>
<td>69</td>
<td>14.4</td>
</tr>
<tr>
<td>60-64</td>
<td>63</td>
<td>13.1</td>
</tr>
<tr>
<td>65-69</td>
<td>19</td>
<td>4.0</td>
</tr>
<tr>
<td>70-74</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>70</td>
<td>14.6</td>
</tr>
<tr>
<td>Females</td>
<td>410</td>
<td>85.4</td>
</tr>
<tr>
<td><strong>Respondent Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>442</td>
<td>92.1</td>
</tr>
<tr>
<td>Black</td>
<td>16</td>
<td>3.3</td>
</tr>
<tr>
<td>Asian</td>
<td>4</td>
<td>0.8</td>
</tr>
<tr>
<td>Southeast Asian</td>
<td>10</td>
<td>2.1</td>
</tr>
<tr>
<td>First Nations</td>
<td>6</td>
<td>1.3</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>South Asian</td>
<td>4</td>
<td>0.8</td>
</tr>
<tr>
<td>Middle Eastern</td>
<td>4</td>
<td>0.8</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>Parenthood</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>352</td>
<td>73.3</td>
</tr>
<tr>
<td>No</td>
<td>128</td>
<td>26.7</td>
</tr>
<tr>
<td><strong>Completed Degrees</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSW</td>
<td>116</td>
<td>24.2</td>
</tr>
<tr>
<td>MSW</td>
<td>402</td>
<td>83.8</td>
</tr>
<tr>
<td>PhD</td>
<td>12</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Completed Degree Location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>437</td>
<td>91.0</td>
</tr>
<tr>
<td>United States</td>
<td>26</td>
<td>5.4</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>3.5</td>
</tr>
<tr>
<td><strong>Years Practicing as a Social Worker</strong></td>
<td>17.45 (M)</td>
<td>10.61 (SD)</td>
</tr>
<tr>
<td><strong>Years Practicing with Children / Adolescents</strong></td>
<td>13.69 (M)</td>
<td>10.483 (SD)</td>
</tr>
<tr>
<td><strong>Current Social Work Area of Practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital social work</td>
<td>93</td>
<td>19.4</td>
</tr>
<tr>
<td>Elementary / secondary school social</td>
<td>36</td>
<td>7.5</td>
</tr>
</tbody>
</table>
work
University / college social work 13 2.7
Private practice / employee assistance 118 24.6
Children’s mental health 46 9.6
Community mental health 61 12.7
Case management 14 2.9
Child welfare / child protection 19 4.0
Management / government 24 5.0
Family health team 35 7.3
Retired 7 1.5
Other 8 1.7
Long-term care 4 0.8
Missing 2 0.4

Former Social Work Area of Practice
Hospital social work 77 16.0
Elementary / secondary school social work 17 3.5
University / college social work 3 0.6
Private practice / employee assistance 27 5.6
Children’s mental health 75 15.6
Community mental health 51 10.6
Case management 9 1.9
Child welfare / child protection 101 21.0
Management / government 21 4.4
Family health team 9 1.9
Long-term care 1 0.2
Other 34 7.1
None 55 11.5

Training in Child Maltreatment
None 42 8.8
Workshop / seminar 253 52.7
Workplace in-service 247 51.5
On the job training 282 58.8
College course 15 3.1
University course 161 33.5
Other 22 4.6

Reporting Suspected Child Maltreatment Over the Past 12 Months
0-58 (range) 0 1 3 (quartiles)
Consulting Around Child Maltreatment Over the Past 12 Months
0-75 (range) 0 1 2 (quartiles)

Not Contacting the CAS
Insufficient evidence 68 14.2
Believed you could work with the family 35 7.3
Family demonstrated a willingness to be in treatment 55 11.5
Concerned about the family terminating treatment 13 2.7

Attitude Toward CAS
Very positive 50 10.4
Positive 210 43.8
Neutral 128 26.7
Negative 49 10.2
Very negative 14 2.9
Missing 29 6.0

The typical respondent was a Caucasian female social worker with an MSW degree completed in Canada. In addition, the age distribution of the sample appeared to be normally distributed. Most respondents were working in either private practice / employee assistance or in hospital social work. Many respondents reported having a positive experience with the CAS. In addition, many respondents received some training in child maltreatment; however, 22 respondents (4.6%) listed “other” as their child maltreatment training. Responses in the “other” grouping were categorized by theme. The results are presented in Table 4.

Table 4.
Content Analysis of the Training in Child Maltreatment – Other Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td>6</td>
</tr>
<tr>
<td>Work environment closely aligned with the CAS</td>
<td>4</td>
</tr>
<tr>
<td>Practicum placement at the CAS</td>
<td>4</td>
</tr>
<tr>
<td>Attending conferences</td>
<td>3</td>
</tr>
<tr>
<td>Other – not categorized</td>
<td>3</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>1</td>
</tr>
</tbody>
</table>

As this question was designated as “select all that apply” some responses were applicable to more than one category.

Within this category a number of respondents noted doing independent study on child maltreatment which involved reading while other respondents sought clinical supervision or attended conferences which informed their knowledge of the subject area. A number of other respondents gained knowledge through completing a practicum at the CAS during their formal schooling while other respondents worked at places of employment which were closely aligned
with the CAS. Finally, there were 3 responses, “part of my responsibilities at my former employment (also rehab with children with disabilities) was to educate staff about CAS policies / procedures / duty to report,” “family violence training,” and “research, management” which could not be categorized.

The study also asked respondents about their reporting or consulting history with the CAS. The majority of respondents who had reported or consulted with the CAS had done so between 1-3 times over the past 12 months.

Scale Reliability Results

The following variables, Regulatory Body Requirements, are comprised of question A2 *I have an ethical obligation under the College of Social Workers and Social Service Workers to report this situation* and question A3 *I have a legal obligation under the Ontario provincial mandatory reporting laws to report this situation* while Consultation / Supervision, are comprised of question A5 *I would seek the advice of a colleague in deciding whether or not to report this situation* and question A6 *I would seek the advice of a supervisor / manager whether or not to report this situation*. The two questions under each variable were highly correlated. The results are presented in Table 5.

Originally, the respondents were asked whether they would agree to report a situation outlined in the vignette on the 5 point scale ranging from *strongly agree* to *strongly disagree*. The distributions of these responses were examined and it was decided to dichotomize these variables for further analyses. Therefore, the *strongly agree* and *agree* categories were combined into a category called “definitely report” and the *uncertain, disagree*, and *strongly disagree* categories were combined into a category called “not sure / not report.”
Table 5.

*Scale Reliability Results (Pearson correlations) for the Predictors: Regulatory Body Requirements and Consultation / Supervision*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group 1</th>
<th>Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethics / Legal (Vignette 1)</td>
<td>.925</td>
<td>.889</td>
</tr>
<tr>
<td>Ethics / Legal (Vignette 2)</td>
<td>.939</td>
<td>.946</td>
</tr>
<tr>
<td>Ethics / Legal (Vignette 3)</td>
<td>.931</td>
<td>.944</td>
</tr>
<tr>
<td>Consultation / Supervision (Vignette 1)</td>
<td>.856</td>
<td>.795</td>
</tr>
<tr>
<td>Consultation / Supervision (Vignette 2)</td>
<td>.831</td>
<td>.825</td>
</tr>
<tr>
<td>Consultation / Supervision (Vignette 3)</td>
<td>.864</td>
<td>.875</td>
</tr>
</tbody>
</table>

As the results are all well above .70, it was possible to compute scale scores for Regulatory Body Requirements and Consultation / Supervision. Therefore, scale scores for Ethical / Legal and Consultation / Supervision were constructed by averaging the scores from questions A2 and A3, and A5 and A6 respectively. These scale scores were used in further analyses.

*Descriptive Statistics of the Likelihood of Reporting Suspected Child Maltreatment by Vignette and Group*

The survey contained 3 vignettes with one manipulated variable in each vignette, recantation (Group 1) versus confirmation of abuse (Group 2) in Vignette 1, maltreatment from immigrant parents (Group 1) versus maltreatment from Canadian born parents (Group 2) in Vignette 2, and parents disclose abuse (Group 1) versus child discloses abuse (Group 2) in Vignette 3. Survey respondents were divided into 2 groups and each group received a different
vignette with the manipulated variable. Table 6 presents the likelihood of reporting suspected child maltreatment by group and by vignette.

Table 6.

*Descriptive Statistics of the Likelihood of Reporting Suspected Child Maltreatment by Vignette and Group*

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 1</th>
<th>Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Definitely Report</td>
<td>181 (71.8%)</td>
<td>182 (79.8%)</td>
<td>123 (48.8%)</td>
<td>113 (49.8%)</td>
<td>164 (65.1%)</td>
<td>153 (67.4%)</td>
</tr>
<tr>
<td>Not Sure / Not Report</td>
<td>71 (28.2%)</td>
<td>46 (20.2%)</td>
<td>129 (51.2%)</td>
<td>114 (50.2%)</td>
<td>88 (34.9%)</td>
<td>74 (32.6%)</td>
</tr>
</tbody>
</table>

In examining the manipulated variable in each vignette in the sample, when the mother confirmed the abuse in Vignette 1 Group 2, more respondents reported the situation as opposed to when the girl recanted the abuse in Group 1. In Vignette 2, fewer respondents in Group 2, with the Canadian born parents, reported the situation. In Vignette 3, the results for reporting were similar between Groups 1 and 2 whether the child or parents revealed the abuse.

In examining each vignette from the perspective of type of maltreatment – a child witnessing domestic violence in Vignette 1, physical maltreatment in Vignette 2, and emotional maltreatment in Vignette 3, the majority of respondents in Vignette 1 reported the situation. In Vignette 2 the respondents were evenly split between those who would report and those who would not report or who were undecided. In Vignette 3 more respondents would report but roughly a third of respondents were either uncertain or would not report.
As will be reported later in this chapter, Regulatory Body Requirements and Consultation/Supervision were the most important factors in the decision to report or not report suspected child maltreatment. Descriptive statistics, numbers and percentages for each group and vignette, for Regulatory Body Requirements and Consultation/Supervision for respondents that *definitely report* and *not sure / not report* are presented in Tables 7 and 8.

Table 7.

**Descriptive Statistics (Numbers and Percentages) of Regulatory Body Requirements Scales by Vignette and Group**

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Vignette</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Vignette</th>
<th>Group 1</th>
<th>Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Definitely Report</td>
<td>188 (74.6)</td>
<td>185 (81.2)</td>
<td>142 (56.3)</td>
<td>123 (53.9)</td>
<td>162 (64.8)</td>
<td>156 (68.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Sure / Not Report</td>
<td>64 (25.4)</td>
<td>43 (18.8)</td>
<td>110 (43.7)</td>
<td>105 (46)</td>
<td>90 (35.7)</td>
<td>70 (30.6)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 8.

**Descriptive Statistics (Numbers and Percentages) of Consultation / Supervision Scales by Vignette and Group**

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Vignette</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Vignette</th>
<th>Group 1</th>
<th>Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Definitely Report</td>
<td>149 (59.2)</td>
<td>116 (50.8)</td>
<td>166 (65.8)</td>
<td>145 (63.6)</td>
<td>156 (61.9)</td>
<td>140 (61.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Sure / Not Report</td>
<td>102 (40.6)</td>
<td>112 (49.1)</td>
<td>85 (33.8)</td>
<td>82 (36)</td>
<td>95 (37.8)</td>
<td>87 (38.2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In Tables 7 and 8 the frequencies for definitely report were consistently higher than those for not sure / not report. Respondents who stated they would definitely report were more likely to believe they had an ethical and / or legal obligation to report and were more likely to seek the advice of a colleague or supervisor in deciding whether or not to report the situation.

*Descriptive Statistics of Respondents’ Top Three Decision-Making Factors to Report Suspected Child Maltreatment*

A frequency analysis was also run for question B1 *when faced with a suspicion of child maltreatment, what factors do you include in your decision-making process? Please rank the top three factors*. Descriptive statistics including number and percentage were run for the following factors: Duty to Report, Fine for Not Reporting, Ethical Obligation to the OASW, Comfort Speaking to Parents / Caregivers about your Concerns, Type of Maltreatment, the Effectiveness of your Local CAS, the Opinion of your Supervisor / Manager, the Opinion of your Colleague, Who in the Family Discloses the Abuse, and Other. The results are presented in Table 9.
Table 9.

*Descriptive Statistics of Respondents’ Top Three Decision-Making Factors to Report Suspected Child Maltreatment*

<table>
<thead>
<tr>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number</strong></td>
<td><strong>Percentage</strong></td>
<td><strong>Number</strong></td>
</tr>
<tr>
<td>Duty to Report</td>
<td>16</td>
<td>126</td>
</tr>
<tr>
<td>Fine for Not Reporting</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Ethical Obligation to the OASW</td>
<td>48</td>
<td>161</td>
</tr>
<tr>
<td>Comfort speaking to parents / caregivers about your concerns</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Type of maltreatment</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td>The effectiveness of your local CAS</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>The opinion of your supervisor / manager</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>The opinion of your colleague(s)</td>
<td>373</td>
<td>75</td>
</tr>
<tr>
<td>Who in the family discloses the abuse</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>26</td>
<td>22</td>
</tr>
</tbody>
</table>

The overwhelming first factor for study respondents was the opinions of colleague(s) when making the decision to report suspected child maltreatment. The opinion of one’s manager rated minimally. Who discloses abuse in the family did not figure as a first factor. The ethical and legal obligations to report suspected child maltreatment both figured prominently as the second factor. Finally, the ethical obligation and to a lesser extent, the type of maltreatment and duty to report comprised the third factors. Responses in the “other” grouping were categorized by theme and are presented in Table 10.
Table 10.

*Content Analysis of Respondents’ Top Three Decision-Making Factors – Other Category*

<table>
<thead>
<tr>
<th>Factor 1</th>
<th>Category</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Safety and wellbeing of the child</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Case specific factors</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Clients’ response to CAS report</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Further assessment required</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other – not specified</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor 2</th>
<th>Category</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Safety and wellbeing of the child</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Ethical obligation to child and family</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Social worker concern about maltreatment</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Knowledge of the family and their situation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Available supports</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Clients’ response to CAS report</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Other – not specified</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor 3</th>
<th>Category</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Safety and wellbeing of the child</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Remaining factors would not impact decision-making</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Assessment of familial factors</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Personal ethical obligations</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Legal responsibility (not duty to report)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Other – not specified</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Consult CAS intake department to determine if situation requires reporting</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Social worker concern about maltreatment</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Social worker role on treatment team</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Opportunity to improve family functioning</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Available supports</td>
<td>1</td>
</tr>
</tbody>
</table>

The overwhelming factor in the “other” category was the safety and wellbeing of the child in question. This factor alone dominated to the relative exclusion of other factors. There was a variety of single responses which focused on factors such as “supports available to the
clients” and the “clients’ response to the CAS report.” Finally there was one response that could not be specified, as the respondent could not rank his or her answer due to the reported complexity of the issue.

**Chi-square and Correlation Analyses Results**

The first statement on the survey, *I would report this situation to the CAS* is the outcome variable and refers to the likelihood of reporting or not reporting. Prior to answering the first research question, *what are the factors that predict a social worker’s decision to report or not report suspected child maltreatment*, chi-square tests of independence and correlation coefficients were computed to determine which variables were significantly related to the outcome variable. The variables that were included in this analysis were: Regulatory Body Requirements, Consultation / Supervision, Comfort with Conflict, Gender, Parenthood, Culture, Religion & Ethnicity, Circumstances Around Disclosure, Reporting History, Attitude Toward CAS and Field of Practice.

Prior to running these analyses investigation into the distribution of responses for 5-point Likert scale variables occurred. Variables that were highly skewed and had very few responses in some categories were dichotomized into 2 categories. The first category includes *strongly agree and agree*. The second category includes *uncertain, disagree, and strongly disagree*. These variables were Comfort with Conflict, Culture, Religion & Ethnicity, Circumstances Around Disclosure, Reporting History, and Attitude Toward CAS. This dichotomization was needed as otherwise the assumption of chi-square test of independence of the minimum expected frequency of 5 in each cell would not have been met. The analysis was run separately for Groups 1 and 2 by vignette. The results are presented in Table 11.
Table 11.

Chi-square and Correlation Analyses Results of Factors that Predict a Social Worker’s Tendency to Report Suspected Child Maltreatment

<table>
<thead>
<tr>
<th>Characteristics of the Respondent</th>
<th>Vignette 1</th>
<th>Vignette 2</th>
<th>Vignette 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group 1</td>
<td>Group 2</td>
<td>Group 1</td>
</tr>
<tr>
<td>Regulatory Body Requirements</td>
<td>- .77**</td>
<td>- .71**</td>
<td>- .79**</td>
</tr>
<tr>
<td>Consultation / Supervision</td>
<td>.26**</td>
<td>.38**</td>
<td>.32**</td>
</tr>
<tr>
<td>Comfort with Conflict</td>
<td>3.63</td>
<td>2.53</td>
<td>1.65</td>
</tr>
<tr>
<td>Gender</td>
<td>.08</td>
<td>2.84</td>
<td>.26</td>
</tr>
<tr>
<td>Parenthood</td>
<td>.03</td>
<td>.12</td>
<td>.04</td>
</tr>
<tr>
<td>Reporting History</td>
<td>7.52**</td>
<td>2.62</td>
<td>6.15*</td>
</tr>
<tr>
<td>Attitude Toward CAS</td>
<td>2.77</td>
<td>.12</td>
<td>3.02</td>
</tr>
<tr>
<td>Field of Practice</td>
<td>2.67</td>
<td>12.14**</td>
<td>5.40</td>
</tr>
<tr>
<td>Case Characteristics</td>
<td>15.31**</td>
<td>16.26**</td>
<td>4.52*</td>
</tr>
<tr>
<td>Culture, Religion &amp; Ethnicity</td>
<td>3.95*</td>
<td>3.18</td>
<td>4.40*</td>
</tr>
<tr>
<td>Circumstances Around Disclosure</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .05
** p < .01

Spearman’s Rho was used for Regulatory Body Requirements and Consultation / Supervision. Otherwise, Pearson Chi-square test of independence is reported.

As can be seen in the above table, Regulatory Body Requirements, Consultation / Supervision, Culture, Religion & Ethnicity, Circumstances Around Disclosure, Reporting
History and Field of Practice were all significant and were thus included as predictors in the logistic regression analyses. To maintain consistency throughout the analyses, these five predictors were included even when significance was not attained in each vignette. Since the content of vignettes was slightly different in Groups 1 and 2, logistic regression was run separately for these groups of respondents.

**Multiple Logistic Regression Analyses Results (Decision-making)**

To include the variable Current Area of Practice in the logistic regression analysis, the categories of “retired” and “other” were removed from the analysis as the numbers in these categories were sparse. The remaining 11 categories were reduced to 4: medical, child, community, and private practice settings. Practice areas in the “medical” category included hospital social work, family health team, and long-term care. Practice areas in the “child” category were children’s mental health, child welfare / child protection, and elementary / secondary school social work. Practice areas in the “community” category included community mental health; case management, and university / college social work. Private practice / Employee Assistance Program were maintained as a separate category as elements of this occupational category could be included in either child or community. Descriptive statistics were then run for this new variable and are presented in Table 12.

**Table 12.**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>132</td>
<td>30.1</td>
</tr>
<tr>
<td>Private Practice</td>
<td>118</td>
<td>26.9</td>
</tr>
<tr>
<td>Child</td>
<td>101</td>
<td>23.0</td>
</tr>
<tr>
<td>Community</td>
<td>88</td>
<td>20.0</td>
</tr>
</tbody>
</table>
To answer the first research question *what are the factors that predict a social worker’s decision to report or not report suspected child maltreatment* multiple logistic regression analyses using the enter method were run with Regulatory Body Requirements, Culture, Religion & Ethnicity, Circumstances Around Disclosure, Reporting History, Consultation / Supervision and Field of Practice for each group and vignette separately. The logistic regression results for Groups 1 and 2 of Vignette 1 are presented in Tables 13 and 14.

Table 13.

*Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker’s Tendency to Report or Not Report Suspected Child Maltreatment (Vignette 1) (Group 1)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Odds ratio (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory Body Requirements</td>
<td>.05 (.02, .13)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Culture, Religion &amp; Ethnicity</td>
<td>.37 (.07, 1.84)</td>
<td>NS</td>
</tr>
<tr>
<td>Circumstances Around Disclosure</td>
<td>.66 (.17, 2.55)</td>
<td>NS</td>
</tr>
<tr>
<td>Reporting History</td>
<td>.40 (.12, 1.34)</td>
<td>NS</td>
</tr>
<tr>
<td>Consultation / Supervision</td>
<td>2.29 (1.10, 4.77)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Field of Practice (reference)</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Field of Practice (Medical)</td>
<td>1.33 (.25, 7.10)</td>
<td>NS</td>
</tr>
<tr>
<td>Field of Practice (Child Related)</td>
<td>2.40 (.43, 13.41)</td>
<td>NS</td>
</tr>
<tr>
<td>Field of Practice (Community Related)</td>
<td>.34 (.07, 1.71)</td>
<td>NS</td>
</tr>
</tbody>
</table>
Table 14.

**Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker’s Tendency to Report or Not Report Suspected Child Maltreatment (Vignette 1) (Group 2)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Odds ratio (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory Body Requirements</td>
<td>.11 (.05, .22)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Culture, Religion &amp; Ethnicity</td>
<td>.18 (.04, .96)</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Circumstances Around Disclosure</td>
<td>3.74 (1.00, 13.96)</td>
<td>NS</td>
</tr>
<tr>
<td>Reporting History</td>
<td>.45 (.14, 1.45)</td>
<td>NS</td>
</tr>
<tr>
<td>Consultation / Supervision</td>
<td>2.23 (1.13, 4.38)</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Field of Practice (reference)</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Field of Practice (Medical)</td>
<td>1.25 (.34, 4.61)</td>
<td>NS</td>
</tr>
<tr>
<td>Field of Practice (Child Related)</td>
<td>2.79 (.36, 21.57)</td>
<td>NS</td>
</tr>
<tr>
<td>Field of Practice (Community Related)</td>
<td>.82 (.19, 3.55)</td>
<td>NS</td>
</tr>
</tbody>
</table>

**Group 1 Results**

Regulatory Body Requirements significantly predicts the tendency to report or not report suspected child maltreatment, p < .01. As Regulatory Body Requirements increases by one unit, the odds of reporting suspected child maltreatment decrease by 95% (1 - .05%). Respondents with higher Regulatory Body Requirements scores on the survey indicating they did not agree they had either an ethical obligation to the College of Social Workers and Social Service Workers (CSWSSWW) or a legal obligation to the Ontario provincial mandatory reporting laws were less likely to report this situation to the CAS.

Consultation / Supervision also significantly predict the tendency to report or not report suspected child maltreatment, p < .05. As Consultation / Supervision increases by one unit, the odds of reporting suspected child maltreatment increase by more than twice (2.29). Respondents with higher Consultation / Supervision scores on the survey indicating they did not agree with the need to consult with others or seek supervision were more likely to report this situation to the CAS. The other variables are not significant.
Group 2 Results

Regulatory Body Requirements significantly predicts the tendency to report or not report suspected child maltreatment, $p < .01$. As Regulatory Body Requirements increases by one unit, the odds of reporting suspected child maltreatment decrease by roughly 90%. Respondents with higher Regulatory Body Requirements scores on the survey indicating they did not agree they had either an ethical obligation to the College of Social Workers and Social Service Workers (CSWSSW) or a legal obligation to the Ontario provincial mandatory reporting laws were less likely to report this situation to the CAS.

Culture, Religion & Ethnicity significantly predict the tendency to report or not report suspected child maltreatment, $p < .05$. As Culture, Religion & Ethnicity increases by one unit, the odds of reporting suspected child maltreatment decrease by almost 80%. Respondents with higher Culture, Religion & Ethnicity scores on the survey indicating they did not agree the culture of the parents would influence their decision to report were less likely to report this situation to the CAS.

Consultation / Supervision also significantly predict the tendency to report or not report suspected child maltreatment, $p < .05$. As Consultation / Supervision increases by one unit, the odds of reporting suspected child maltreatment increase by more than twice (2.23). Respondents with higher Consultation / Supervision scores on the survey indicating they did not agree with the need to consult with others or seek supervision were more likely to report this situation to the CAS. The other variables are not significant.

Multiple logistic regression analyses using enter method were run with Regulatory Body Requirements, Culture, Religion & Ethnicity, Circumstances Around Disclosure, Reporting History, Consultation / Supervision and Field of Practice for each group and vignette separately.
The multiple logistic regression results for Groups 1 and 2 of Vignette 2 are presented in Tables 15 and 16.

Table 15.

**Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker’s Tendency to Report or Not Report Suspected Child Maltreatment (Vignette 2) (Group 1)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Odds ratio (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory Body Requirements</td>
<td>.02 (.01, .06)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Culture, Religion &amp; Ethnicity</td>
<td>1.07 (.21, 5.53)</td>
<td>NS</td>
</tr>
<tr>
<td>Circumstances Around Disclosure</td>
<td>.97 (.27, 3.49)</td>
<td>NS</td>
</tr>
<tr>
<td>Reporting History</td>
<td>.27 (.08, .95)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Consultation / Supervision</td>
<td>2.89 (1.31, 6.38)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Field of Practice (reference)</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Field of Practice (Medical)</td>
<td>.69 (.14, 3.47)</td>
<td>NS</td>
</tr>
<tr>
<td>Field of Practice (Child Related)</td>
<td>.99 (.17, 5.62)</td>
<td>NS</td>
</tr>
<tr>
<td>Field of Practice (Community Related)</td>
<td>.65 (.11, 3.88)</td>
<td>NS</td>
</tr>
</tbody>
</table>

Table 16.

**Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker’s Tendency to Report or Not Report Suspected Child Maltreatment (Vignette 2) (Group 2)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Odds ratio (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory Body Requirements</td>
<td>.01 (.03, .05)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Culture, Religion &amp; Ethnicity</td>
<td>2.08 (.17, 25.61)</td>
<td>NS</td>
</tr>
<tr>
<td>Circumstances Around Disclosure</td>
<td>.30 (.08, 1.12)</td>
<td>NS</td>
</tr>
<tr>
<td>Reporting History</td>
<td>.57 (.16, 2.06)</td>
<td>NS</td>
</tr>
<tr>
<td>Consultation / Supervision</td>
<td>1.94 (.90, 4.19)</td>
<td>NS</td>
</tr>
<tr>
<td>Field of Practice (reference)</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Field of Practice (Medical)</td>
<td>2.80 (.46, 17.04)</td>
<td>NS</td>
</tr>
<tr>
<td>Field of Practice (Child Related)</td>
<td>5.15 (.89, 29.79)</td>
<td>NS</td>
</tr>
<tr>
<td>Field of Practice (Community Related)</td>
<td>.46 (.09, 2.34)</td>
<td>NS</td>
</tr>
</tbody>
</table>

**Group 1 Results**

Regulatory Body Requirements significantly predicts the tendency to report or not report suspected child maltreatment, p < .01. As Regulatory Body Requirements increases by one unit,
the odds of reporting suspected child maltreatment decrease by 98%. Respondents with higher Regulatory Body Requirements scores on the survey indicating they did not agree they had either an ethical obligation to the College of Social Workers and Social Service Workers (CSWSSW) or a legal obligation to the Ontario provincial mandatory reporting laws were less likely to report this situation to the CAS.

Reporting History significantly predicts the tendency to report or not report suspected child maltreatment, p < .05. As Reporting History increases by one unit, the odds of reporting suspected child maltreatment decrease by almost 70%. Respondents with higher Reporting History scores on the survey indicating they did not agree that their previous experience in calling the CAS influenced their decision of the current case were less likely to report this situation to the CAS.

Consultation / Supervision also significantly predict the tendency to report or not report suspected child maltreatment, p < .05. As Consultation / Supervision increases by one unit, the odds of reporting suspected child maltreatment increase by almost three times (2.89). Respondents with higher Consultation / Supervision scores on the survey indicating they did not agree with the need to consult with others or seek supervision were more likely to report this situation to the CAS. The other variables were not significant.

**Group 2 Results**

Regulatory Body Requirements significantly predicts the tendency to report or not report suspected child maltreatment, p < .01. As Regulatory Body Requirements increases by one unit, the odds of reporting suspected child maltreatment decrease by 99%. Respondents with higher Regulatory Body Requirements scores on the survey indicating they did not agree they had either an ethical obligation to the College of Social Workers and Social Service Workers (CSWSSW)
or a legal obligation to the Ontario provincial mandatory reporting laws were less likely to report this situation to the CAS. The other variables are not significant.

Multiple logistic regression analyses using enter method were run with Regulatory Body Requirements, Culture, Religion & Ethnicity, Circumstances Around Disclosure, Reporting History, Consultation / Supervision and Field of Practice for each group and vignette separately. The multiple logistic regression results for Groups 1 and 2 of Vignette 3 are presented in Tables 17 and 18.

Table 17.

**Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker’s Tendency to Report or Not Report Suspected Child Maltreatment (Vignette 3) (Group 1)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Odds ratio (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory Body Requirements</td>
<td>.04 (.01, .09)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Culture, Religion &amp; Ethnicity</td>
<td>1.84 (.26, 13.21)</td>
<td>NS</td>
</tr>
<tr>
<td>Circumstances Around Disclosure</td>
<td>1.53 (.53, 4.40)</td>
<td>NS</td>
</tr>
<tr>
<td>Reporting History</td>
<td>.53 (.19, 1.52)</td>
<td>NS</td>
</tr>
<tr>
<td>Consultation / Supervision</td>
<td>1.63 (.95, 2.78)</td>
<td>NS</td>
</tr>
<tr>
<td>Field of Practice (reference)</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>Field of Practice (Medical)</td>
<td>.63 (.17, 2.29)</td>
<td>NS</td>
</tr>
<tr>
<td>Field of Practice (Child Related)</td>
<td>1.17 (.30, 4.64)</td>
<td>NS</td>
</tr>
<tr>
<td>Field of Practice (Community Related)</td>
<td>1.24 (.30, 5.13)</td>
<td>NS</td>
</tr>
</tbody>
</table>

Table 18.

**Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker’s Tendency to Report or Not Report Suspected Child Maltreatment (Vignette 3) (Group 2)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Odds ratio (95% CI)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory Body Requirements</td>
<td>.03 (.01, .07)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Culture, Religion &amp; Ethnicity</td>
<td>.78 (.12, 5.07)</td>
<td>NS</td>
</tr>
<tr>
<td>Circumstances Around Disclosure</td>
<td>.27 (.07, .97)</td>
<td>NS</td>
</tr>
<tr>
<td>Reporting History</td>
<td>.33 (.10, 1.07)</td>
<td>NS</td>
</tr>
<tr>
<td>Consultation / Supervision</td>
<td>2.61 (1.26, 5.39)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Field of Practice (reference)</td>
<td>--</td>
<td></td>
</tr>
</tbody>
</table>
Group 1 Results

Regulatory Body Requirements significantly predicts the tendency to report or not report suspected child maltreatment, \( p < .01 \). As Regulatory Body Requirements increases by one unit, the odds of reporting suspected child maltreatment decrease by 96%. Respondents with higher Regulatory Body Requirements scores on the survey indicating they did not agree they had either an ethical obligation to the College of Social Workers and Social Service Workers (CSWSSW) or a legal obligation to the Ontario provincial mandatory reporting laws were less likely to report this situation to the CAS. The other variables in the equation were not significant.

Group 2 Results

Regulatory Body Requirements significantly predicts the tendency to report or not report suspected child maltreatment, \( p < .01 \). As Regulatory Body Requirements increases by one unit, the odds of reporting suspected child maltreatment decrease by 97%. Respondents with higher Regulatory Body Requirements scores on the survey indicating they did not agree they had either an ethical obligation to the College of Social Workers and Social Service Workers (CSWSSW) or a legal obligation to the Ontario provincial mandatory reporting laws were less likely to report this situation to the CAS.

Consultation / Supervision also significantly predict the tendency to report or not report suspected child maltreatment, \( p < .05 \). As Consultation / Supervision scores increase by one unit, the odds of reporting suspected child maltreatment increase by more than 2.5 times. Respondents with higher Consultation / Supervision scores on the survey indicating they did not agree with
the need to consult with others or seek supervision were more likely to report this situation to the CAS. The other variables were not significant.

A summary of the significant predictors for the multiple logistic regression results for Groups 1 and 2 of each vignette is presented in Table 19.

Table 19.

Summary of Multiple Logistic Regression Results to Determine Factors that Predict a Social Worker's Tendency to Report or Not Report Suspected Child Maltreatment

<table>
<thead>
<tr>
<th>Vignette</th>
<th>Group</th>
<th>Significant Predictor</th>
</tr>
</thead>
</table>
| 1        | 1     | Regulatory Body Requirements  
|          |       | Consultation / Supervision                                |
|          | 2     | Regulatory Body Requirements  
|          |       | Culture, Religion & Ethnicity  
|          |       | Consultation / Supervision                                |
| 2        | 1     | Regulatory Body Requirements  
|          |       | Reporting History  
|          |       | Consultation / Supervision                                |
|          | 2     | Regulatory Body Requirements                                |
| 3        | 1     | Regulatory Body Requirements                                |
|          | 2     | Regulatory Body Requirements  
|          |       | Consultation / Supervision                                |

As can be seen in Table 19, Regulatory Body Requirements significantly predicts the tendency to report or not report suspected child maltreatment across all vignettes and in both groups while Consultation / Supervision is also a significant predictor within each vignette but in selected groups.
Interaction Effects

To answer the second research question, what is the interaction between legal, clinician, situational, and professional factors; interaction effects for the following four pairs of variables were explored: Comfort with Conflict and Parenthood, Regulatory Body Requirements and Consultation / Supervision, Gender and Parenthood, and Attitude Toward CAS and Reporting History. Analysis was run for each pair of variables for each vignette and group separately. An interaction effect between the two variables of interest as well as the main effects of the variables participating in interaction was included in each analysis together with other significant predictors from previous analyses.

The decision to report suspected child maltreatment is not a solitary decision based on one factor alone but includes the interaction between factors. The following is a summary of the theoretical rationale underlying the selected interactions.

Comfort with Conflict and Parenthood

Decision-making theory notes that decisions do not occur in an emotional vacuum (Finucane et al., 2003) but that emotions can affect the decision-making process. A clinician may fear engendering conflict with the family for calling CAS to report suspected child maltreatment and allow this fear to skew their decision-making in an ultimately inappropriate manner. In addition, many clinicians are presently or formerly parents of minor children. A clinician who is also a parent and who has a physiological reaction to how a client chooses to discipline his or her child may be affected by the meaning of the discipline, the effect on the child, and the remembrance of similar parental feelings of frustration and impatience. The interaction of a clinician’s comfort with conflict and his or her concurrent status of parenthood require examination and are included in the analysis.
Regulatory Body Requirements and Consultation / Supervision

Kitchener (1984) posits that an intuitive level of decision-making is necessary when faced with deciding the most ethical course of action. The intuitive level involves the knowledge base of professional codes of conduct. For the present study this would encompass the regulatory body requirements of the OASW. Jankowski and Ivey (2001) note the importance of a conversational decision-making approach which includes others in the decision-making process. While this approach has traditionally considered clients in the decision-making process, the approach can also refer to discussion with superiors and peers as part of their decision-making process. Thus, decision-making theory from intuitive and conversational approaches includes the interaction between an intuitive level of one’s knowledge of regulatory body requirements and an interactive form of decision-making which includes consultation with supervisors and colleagues.

Gender and Parenthood

Ecological theory is a foundational social work theory which focuses on the fit of organisms and their environments (Rothery, 2005). Embedded within the ecological framework is the concept of biology which includes gender. Gender is inherited, defines individuals through maleness or femaleness, and helps shape how one understands his or her relationship to others. The person-in-environment perspective, an integral component of the ecological framework, posits that the environment within which one lives shapes such factors as his or her strengths, competencies, needs, and beliefs (Saleeby, 2006). Included in the environmental perspective may be parenthood and how one’s demands, resources, beliefs, and strengths around parenting impact on one’s ability to cope and adapt to parenthood. As gender defines individuals and shapes their relationship with their children, the interaction between gender and parenthood within the
context of social worker decision-making requires examination.

**Attitudes Towards the CAS and Reporting History**

Structural theory studies how organizations arrange themselves to achieve goals (Handy, 1999). Within the context of the CAS, this theory includes ways the society is organized, delivers services, makes decisions, and relays information to those outside the society such as mandated reporters. Given the varying jurisdictions of the CAS, their structure can differ between provinces and territories. A social worker’s history of reporting to the CAS may be impacted by the particular society in their local jurisdiction and the manner in which that society is organized. A social worker who has found their local CAS’s organizational structure more restrictive in terms of service delivery and imparting information may be hesitant with regards to contacting that CAS, thus interaction between these two variables requires examination.

**Interaction Effects Results**

The interactions for all pairs of variables Comfort with Conflict and Parenthood, Regulatory Body Requirements and Consultation / Supervision, Gender and Parenthood and Reporting History and Attitude Toward CAS were not significant for Groups 1 and 2 in all vignettes.

**Therapeutic Alliance Descriptive Statistics Results**

Descriptive statistics were run for question A11 *Should I decide to file a report with the CAS regarding this case, I would take the following steps to maintain the therapeutic alliance with the family* and question A12 *I would say or do the following things to maintain the therapeutic alliance with the family after I file a report with the CAS* in all three vignettes. As this question was designated as *select all that apply* the numbers across rows will sum more than 480. Descriptive statistics were run for Groups 1 and 2 for each vignette. The results are
presented in Table 20.

Table 20.

Descriptive Statistics to Explore Respondents’ Steps and Actions to Maintain the Therapeutic Alliance after Reporting Suspected Child Maltreatment

<table>
<thead>
<tr>
<th>Steps (Survey Question A11)</th>
<th>Vignette 1</th>
<th>Vignette 2</th>
<th>Vignette 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group 1 Number (%)</td>
<td>Group 2 Number (%)</td>
<td>Group 1 Number (%)</td>
</tr>
<tr>
<td>No steps required</td>
<td>8 (3.2%)</td>
<td>6 (2.6%)</td>
<td>11 (4.4%)</td>
</tr>
<tr>
<td>Offer additional sessions</td>
<td>208 (82.5%)</td>
<td>188 (82.5%)</td>
<td>215 (85.3%)</td>
</tr>
<tr>
<td>Speak to clients via telephone</td>
<td>153 (60.7%)</td>
<td>141 (61.8%)</td>
<td>177 (70.2%)</td>
</tr>
<tr>
<td>Meet client(s) in their home</td>
<td>53 (21%)</td>
<td>42 (18.4%)</td>
<td>68 (27%)</td>
</tr>
<tr>
<td>Steps – Other</td>
<td>63 (25%)</td>
<td>77 (33.8%)</td>
<td>50 (19.8%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actions (Survey Question A12)</th>
<th>Vignette 1</th>
<th>Vignette 2</th>
<th>Vignette 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group 1 Number (%)</td>
<td>Group 2 Number (%)</td>
<td>Group 1 Number (%)</td>
</tr>
<tr>
<td>No actions required to maintain the alliance</td>
<td>2 (0.8%)</td>
<td>3 (1.3%)</td>
<td>3 (1.2%)</td>
</tr>
<tr>
<td>Validate client(s) emotions</td>
<td>237 (94%)</td>
<td>213 (93.4%)</td>
<td>237 (94%)</td>
</tr>
<tr>
<td>Explain your reasons for reporting numerous times</td>
<td>153 (60.7%)</td>
<td>133 (58.3%)</td>
<td>149 (59.1%)</td>
</tr>
<tr>
<td>Help clients prepare</td>
<td>170</td>
<td>151</td>
<td>164</td>
</tr>
</tbody>
</table>
The range within each category between Groups 1 and 2 did not exceed 30 which points to a consistency between the two groups in the steps or actions they would take following the decision to report suspected child maltreatment. In addition, relatively few respondents (less than 7%) indicated that they would take no further steps or actions to maintain the therapeutic alliance with the family following the decision to report to CAS.

Within the steps category, the majority of respondents indicated that they would offer additional sessions or speak to the client(s) via telephone, indicating that they would attempt a verbal or face-to-face connection with clients. Across all three vignettes, fewer respondents indicated that they would be willing to meet clients in their home. In the action category, most respondents indicated that they would validate client(s) emotions and explain the reasons behind mandatory reporting. In essence, they would offer emotional support as well as information to back their decision. To a lesser extent, respondents would explain their clinical reasons for contacting the CAS and help clients prepare for the CAS visit. Finally, roughly a quarter of respondents indicated they would apologize for the impact of reporting.

In the category of “other,” at least 20% of respondents indicated that they would take another step not listed to maintain the therapeutic alliance with the family; however, less than 12% of respondents indicated that they would take some further action. Responses in the “other”
grouping were categorized by theme. The results are presented in Tables 21 and 22.

Table 21.

**Content Analysis of Steps to Maintain the Therapeutic Alliance - Other Category**

<table>
<thead>
<tr>
<th>Category</th>
<th>Vignette 1 Number of Responses</th>
<th>Vignette 2 Number of Responses</th>
<th>Vignette 3 Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer psycho-educational / counselling services</td>
<td>34</td>
<td>38</td>
<td>55</td>
</tr>
<tr>
<td>Provide information</td>
<td>71</td>
<td>46</td>
<td>25</td>
</tr>
<tr>
<td>Utilize resources</td>
<td>41</td>
<td>20</td>
<td>22</td>
</tr>
<tr>
<td>Advocate on behalf of clients</td>
<td>18</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Reporting options</td>
<td>32</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>Efforts to maintain the relationship</td>
<td>13</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Response demonstrates cultural awareness</td>
<td>14</td>
<td>7</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 22.

**Content Analysis of Actions to Maintain the Therapeutic Alliance – Other Category**

<table>
<thead>
<tr>
<th>Category</th>
<th>Vignette 1 Number of Responses</th>
<th>Vignette 2 Number of Responses</th>
<th>Vignette 3 Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer psycho-education / counselling services</td>
<td>23</td>
<td>17</td>
<td>22</td>
</tr>
<tr>
<td>Provide information</td>
<td>13</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Utilize resources</td>
<td>10</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Advocate on behalf of clients</td>
<td>3</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Reporting options</td>
<td>8</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Efforts to maintain the relationship</td>
<td>6</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Response demonstrates cultural awareness</td>
<td>10</td>
<td>8</td>
<td>-</td>
</tr>
</tbody>
</table>
As this question was designated as “select all that apply” some responses were applicable to more than one category.

Responses demonstrated that the majority of respondents would offer psycho-education or counselling services to the family such as individual, couple or family counselling or group work around the presented issues. Thus, many respondents expressed the desire to continue their clinical work with the family in question. In addition, respondents indicated they would provide information to the family such as the reason for the report, the role and benefits of the CAS, or would have discussed mandatory reporting at the start of counselling. Respondents also noted they would utilize various resources such as colleagues, managers, or clients’ extended family. Respondents would also use a variety of reporting options such as encouraging the client to report, reporting with the client present, or reporting together with the client. Respondents would also make efforts to maintain the relationship such as discussing clients’ feelings about the report, exploring how clients feel about the social worker breaking confidentiality, and offering to support clients through the CAS investigation. Finally, given the cultural aspects of Vignettes 1 and 2, the responses of some respondents demonstrated a cultural awareness. Specifically they indicated referring the clients to cultural specific resources, consulting with a colleague knowledgeable of the client’s culture or explaining mandatory reporting laws as they exist in Ontario.

Multiple Logistic Regression Analysis Results (Therapeutic Alliance)

To answer the third research question what factors predict the likelihood of social workers undertaking specific steps and actions to maintain the therapeutic alliance once they report suspected child maltreatment multiple logistic regression (parameter estimates (OR) and their confidence intervals (CI)) analyses using enter method were run for the following steps: offer additional sessions, speak to clients via telephone, and meet clients in their home. The predictors used in the analysis include Gender, Parenthood, Attitude toward CAS, Medical
Related Practice, Child Related Practice, Community Related Practice, Regulatory Body

Requirements, Consultation / Supervision, Comfort with Conflict, Reporting History, Culture, Religion & Ethnicity, and Circumstances Around Disclosure. The results are presented in Tables 23, 24, and 25.

Table 23.

*Multiple Logistic Regression Analysis of Steps to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Offer Additional Sessions*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Vignette 1</th>
<th>Vignette 2</th>
<th>Vignette 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group 1</td>
<td>Group 2</td>
<td>Group 1</td>
</tr>
<tr>
<td></td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td><strong>Characteristics of the Respondent</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>1.18 (.37; 3.77)</td>
<td><strong>3.29 (1.24; 8.72)</strong>*</td>
<td>3.50 (.87; 14.05)</td>
</tr>
<tr>
<td>Parenthood</td>
<td>.66 (.24; 1.87)</td>
<td>1.00 (.38; 2.65)</td>
<td><strong>.25 (.07; .91)</strong>*</td>
</tr>
<tr>
<td>Attitude Toward CAS</td>
<td>1.29 (.57; 2.88)</td>
<td>.94 (.43; 2.04)</td>
<td>1.35 (.54; 3.36)</td>
</tr>
<tr>
<td>Medical Related Practice</td>
<td>1.47 (.51; 4.25)</td>
<td>1.17 (.42; 3.25)</td>
<td>.48 (.14; 1.67)</td>
</tr>
<tr>
<td>Child Related Practice</td>
<td>1.00 (.35; 2.86)</td>
<td>2.10 (.64; 6.85)</td>
<td>.48 (.13; 1.69)</td>
</tr>
<tr>
<td>Community Related Practice</td>
<td><strong>6.19 (1.24; 30.85)</strong>*</td>
<td>.63 (.20; 1.95)</td>
<td>2.02 (.43; 9.45)</td>
</tr>
</tbody>
</table>
In interpreting the above table, predictors with values for OR that are less than 1 mean that respondents who expressed disagreement on the survey for that predictor would be less likely to offer additional sessions to maintain the therapeutic alliance. Predictors with values for OR that are greater than 1 mean that respondents who expressed agreement on the survey for that predictor would be more likely to offer additional sessions to maintain the therapeutic alliance.

In Vignette 1 Group 1 respondents in Community Related Practice were more likely to offer additional sessions compared to respondents working in Private Practice. In Vignette 1 Group 2 female respondents were more likely to offer additional sessions than males.
In Vignette 2 Group 1 respondents who were parents were less likely to offer additional sessions. Respondents who felt comfortable discussing their concerns with the parents / caregivers and respondents who agreed that the circumstances around disclosure were important to them in their clinical decision-making were more likely to offer additional sessions. In Vignette 2 Group 2 female respondents were more likely to offer additional sessions than males while respondents with an overall negative experience in reporting or consulting to the CAS were less likely to offer additional sessions.

In Vignette 3 Group 1 respondents who felt comfortable discussing their concerns with parents / caregivers were more likely to offer additional sessions. In Vignette 3 Group 2 female respondents were more likely to offer additional sessions to maintain the therapeutic alliance.

Table 24.

Multiple Logistic Regression Analysis of Steps to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Speak to Clients via Telephone

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Vignette 1</th>
<th>Vignette 2</th>
<th>Vignette 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group 1</td>
<td>Group 2</td>
<td>Group 1</td>
</tr>
<tr>
<td></td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>Characteristics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of the Respondent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>1.28 (.53; 3.10)</td>
<td>1.99 (.83; 4.79)</td>
<td>1.33 (.52; 3.40)</td>
</tr>
<tr>
<td>Parenthood</td>
<td>1.03 (.49; 2.14)</td>
<td>.87 (.42; 1.84)</td>
<td>64 (.30; 1.37)</td>
</tr>
<tr>
<td>Attitude Toward CAS</td>
<td>1.63 (.86; 3.07)</td>
<td>1.36 (.74; 2.52)</td>
<td>1.48 (.77; 2.83)</td>
</tr>
<tr>
<td>Case Characteristics</td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------------</td>
<td>----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Medical Related Practice</td>
<td>1.24 (.51; 2.97)</td>
<td>1.58 (.71; 3.53)</td>
<td>.71 (.29; 1.77)</td>
</tr>
<tr>
<td>Child Related Practice</td>
<td>1.69 (.66; 4.30)</td>
<td>1.01 (.43; 2.35)</td>
<td>.82 (.31; 2.18)</td>
</tr>
<tr>
<td>Community Related Practice</td>
<td>.92 (.38; 2.26)</td>
<td>1.67 (.63; 4.45)</td>
<td>.65 (.25; 1.64)</td>
</tr>
<tr>
<td>Regulatory Body Requirements</td>
<td>.77 (.57; 1.04)</td>
<td>.68 (.46; .99)*</td>
<td>.87 (.64; 1.83)</td>
</tr>
<tr>
<td>Consultation / Supervision</td>
<td>.64 (.48; .87)**</td>
<td>.82 (.60; 1.11)</td>
<td>.84 (.62; 1.14)</td>
</tr>
<tr>
<td>Comfort with Conflict</td>
<td>.84 (.36; 1.96)</td>
<td>1.70 (.72; 4.04)</td>
<td>2.57 (.82; 8.09)</td>
</tr>
<tr>
<td>Reporting History</td>
<td>1.13 (.61; 2.11)</td>
<td>1.07 (.55; 2.08)</td>
<td>1.19 (.62; 2.28)</td>
</tr>
<tr>
<td>Culture, Religion &amp; Ethnicity</td>
<td>1.36 (.44; 4.19)</td>
<td>.53 (.17; 1.66)</td>
<td>1.19 (.41; 3.46)</td>
</tr>
<tr>
<td>Circumstances Around Disclosure</td>
<td>1.10 (.58; 2.09)</td>
<td>2.03 (1.01; 4.09)*</td>
<td>1.17 (.59; 2.31)</td>
</tr>
</tbody>
</table>

* p < .05  
** p < .01

In interpreting the above table, predictors with values for OR that are less than 1 mean that respondents who expressed disagreement on the survey for that predictor would be less likely to speak to clients via telephone to maintain the therapeutic alliance. Predictors with values for OR that are greater than 1 mean that respondents who expressed agreement on the survey for that
predictor would be more likely to speak to clients via telephone to maintain the therapeutic alliance.

In Vignette 1 Group 1 respondents who expressed disagreement with the need to consult with a colleague or supervisor around their reporting decision were less likely to speak to clients via telephone in an effort to maintain the therapeutic alliance. In Vignette 1 Group 2 respondents who agreed that the circumstances around disclosure were important to them in their clinical decision-making were more likely to speak to clients via telephone whereas respondents who disagreed that they had either an ethical obligation to the CSWSSW or a legal obligation to Ontario’s provincial mandatory reporting laws were less likely to speak to clients via telephone.

In Vignette 2 Group 2 female respondents and respondents in Community Related Practice were more likely to speak to clients via telephone. In Vignette 3 Group 1 respondents who disagreed with the need to consult with colleagues or obtain supervision around their reporting decision were less likely to speak to clients via telephone. Respondents who agreed that their previous experience in calling the CAS influenced their decision of the current case and respondents who had an overall positive attitude toward the CAS were more likely to speak to clients via telephone. In Vignette 3 Group 2 female respondents were more likely to speak to clients via telephone to maintain the therapeutic alliance.

Table 25.

*Multiple Logistic Regression Analysis of Steps to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Meet Clients in their Home*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Vignette 1 Group 1 OR</th>
<th>Vignette 2 Group 1 OR</th>
<th>Vignette 3 Group 1 OR</th>
<th>Vignette 1 Group 2 OR</th>
<th>Vignette 2 Group 2 OR</th>
<th>Vignette 3 Group 2 OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics of the Respondent</td>
<td>(95% CI)</td>
<td>(95% CI)</td>
<td>(95% CI)</td>
<td>(95% CI)</td>
<td>(95% CI)</td>
<td>(95% CI)</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Gender</td>
<td>.62 (.20; 1.89)</td>
<td>1.44 (.49; 4.29)</td>
<td>.88 (.31; 2.50)</td>
<td>2.05 (.63; 6.74)</td>
<td>.37 (.12; 1.21)</td>
<td>1.36 (.40; 4.66)</td>
</tr>
<tr>
<td>Parenthood</td>
<td>.66 (.26; 1.71)</td>
<td><strong>4.34 (1.39; 13.57)</strong></td>
<td>.77 (.33; 1.78)</td>
<td><strong>3.39 (1.15; 9.97)</strong></td>
<td>.83 (.31; 2.24)</td>
<td><strong>4.24 (1.19; 15.18)</strong></td>
</tr>
<tr>
<td>Attitude Toward CAS</td>
<td>1.83 (.76; 4.38)</td>
<td>.81 (.38; 1.71)</td>
<td>1.17 (.55; 2.49)</td>
<td>.84 (.37; 1.89)</td>
<td>1.77 (.72; 4.31)</td>
<td>.66 (.27; 1.60)</td>
</tr>
<tr>
<td>Medical Related Practice</td>
<td>.41 (.12; 1.40)</td>
<td>1.70 (.64; 4.47)</td>
<td>.35 (.12; 1.02)</td>
<td>1.68 (.61; 4.59)</td>
<td><strong>.20 (.05; .77)</strong></td>
<td>1.10 (.36; 3.36)</td>
</tr>
<tr>
<td>Child Related Practice</td>
<td>.94 (.29; 3.06)</td>
<td>1.51 (.51; 4.48)</td>
<td>.87 (.30; 2.55)</td>
<td>1.09 (.35; 3.41)</td>
<td>.81 (.25; 2.66)</td>
<td>.54 (.14; 2.08)</td>
</tr>
<tr>
<td>Community Related Practice</td>
<td>1.78 (.39; 3.58)</td>
<td>2.10 (.68; 6.53)</td>
<td>1.29 (.48; 3.47)</td>
<td><strong>3.86 (1.22; 12.24)</strong></td>
<td>1.43 (.48; 4.27)</td>
<td>2.65 (.79; 8.87)</td>
</tr>
<tr>
<td>Regulatory Body Requirements</td>
<td>1.25 (.86; 1.83)</td>
<td>.88 (.56; 1.37)</td>
<td>1.12 (.78; 1.56)</td>
<td>.85 (.56; 1.27)</td>
<td>.72 (.44; 1.18)</td>
<td>.68 (.41; 1.43)</td>
</tr>
<tr>
<td>Consultation / Supervision</td>
<td>.72 (.47; 1.11)</td>
<td>.92 (.63; 1.34)</td>
<td>.92 (.64; 1.31)</td>
<td>.76 (.50; 1.16)</td>
<td>.74 (.49; 1.23)</td>
<td>.69 (.45; 1.07)</td>
</tr>
<tr>
<td>Comfort with Conflict</td>
<td>2.21 (.58; 8.42)</td>
<td>3.76 (.81; 17.40)</td>
<td>4.56 (.54; 38.74)</td>
<td>3.22 (.64; 16.16)</td>
<td>1.00 (not reported)</td>
<td>1.00 (.26; 3.86)</td>
</tr>
<tr>
<td>Reporting History</td>
<td>1.45 (.64; 3.29)</td>
<td>1.64 (.75; 3.61)</td>
<td><strong>2.17 (1.04; 4.53)</strong></td>
<td>2.01 (.91; 4.42)</td>
<td><strong>3.35 (1.40; 8.02)</strong></td>
<td>1.67 (.47; 2.88)</td>
</tr>
</tbody>
</table>

Case Characteristics

Culture, 2.42 (.76; .92 (.25; 2.01 (.41;
In interpreting the above table, predictors with values for OR that are less than 1 mean that respondents who expressed disagreement on the survey for that predictor would be less likely to meet clients in their home to maintain the therapeutic alliance. Predictors with values for OR that are greater than 1 mean that respondents who expressed agreement on the survey for that predictor would be more likely to meet clients in their home to maintain the therapeutic alliance.

In Vignette 1 Group 2 respondents who were parents were more likely to meet clients in their home in an effort to maintain the therapeutic alliance. In Vignette 2 Group 1 respondents who agreed that the cultural background of the parents influenced their decision-making of the case and respondents who agreed that their previous experience in calling the CAS would influence their decision of the current case were more likely to meet clients in their home. In Vignette 2 Group 2 respondents who were parents and respondents who worked in Community Related Practice were more likely to meet clients in their home.

In Vignette 3 Group 1 respondents who agreed that their previous experience in calling CAS influenced their decision of the current situation and respondents who agreed that the cultural background of the parents influenced their decision-making were more likely to meet clients in their home. Respondents who worked in Medical Related Practice were less likely to meet clients in their home. In Vignette 3 Group 2 respondents who were parents and who agreed

<table>
<thead>
<tr>
<th>Religion &amp; Ethnicity</th>
<th>7.71</th>
<th>3.47</th>
<th>2.84 (1.03; 7.85)*</th>
<th>6.59 (1.36; 31.94)*</th>
<th>8.19 (1.71; 39.24)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circumstances</td>
<td>1.79 (.74; 4.35)</td>
<td>1.84 (.83; 4.09)</td>
<td>2.15 (1.00; 4.62)</td>
<td>2.34 (.99; 5.04)</td>
<td>.66 (.28; 1.59)</td>
</tr>
<tr>
<td>Around Disclosure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .05
** p < .01
that the cultural background of the parents influenced their decision-making were more likely to meet clients in their home.

A summary of the statistically significant predictors for the multiple logistic regression analyses for the steps to maintain the therapeutic alliance following the decision to report suspected child maltreatment is presented in Table 26.

Table 26.

Summary of Multiple Logistic Regression Analyses of the Steps to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment

<table>
<thead>
<tr>
<th>Type of Steps</th>
<th>More / Fewer Steps</th>
<th>Significant Predictors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer Additional Sessions</td>
<td>More Likely</td>
<td>Gender (female)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Related Practice</td>
</tr>
<tr>
<td></td>
<td>Less Likely</td>
<td>Comfort with Conflict</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Circumstances Around Disclosure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parenthood</td>
</tr>
<tr>
<td>Speak to Clients via Telephone</td>
<td>More Likely</td>
<td>Attitude Toward CAS</td>
</tr>
<tr>
<td>Meet Clients in their Home</td>
<td>More Likely</td>
<td>Reporting History</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Circumstances Around Disclosure</td>
</tr>
<tr>
<td></td>
<td>Less Likely</td>
<td>Regulatory Body Requirements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consultation / Supervision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parenthood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Related Practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reporting History</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Culture, Religion &amp; Ethnicity</td>
</tr>
<tr>
<td></td>
<td>Less Likely</td>
<td>Medical Related Practice</td>
</tr>
</tbody>
</table>
In examining the multiple logistic regression analyses there are several trends to note. First, respondents working in Community Related Practice are more likely to reach out to clients by offering additional sessions, speaking to clients via telephone, and by meeting clients in their home. Second, respondents who felt comfortable discussing their concerns with parents / caregivers were more likely to offer additional sessions.

Third, female respondents were more likely to offer additional sessions and speak to clients via telephone. Fourth, respondents who were parents were less likely to offer additional sessions; however, they were also more likely to meet clients in their home.

Fifth, respondents who agreed that their reporting history influenced their decision in the current case were more likely to speak to clients via telephone and were more likely to meet clients in their home. Sixth, respondents who agreed that the circumstances around disclosure influenced their reporting decision were more likely to offer additional sessions, and were more likely to speak to clients via telephone. Seventh, respondents who disagreed with the need to consult with a colleague or supervisor around their reporting decision were less likely to speak to clients via telephone.

To answer the third research question what factors predict the likelihood of social workers undertaking specific steps and actions to maintain the therapeutic alliance once they report suspected child maltreatment multiple logistic regression (parameter estimates (OR) and their confidence intervals (CI) analyses using enter method were run for the following actions: validate clients emotions, explain your reasons for reporting numerous times, help clients prepare for the CAS visit, explain the reasons behind mandated reporting, and apologize for the impact of reporting. The predictors used in the analysis include Gender, Parenthood, Attitude Toward
CAS, Medical Related Practice, Child Related Practice, Community Related Practice, Regulatory
Body Requirements, Consultation / Supervision, Comfort with Conflict, Reporting History,
Culture, Religion & Ethnicity, and Circumstances Around Disclosure. The results are presented
in Tables 27, 28, 29, 30, and 31.

Table 27.

**Multiple Logistic Regression Analysis of Actions to Maintain the Therapeutic Alliance Following
the Decision to Report Suspected Child Maltreatment – Validate Clients Emotions**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Vignette 1</th>
<th>Vignette 2</th>
<th>Vignette 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group 1</td>
<td>Group 2</td>
<td>Group 1</td>
</tr>
<tr>
<td></td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>Characteristics of the Respondent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.65 (.12; 3.64)</td>
<td><strong>14.42 (2.71; 76.75)</strong></td>
<td>.37 (.04; 3.65)</td>
</tr>
<tr>
<td>Parenthood</td>
<td>1.33 (.28; 6.21)</td>
<td>1.81 (.29; 11.43)</td>
<td>.74 (.17; 3.17)</td>
</tr>
<tr>
<td>Attitude Toward CAS</td>
<td>1.93 (.54; 6.92)</td>
<td>.34 (.07; 1.57)</td>
<td>1.25 (.36; 4.41)</td>
</tr>
<tr>
<td>Medical Related Practice</td>
<td>.82 (.13; 5.34)</td>
<td><strong>8.21 (1.13; 59.89)</strong></td>
<td>1.12 (.19; 6.69)</td>
</tr>
<tr>
<td>Child Related Practice</td>
<td>.73 (.12; 4.53)</td>
<td>2.05 (.35; 12.10)</td>
<td>.64 (.12; 3.43)</td>
</tr>
<tr>
<td>Community</td>
<td>.87 (.11; 1.00)</td>
<td>1.25 (.18; 2.04)</td>
<td>.51 (.12; 1.43)</td>
</tr>
<tr>
<td>Related Practice</td>
<td>6.80</td>
<td>reported</td>
<td>8.63</td>
</tr>
<tr>
<td>------------------------</td>
<td>------</td>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td>Regulatory Body</td>
<td>.91</td>
<td>.91</td>
<td>1.38</td>
</tr>
<tr>
<td>Requirements</td>
<td>1.67</td>
<td>2.34</td>
<td>2.62</td>
</tr>
<tr>
<td>Consultation / Supervision</td>
<td>.58</td>
<td>.65</td>
<td>.58</td>
</tr>
<tr>
<td></td>
<td>1.07</td>
<td>1.32</td>
<td>1.01</td>
</tr>
<tr>
<td>Comfort with Conflict</td>
<td>4.92</td>
<td>7.49</td>
<td>2.54</td>
</tr>
<tr>
<td></td>
<td>19.31</td>
<td>(1.41; 39.75)</td>
<td>13.97</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting History</td>
<td>2.89</td>
<td>1.61</td>
<td>1.62</td>
</tr>
<tr>
<td></td>
<td>11.04</td>
<td>.34</td>
<td>.46</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.69</td>
<td>5.67</td>
</tr>
</tbody>
</table>

**Case Characteristics**

| Culture, Religion & Ethnicity | 1.19 | .15 | .71 | .67 | .23 | .24 |
|                              | .11  | .01 | .11 | .07 | .04 | .04 |
|                              | 12.48| 2.48| 4.74| 6.75| 1.19| 1.46|

| Circumstances Around Disclosure | .35 | 5.31 | .45 | 1.13 | .73 | 1.67 |
|                                | .08 | (.77)| .12 | (.37)| .27 | (.54)|
|                                | 1.44| 36.43)| 1.69| 3.43| 1.96| 5.19|

* p < .05
** p < .01

In interpreting the above table, predictors with values for OR that are less than 1 mean that respondents who expressed disagreement on the survey for that predictor will be less likely to validate clients’ emotions to maintain the therapeutic alliance. Predictors with values for OR that are greater than 1 mean that respondents who expressed agreement on the survey for that predictor will be more likely to validate clients’ emotions to maintain the therapeutic alliance.
In Vignette 1 Group 1 respondents who agreed that they felt comfortable discussing their concerns with the parents / caregivers were more likely to validate clients’ emotions. In Vignette 1 Group 2 female respondents, respondents working in Medical Related Practice and respondents who agreed that they felt comfortable discussing their concerns with the parents / caregivers were more likely to validate clients’ emotions.

In Vignette 3 Group 1 respondents who disagreed with the need to consult a colleague or supervisor around their reporting decision were less likely to validate clients’ emotions while respondents with a positive attitude toward the CAS were more likely to validate clients’ emotions.

Table 28.

Multiple Logistic Regression Analysis of Actions to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Explain Your Reasons for Reporting Numerous Times

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Vignette 1</th>
<th>Vignette 2</th>
<th>Vignette 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group 1</td>
<td>Group 2</td>
<td>Group 1</td>
</tr>
<tr>
<td></td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>Gender</td>
<td>.42 (.16; 1.13)</td>
<td>1.09 (.45; 2.67)</td>
<td>.77 (.30; 1.97)</td>
</tr>
<tr>
<td>Parenthood</td>
<td>.52 (.24; 1.11)</td>
<td>1.49 (.73; 3.03)</td>
<td>.36 (.17; .78)**</td>
</tr>
<tr>
<td>Attitude Toward CAS</td>
<td>2.17 (1.14; 4.14)*</td>
<td>.44 (.24; .82)**</td>
<td>1.76 (.93; 3.33)</td>
</tr>
</tbody>
</table>
In interpreting the above table, predictors with values for OR that are less than 1 mean that respondents who expressed disagreement on the survey for that predictor will be less likely to explain their reasons for reporting numerous times to maintain the therapeutic alliance.

Predictors with values for OR that are greater than 1 mean that respondents who expressed
agreement on the survey for that predictor will be more likely to explain their reasons for reporting numerous times to maintain the therapeutic alliance.

In Vignette 1 Group 1 respondents who disagreed with the need to consult with a colleague or supervisor around their reporting decision were less likely to explain their reasons for reporting numerous times whereas respondents with an overall positive experience in reporting or consulting to the CAS were more likely to explain their reasons for reporting numerous times. In Vignette 1 Group 2 respondents with an overall negative experience in reporting or consulting to the CAS and who disagreed that the cultural background of the parents influenced their reporting decision were less likely to explain their reasons for reporting numerous times.

In Vignette 2 Group 1 respondents who were parents were less likely to explain their reasons for reporting while respondents who agreed that they felt comfortable discussing their concerns with the parents / caregivers were more likely to explain their reasons for reporting numerous times. In Vignette 2 Group 2 respondents with a negative overall experience in reporting or consulting to the CAS were less likely to explain their reasons for reporting.

In Vignette 3 Group 1 respondents who were parents were less likely to explain their reasons for reporting. In Vignette 3 Group 2 respondents with an overall negative experience in reporting or consulting to the CAS were less likely to explain their reasons for reporting whereas respondents who were parents were more likely to explain their reasons for reporting.

Table 29.

Multiple Logistic Regression Analysis of Actions to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Help Clients Prepare for the CAS Visit

<table>
<thead>
<tr>
<th>Vignette 1</th>
<th>Vignette 2</th>
<th>Vignette 3</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Group 1 OR (95% CI)</th>
<th>Group 2 OR (95% CI)</th>
<th>Group 1 OR (95% CI)</th>
<th>Group 2 OR (95% CI)</th>
<th>Group 1 OR (95% CI)</th>
<th>Group 2 OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Characteristics of the Respondent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>1.39 (.55; 3.50)</td>
<td><strong>3.80 (1.50; 9.66)</strong></td>
<td>1.48 (.58; 3.74)</td>
<td>1.75 (.71; 4.29)</td>
<td>1.94 (.74; 5.07)</td>
<td>2.30 (.92; 5.75)</td>
</tr>
<tr>
<td>Parenthood</td>
<td>.82 (.38; 1.76)</td>
<td>.81 (.36; 1.83)</td>
<td>.61 (.29; 1.31)</td>
<td>.98 (.47; 2.04)</td>
<td>.70 (.32; 1.53)</td>
<td>1.05 (.51; 2.15)</td>
</tr>
<tr>
<td>Attitude Toward CAS</td>
<td>1.44 (.74; 2.78)</td>
<td>.89 (.46; 1.74)</td>
<td>1.10 (.58; 2.10)</td>
<td>.69 (.37; 1.31)</td>
<td>1.02 (.53; 1.95)</td>
<td>1.13 (.60; 2.12)</td>
</tr>
<tr>
<td>Medical Related Practice</td>
<td>1.15 (.47; 2.82)</td>
<td><strong>1.55 (0.66; 3.65)</strong></td>
<td>1.05 (.44; 2.52)</td>
<td>1.71 (.77; 3.81)</td>
<td>1.62 (.68; 3.86)</td>
<td>1.19 (.53; 2.66)</td>
</tr>
<tr>
<td>Child Related Practice</td>
<td>.69 (.27; 1.73)</td>
<td>.53 (.22; 1.27)</td>
<td>.69 (.28; 1.73)</td>
<td>.62 (.27; 1.41)</td>
<td>.69 (.28; 1.71)</td>
<td>.38 (.16; 0.86)</td>
</tr>
<tr>
<td>Community Related Practice</td>
<td>1.77 (.68; 4.65)</td>
<td>3.44 (1.05; 11.29)</td>
<td>1.38 (.55; 3.45)</td>
<td>2.45 (.81; 6.28)</td>
<td>1.58 (.61; 4.07)</td>
<td><strong>1.81 (0.64; 5.12)</strong></td>
</tr>
<tr>
<td>Regulatory Body Requirements</td>
<td><strong>1.43 (1.02; 2.00)</strong></td>
<td>.96 (.63; 1.46)</td>
<td>1.26 (.93; 1.72)</td>
<td>1.10 (.81; 1.48)</td>
<td>.80 (.56; 1.14)</td>
<td>.97 (.70; 1.34)</td>
</tr>
<tr>
<td>Consultation / Supervision</td>
<td>.97 (1.31) .90 (1.25)</td>
<td>1.03 (1.38) .81 (1.09)</td>
<td>.80 (1.08) .77 (1.04)</td>
<td>.77 (1.04)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comfort with Conflict</td>
<td><strong>2.30 (1.01; 5.25)</strong></td>
<td>.62 (.23; 1.67)</td>
<td><strong>5.17 (1.47; 18.17)</strong></td>
<td>1.37 (.54; 3.53)</td>
<td>2.61 (.89; 7.67)</td>
<td>1.50 (.61; 3.66)</td>
</tr>
<tr>
<td>Reporting History</td>
<td>1.44 (.75; 2.76)</td>
<td>1.34 (.66; 2.76)</td>
<td>1.36 (.72; 2.57)</td>
<td>.88 (.46; 1.66)</td>
<td>1.46 (.76; 2.82)</td>
<td>1.06 (.55; 2.07)</td>
</tr>
<tr>
<td><strong>Case Characteristics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In interpreting the above table, predictors with values for OR that are less than 1 mean that respondents who expressed disagreement on the survey for that predictor will be less likely to help clients prepare for the CAS visit. Predictors with values for OR that are greater than 1 mean that respondents who expressed agreement on the survey for that predictor will be more likely to help clients prepare for the CAS visit.

In Vignette 1 Group 1 respondents who agreed that they felt comfortable discussing their concerns with the parents / caregivers and respondents who agreed that they had an ethical obligation to CSWSSW and a legal obligation to Ontario’s mandatory reporting laws were more likely to help clients prepare for the CAS visit. In Vignette 1 Group 2 female respondents, respondents in Medical Related Practice and respondents who agreed that the circumstances around disclosure influenced their clinical decision to report or not report were more likely to help clients prepare for the CAS visit.

In Vignette 2 Group 1 respondents who agreed that they felt comfortable discussing their concerns with the parents / caregivers were more likely to help clients prepare for the CAS visit.

In Vignette 3 Group 2 respondents in Community Related Practice and respondents who agreed that the circumstances around disclosure were important in their clinical decision were more likely to help clients prepare for the CAS visit.
Table 30.

**Multiple Logistic Regression Analysis of Actions to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Explain the Reasons behind Mandatory Reporting**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Vignette 1</th>
<th>Vignette 2</th>
<th>Vignette 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group 1</td>
<td>Group 2</td>
<td>Group 1</td>
</tr>
<tr>
<td></td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>Characteristics of the Respondent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>.52 (.06; 4.06)</td>
<td><strong>8.89 (1.88; 42.11)</strong></td>
<td>.23 (.01; 5.88)</td>
</tr>
<tr>
<td>Parenthood</td>
<td>1.22 (.26; 5.64)</td>
<td>3.93 (.84; 18.36)</td>
<td>1.22 (.16; 9.47)</td>
</tr>
<tr>
<td>Attitude Toward CAS</td>
<td>1.30 (.32; 5.35)</td>
<td>.44 (.10; 1.86)</td>
<td>7.10 (.84; 59.95)</td>
</tr>
<tr>
<td>Medical Related Practice</td>
<td>.57 (.09; 3.50)</td>
<td>1.67 (.29; 9.65)</td>
<td>.08 (.01; 1.01)</td>
</tr>
<tr>
<td>Child Related Practice</td>
<td>1.38 (.16; 12.27)</td>
<td>1.60 (.20; 13.10)</td>
<td>.99 (.03; 29.92)</td>
</tr>
<tr>
<td>Community Related Practice</td>
<td>1.80 (.14; 23.10)</td>
<td>.94 (.13; 6.55)</td>
<td>1.00 (not reported)</td>
</tr>
<tr>
<td>Regulatory Body Requirements</td>
<td>1.30 (.63; 2.68)</td>
<td>.69 (.30; 1.59)</td>
<td><strong>.31 (.12; .77)</strong></td>
</tr>
<tr>
<td>Consultation / Supervision</td>
<td>.52 (.27; 1.01)</td>
<td>.65 (.34; 1.26)</td>
<td><strong>.25 (.09; .70)</strong></td>
</tr>
</tbody>
</table>
In interpreting the above table, predictors with values for OR that are less than 1 mean that respondents who expressed disagreement on the survey for that predictor will be less likely to explain the reasons behind mandatory reporting to maintain the therapeutic alliance. Predictors with values for OR that are greater than 1 mean that respondents who expressed agreement on the survey for that predictor will be more likely to explain the reasons behind mandatory reporting to maintain the therapeutic alliance.

In Vignette 1 Group 2 female respondents were more likely to explain to clients the reasons behind mandated reporting. In Vignette 2 Group 1 respondents who disagreed with the need to consult a colleague or supervisor around their reporting decision, respondents who disagreed that their previous experience in calling the CAS influenced their decision of the current case, and respondents who disagreed that they have a legal obligation under Ontario’s mandatory reporting laws or an ethical obligation to the CSWSSW were less likely to explain the reasons behind mandated reporting. In Vignette 2 Group 2 respondents who disagreed that they...
have a legal obligation under Ontario’s mandatory reporting laws or an ethical obligation to the CSWSSW were less likely to explain the reasons behind mandated reporting. Respondents who agreed that the circumstances around disclosure were important in their clinical decision were more likely to explain the reasons behind mandated reporting.

In Vignette 3 Group 1 respondents who agreed that they felt comfortable discussing their concerns with the parents / caregivers were more likely to explain the reasons behind mandated reporting whereas respondents who disagreed that they have a legal obligation under Ontario’s mandatory reporting laws or an ethical obligation to the CSWSSW were less likely to explain the reasons behind mandated reporting. In Vignette 3 Group 2 respondents who disagreed that they have a legal obligation under Ontario’s mandatory reporting laws or an ethical obligation to the CSWSSW were less likely to explain the reasons behind mandated reporting.

Table 31.

Multiple Logistic Regression Analysis of Actions to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment – Apologize for the Impact of Reporting

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Vignette 1</th>
<th>Vignette 2</th>
<th>Vignette 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group 1</td>
<td>Group 2</td>
<td>Group 1</td>
</tr>
<tr>
<td></td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
<td>OR (95% CI)</td>
</tr>
<tr>
<td>Gender</td>
<td>1.34 (.51; 3.47)</td>
<td>1.09 (.41; 2.91)</td>
<td>1.25 (.46; 3.38)</td>
</tr>
<tr>
<td>Parenthood</td>
<td>.59 (.29; 1.21)</td>
<td>.77 (.36; 1.63)</td>
<td>.73 (.35; 1.51)</td>
</tr>
<tr>
<td>Attitude</td>
<td>.87 (.46; 1.87)</td>
<td>.71 (.36; 1.63)</td>
<td>.84 (.44; 1.51)</td>
</tr>
</tbody>
</table>
In interpreting the above table, predictors with values for OR that are less than 1 mean that respondents who expressed disagreement on the survey for that predictor will be less likely to apologize for the impact of reporting in an effort to maintain the therapeutic alliance. Predictors
with values for OR that are greater than 1 mean that respondents who expressed agreement on the survey for that predictor will be more likely to apologize for the impact of reporting in an effort to maintain the therapeutic alliance.

In Vignette 1 Group 1 respondents who disagreed with the need to consult a colleague or supervisor around their reporting decision and respondents who disagreed that the circumstances around disclosure influenced their reporting decision were less likely to apologize for the impact of reporting. In Vignette 1 Group 2 respondents who disagreed that they felt comfortable discussing their concerns with the parents / caregivers were less likely to apologize for the impact of reporting.

In Vignette 2 Group 1 respondents who disagreed with the need to consult a colleague or supervisor around their reporting decision were less likely to apologize for the impact of reporting. In Vignette 2 Group 2 respondents who did not feel comfortable discussing their concerns with the parents / caregivers were less likely to apologize for the impact of reporting.

In Vignette 3 Group 1 respondents who disagreed with the need to consult a colleague or supervisor around their reporting decision were less likely to apologize for the impact of reporting.

A summary of the statistically significant predictors for the multiple logistic regression analyses for the actions to maintain the therapeutic alliance following the decision to report suspected child maltreatment is presented in Table 32.
Table 32.

Summary of Multiple Logistic Regression Analyses of the Actions to Maintain the Therapeutic Alliance Following the Decision to Report Suspected Child Maltreatment

<table>
<thead>
<tr>
<th>Type of Actions</th>
<th>Actions</th>
<th>Significant Predictors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validate clients’ emotions</td>
<td>More Likely</td>
<td>Gender (Female)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attitude Toward CAS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical Related Practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comfort with Conflict</td>
</tr>
<tr>
<td></td>
<td>Less Likely</td>
<td>Consultation / Supervision</td>
</tr>
<tr>
<td>Explain reasons for reporting numerous times</td>
<td>More Likely</td>
<td>Parenthood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attitude Toward CAS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comfort with Conflict</td>
</tr>
<tr>
<td></td>
<td>Less Likely</td>
<td>Parenthood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attitude Toward CAS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consultation / Supervision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Culture, Religion &amp; Ethnicity</td>
</tr>
<tr>
<td>Help prepare clients for the CAS visit</td>
<td>More Likely</td>
<td>Gender (Female)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical Related Practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Related Practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regulatory Body Requirements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comfort with Conflict</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Circumstances Around Disclosure</td>
</tr>
<tr>
<td>Explain reasons behind mandated reporting</td>
<td>More Likely</td>
<td>Gender (Female)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comfort with Conflict</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Circumstances Around Disclosure</td>
</tr>
<tr>
<td></td>
<td>Less Likely</td>
<td>Regulatory Body Requirements</td>
</tr>
<tr>
<td>Apologize for the impact of reporting</td>
<td>Less Likely</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------</td>
<td></td>
</tr>
</tbody>
</table>

In examining the multiple logistic regression analyses there are several trends to note. First, respondents who disagreed with the need to consult with a colleague or supervisor were less likely to validate clients’ emotions, explain the reasons for reporting numerous times, explain the reasons behind mandatory reporting, and apologize for the impact of reporting. Second, respondents who felt less comfortable discussing their concerns with parents / caregivers were less likely to apologize for the impact of reporting. Respondents who felt more comfortable discussing their concerns with parents / caregivers were more likely to validate clients’ emotions, help clients prepare for the CAS visit, and explain the reasons behind mandatory reporting.

Third, female respondents were more likely to validate clients’ emotions, explain the reasons behind mandatory reporting, and help prepare clients for the CAS visit. Fourth, respondents who agreed that they have an ethical obligation to the CSWSSW and a legal obligation to Ontario’s provincial mandatory reporting laws were more likely to prepare clients for the CAS visit but those who disagreed were less likely to explain the reasons behind mandated reporting. Fifth, respondents who agreed that the circumstances around disclosure were important to their clinical decision to report or not report the case were more likely to help clients prepare for the CAS visit and explain the reasons behind mandatory reporting.
Respondents who disagreed that the circumstances around disclosure were important were less likely to apologize for the impact of reporting. Sixth, respondents who were parents were both more likely and less likely to explain the reasons for reporting numerous times depending on the vignette and group.

Summary

Results of the quantitative analysis revealed that Regulatory Body Requirements and Consultation / Supervision were the significant predictors in social workers’ decisions to report or not report suspected child maltreatment. These findings are interesting when compared to social workers’ stated top three decision-making factors, the first being the opinion of colleagues and the second being the duty to report along with the ethical obligation to the OASW. It would appear that social workers take seriously the inclusion of others’ opinions in their decision-making coupled with their ethical obligations to the profession and their legal obligations to the province. The implications of these findings will be further explored in chapter seven.

Chapter six addresses the fourth research question through presenting an analysis of the qualitative data. The chapter initially discusses the trustworthiness of the data before exploring the themes and categories of each qualitative question. Respondent narratives are interspersed to highlight the findings.
CHAPTER SIX: QUALITATIVE DATA: ANALYSIS AND FINDINGS

Introduction

This chapter presents the qualitative findings from the study to answer the fourth research question *what are the strategies to maintain the therapeutic alliance after social workers report suspected child maltreatment*. Beginning with a discussion of using qualitative questions within survey methodology, the chapter moves to a discussion of how the data was collected and analyzed and then to the issue of rigour within online qualitative methodology. The chapter then explores the resultant themes and categories while providing respondent narratives to enrich, contextualize, and give meaning to responses. The chapter concludes with an exploration of respondents’ positive and negative experiences with various Children’s Aid Societies.

*Use of Qualitative Questions within Survey Methodology*

Huberman and Miles (1994) note that qualitative “data analysis is not off-the-shelf, rather, it is custom-built, revised, and ‘choreographed.’” These words ring true for this study as the qualitative data, essentially text-based narratives, was derived via online format. Charmaz (2006) distinguishes between “extant texts” that consist of existing documents and “elicited texts” which involve the respondent producing written data. Internet surveys containing open-ended questions are a common source of these latter forms of texts.

There is a strong rationale for using qualitative methodology within an online context. Electronic surveys that include open-ended questions allow the researcher to learn additional information, allow respondents to describe their true views of the subject (Fowler, 2009), and allow respondents the opportunity to answer questions in their own words, which alleviates respondent frustration at being restricted to choosing a provided response.
Schaefer and Dillman (1998) noted that respondents were more likely to answer open-ended questions in an electronic based survey and the responses were longer than the mail responses while Milberg and Strang (2000) found that a combination of standardized quantitative questions along with open-ended qualitative questions improved the overall value of questionnaires.

The present study utilized three open-ended qualitative questions, with the first two questions focusing specifically on the impact and maintenance of the therapeutic alliance following the report to CAS. An examination of studies focusing on the mandatory reporting of child maltreatment reveals a historical precedent for combining open-ended qualitative questions with vignette methodology. The following studies utilized one open-ended question (Jankowski & Martin, 2003; Levi et al., 2006; Renninger et al., 2002; Strozier et al., 2005; Vullimay & Sullivan, 2000; Zellman, 1990a) and two open-ended questions (Kalichman & Brosig, 1993; Kalichman et al., 1989) in combination with vignette methodology.

Data Collection and Analysis

The qualitative data collection utilized three, open-ended questions using written responses with ample text space to give voice to respondent narratives. The first qualitative question, What is the initial impact of reporting suspected child maltreatment on the relationship between you and the family elicited 458 responses or 95% of the 480 respondents. The second qualitative question, What are the strategies you have found to be effective in maintaining the therapeutic alliance with a family after reporting suspected child maltreatment and why do you think they are effective elicited 451 responses or 94% of the 480 respondents. The third question, If you have comments about the content or structure of the survey, please write them here elicited 102 responses or 21% of the 480 respondents.
As the first two qualitative questions each focused on a distinct aspect of mandatory reporting (i.e., initial impact on the relationship and strategies to maintain the alliance), while the third question focused on the structure of the survey, each qualitative question was coded separately. Participant responses were read for each question and initial codes for segments of the text were developed (Charmaz, 2006). The constant comparison method was used to refine and organize codes into a coding framework (Charmaz, 2006). Once all the participant responses were coded into the framework, some categories were re-examined and regrouped to describe themes. Finally, an examination of the remaining codes that could not be assigned to a theme revealed it was within the seven percent maximum allowance as put forth by Lincoln and Guba (1985).

**Assessing for Rigour and Trustworthiness of the Data**

The categories and themes for each qualitative question appear trustworthy as there is congruence among the responses within each theme as well as sufficient contrast between themes. Second, qualitative analysis included both similar and divergent codes to fully explore all narratives. Third, the survey utilized purposive sampling (Given, 2008) and drew from the opinions of social workers currently or formerly in direct practice with children and adolescents and with experience concerning mandatory reporting and maintaining the alliance. Fourth, to obtain thick description of responses (Geertz, 1973; Ponterotto, 2006) and to allow respondents to write as much or as little as they chose, ample text space for the three qualitative questions was provided on the survey. Fifth, combining open-ended qualitative responses along with survey methodology utilizes the process of triangulation which permits a broader and more certain understanding of the issues under investigation (Fielding & Fielding, 1986).
Assessing for Validity of the Data

Couper, Traugott, and Lamias (2001) found that responses given within open ended text boxes tended to have a high degree of validity. Within the context of this study, validity was assessed and ensured in a number of different respects. First, to maximize validity and reduce inaccuracy, the author constructed qualitative questions that would be consistently understood by respondents. These questions were pilot tested on social workers with child welfare and clinical expertise to ensure understanding. Second, lack of knowledge can be a source of error and surface problems with validity. However, the survey was directed to social workers who practice with children and families. Within the qualitative responses, many social workers provided detailed examples of client feelings and reactions which increased confidence in the validity of the responses. Third, to minimize social desirability of responses which can impact validity, confidentiality was guaranteed to all respondents.

Fourth, the survey posed open-ended questions as opposed to close-ended questions to elicit detailed, contextually rich responses. Finally, catalytic validity “refers to the degree to which the research process re-orient, focuses, and energizes respondents in what Freire (1973) terms ‘conscientization,’ knowing reality in order to better transform it” (Lather, 1986, p. 67). This final element of validity became apparent in question D1, If you have comments about the content or structure of the survey, please write them here. Some respondents described the survey as thought provoking and that the survey prompted them to deepen their knowledge of mandatory reporting. During the data collection period the author was contacted by three separate respondents who requested the survey for their agency or educational setting. They wished to use the survey to examine their agency decision-making processes around mandatory reporting or to use the vignettes as a teaching tool with students.
Qualitative Data Interpretation

Table 33 presents a summary of the themes and their categories based on responses to the first qualitative question: *What is the initial impact of reporting suspected child maltreatment on the relationship between you and the family?*

Table 33.

*Themes and Categories of the Impact of Reporting Suspected Child Maltreatment*

<table>
<thead>
<tr>
<th>Family Feelings and Reactions (Positive)</th>
<th>• Relieved / Validated / Appreciative of Support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Understands reason for report</td>
</tr>
<tr>
<td>Family Feelings and Reactions (Negative)</td>
<td>• Anger / Defensiveness</td>
</tr>
<tr>
<td></td>
<td>• Anxiety / Fear</td>
</tr>
<tr>
<td></td>
<td>• Shame / Stress</td>
</tr>
<tr>
<td></td>
<td>• Suspicious of worker’s motives</td>
</tr>
<tr>
<td></td>
<td>• Violated / Judged</td>
</tr>
<tr>
<td></td>
<td>• Alienated / Betrayed</td>
</tr>
<tr>
<td></td>
<td>• Denial / Blame</td>
</tr>
<tr>
<td></td>
<td>• Disagree with the report</td>
</tr>
<tr>
<td>Impact on Clinical Relationship and Clinical Work (Positive)</td>
<td>• Relationship maintained / strengthened through social worker’s explanation of reporting / support / sensitivity / approach to family</td>
</tr>
<tr>
<td></td>
<td>• Family continues in treatment</td>
</tr>
<tr>
<td>Impact on Clinical Relationship and Clinical Work (Negative)</td>
<td>• Relationship is strained / tense / ruptured / severed</td>
</tr>
<tr>
<td></td>
<td>• Loss of trust</td>
</tr>
<tr>
<td></td>
<td>• Family withdraws from treatment</td>
</tr>
<tr>
<td></td>
<td>• Impact on communication</td>
</tr>
<tr>
<td></td>
<td>• Loss of confidentiality</td>
</tr>
<tr>
<td>Impact on Clinical Relationship and Clinical Work (Positive or Negative)</td>
<td>• Impact depends on the presence and strength of the therapeutic relationship with the family</td>
</tr>
<tr>
<td></td>
<td>• Impact varies from family to family</td>
</tr>
</tbody>
</table>
Family Feelings and Reactions (Positive)

Some respondents spoke of families feeling relieved, validated or appreciative of the support they would receive from the CAS. One respondent noted:

Many of the families I have reported have initially been fearful but realize they need help and continue on in therapy with positive conclusions and return in the future for further assistance. Some are relieved because they need help and don’t have access to resources or feel out of control. (P17)

Feelings of relief may come from one parent, “intervention is needed but the non-offending parent has been powerless to report” (P187) or the other parent, “occasionally, the perpetrator is relieved at having divulged the maltreatment and is guardedly pleased to have CAS assistance” (P75).

Some respondents noted that the family understands the reason for the report. One respondent explained “I have found that many families understand the obligation or duty to report which helps sustain the therapeutic alliance through this event” (P66). Some parents are able to understand that the report is made in the best interests of the child as exemplified by this comment “it is difficult but parents typically understand that the well being of their children is important to them … and when faced with the reality of the impact may not be happy about it but typically will cooperate” (P182).

Family Feelings and Reactions (Negative)

In contrast to the feeling of relief, respondents noted a plethora of negative feelings which may surface in the initial impact of reporting suspected child maltreatment. The most common negative feelings respondents reported were anger and defensiveness. One respondent noted “the initial impact is anger, as clients call in to get help and feel that they are not getting
help when a report has to made,” (P439) while another explained “the family is often angry at me and can be quiet upset (verbally) at me” (P172).

Some respondents explained that the family may exhibit anxiety upon learning of the report. One respondent noted “some discomfort / anxiety on the family usually occurs, needing to deal with that quickly / respond to maintain therapeutic alliance whenever possible to continue treatment” (P325) while another respondent noted that the anxiety may rest with the child in question, “the initial impact is … anxiety and fear in the child who would feel to blame for the family's embroilment with the CAS” (P399). Fear was another negative feeling on the part of the family which surfaced frequently in respondent narratives. The fears may be specific, “the family is often fearful that the child may be taken out of the home” (P431), more general, “fear of the unknown” (P51), or fear of repercussion was voiced by one respondent, “fear that the abuser knows about the report” (P122).

Some respondents noted a report elicits feelings of shame and stress and explained “there is also the risk that they feel embarrassed or ashamed that we have found out” (P98) and “both myself (the worker) and the family are faced with additional increased stress due to the possible involvement of the CAS as we are never quite sure how things will transpire following contact with CAS” (P265).

Families often felt suspicious of the worker’s motives upon hearing of the report. One respondent noted “suspicion that I am aligned with the Children's Aid Society against the family” (P181). Feeling violated and judged were other negative emotions which surfaced in respondent narratives. One respondent noted “parents feel violated, even though they have signed a consent form re. duty to report, and this is talked about in the first session” (P171). Another respondent explained “they fear that whatever they disclose to you, you will report them
again, and that you will also judge them negatively” (P156). Respondents talked of families feeling alienated and betrayed. One respondent noted families “will no longer see me as someone who is ‘on their side’” (P121) and “often there is a sense of betrayal that the person who was supposed to be helping has now made their lives more difficult by involving the Children's Aid Society” (P537).

Some respondents noted denial and blame as common reactions. One respondent explained “they will likely be upset and deny any wrongdoing” (P165). One respondent noted the family “want someone to blame for CAS ‘now being involved.’ This is typically the person making the referral” (P106). Respondents noted families may disagree with the report as exemplified by the following comment “the family is often angry and / or disagrees with the worker’s perception and doesn't believe this has to happen” (P116).

Impact on the Clinical Relationship and Clinical Work (Positive)

Many respondents noted that the relationship is maintained or strengthened through the social worker’s explanation of the reason for the report. One respondent noted “if you are honest and explain the process and why, they can have a sense of understanding and that your first priority is safety of the child” (P119). A social worker offering support to the family also has a positive impact on the clinical relationship. As one respondent explained “it's difficult but not insurmountable … open honest communication, education regarding the process and continued support through the process often result in the building of a stronger alliance” (P443).

Some respondents noted that the family continued in treatment despite the report to the Children’s Aid Society. One respondent explained:

I have been in this situation several times … There has been an initial sense of betrayal but usually the family sees that I am there to help them function in a more healthy way
than they have been and has continued to work with me after the initial anger has been addressed. (P369)

**Impact on the Clinical Relationship and Clinical Work (Negative)**

Respondents also noted negative impacts to the clinical relationship; one such impact is that the *relationship becomes strained* and *tense*. One respondent noted “reporting tends to distress parents / families and leads to some level of tension in the relationship” (P235). One respondent went further and noted “*rupture* in the relationship as the parents are angry and defensive” (P480) while another respondent explained “risk of cessation of the therapeutic relationship. If the relationship was *severed* then I would no longer be able to assist the family with their struggles” (P463). Many respondents noted the *loss of trust* that had been established between social worker and client was diminished or lost. One respondent described “since I would inform the family (caregiver) prior to reporting and at the time of disclosure, the initial impact is that I would need to breach the confidentiality of the clinical setting therefore trust will have been broken” (P471). Another respondent explained that the loss of trust impacts the effectiveness of therapy for “there is the possibility that the family will no longer trust you. You may lose your ability to interact effectively with the family” (P430).

Other respondents outlined negative impacts on clinical work such as the *family withdrawing from treatment*. One respondent shared the following, “they can lose trust in the therapeutic relationship and may end therapy, which could interfere with subsequent healing / working through how to parent without child maltreatment” (P504). Another finding was the *impact on communication and loss of confidentiality* should the family continue in treatment. One respondent noted “often communication is impacted with families / clients decreasing amount of information shared (trust needs to be rebuilt)” (P373) while another respondent
explained “a sense (on behalf of family members) that confidentiality and trust have been lost” (P104).

**Impact on Relationship (Positive or Negative)**

Some respondents noted that the *impact depends on the presence and strength of the therapeutic relationship with the family*. One respondent commented:

> It depends on the nature and extent of relationship with the family ... how long I've known and been working with them, how strong the alliance is ... sometimes the initial impact is that they end service ... other times they trust the relationship more and understand the duty to report. (P462)

Respondents also noted that the *impact can vary from family to family*. One respondent described “Sometimes the family has been appreciative because they know it is wrong but have been unable to do it themselves and at other times they have been very upset and accusatory about me trying to destroy the family” (P111).

Table 34 presents a summary of the themes and their categories based on responses to the second qualitative question: *What are the strategies you have found to be effective in maintaining the therapeutic alliance with a family after reporting suspected child maltreatment and why do you think they are effective?*
Table 34.

*Themes and Categories of the Strategies to Maintain the Therapeutic Alliance*

<table>
<thead>
<tr>
<th>Prevention Strategies</th>
<th>• Explain the limits of confidentiality at the start of counselling</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Build the therapeutic alliance prior to disclosure of child maltreatment</td>
</tr>
<tr>
<td>Reporting Strategies</td>
<td>• Discuss duty to report with the family</td>
</tr>
<tr>
<td></td>
<td>• Involve the family in the reporting process</td>
</tr>
<tr>
<td></td>
<td>• Give the family options around making the report</td>
</tr>
<tr>
<td>Information Strategies</td>
<td>• Revisit signed consent form</td>
</tr>
<tr>
<td></td>
<td>• Provide information on CAS (explain the role of CAS in protecting children, outline the process of a CAS investigation, explain the benefits of involvement with the CAS)</td>
</tr>
<tr>
<td></td>
<td>• Collaborate with CAS</td>
</tr>
<tr>
<td></td>
<td>• Offer psycho-education to family (use theoretical approaches to explain abuse and neglect, explore parental disciplinary history)</td>
</tr>
<tr>
<td>Affect Regulation Strategies</td>
<td>• Social worker affect regulation</td>
</tr>
<tr>
<td></td>
<td>• Family affect regulation (maintain contact with the family, worker is non-judgemental of the family, support family during / following CAS investigation, validate and explore family members’ feelings)</td>
</tr>
<tr>
<td></td>
<td>• Meet with CAS worker and family together</td>
</tr>
<tr>
<td></td>
<td>• Acknowledge the impact of reporting on the relationship</td>
</tr>
<tr>
<td>Advocacy Strategies</td>
<td>• Express concern for child’s safety and well-being</td>
</tr>
<tr>
<td></td>
<td>• Reinforce parenting skills and strengths</td>
</tr>
<tr>
<td></td>
<td>• Advocate on behalf of the family with the CAS</td>
</tr>
<tr>
<td>Resource Strategies</td>
<td>• Community supports</td>
</tr>
<tr>
<td></td>
<td>• Professional supports</td>
</tr>
</tbody>
</table>

*Prevention Strategies*

Many respondents spoke about *explaining the limits to confidentiality at the start of counselling*. One respondent noted “explaining at the first meeting my duty to report any
suspicions of abuse or neglect and reminding them periodically. This is effective in my view, because parents then know that if they disclose what the consequences will be” (P536). One respondent spoke about the duty to report in terms of empowerment, “explaining the limits of confidentiality up front … This empowers the client, in most cases, to decide what information to disclose without blindsiding them” (P502). One respondent discussed the duty to report in terms of control, “ALL of my clients have the limits of confidentiality explained to them BEFORE we engage in service so the information shared with me is firmly under the control of the client” (P396). Another strategy involved building the therapeutic alliance with families prior to a disclosure of child maltreatment. One respondent noted “I think it is more important to engage in strategies BEFORE rather than after reporting … wherever possible it is more effective to work collaboratively with the client to maintain trust” (P483).

**Reporting Strategies**

Respondents outlined numerous strategies they employ when reporting suspected child maltreatment. Some respondents believed it was advisable to discuss the duty to report with the family. One respondent noted “if I hear something in an interview that needs to be reported, then I immediately let my client know that the information they shared may be grounds for calling CAS” (P259). Respondents also described notifying the family either before or after reporting to the CAS. One respondent noted “clients appreciate my honesty in telling them immediately when I believe that I have to make a report” (P312). Another respondent noted this strategy was effective as it removes the sense of betrayal:

When possible, I like to be able to talk to the family about the fact that I did report and hope we have an opportunity to process this before CAS gets involved. Being clear
before reporting is effective because it takes the element of betrayal out of the equation.

(P423)

Some respondents explained that when faced with making a report it was helpful to involve the family in the reporting process as it promotes transparency:

It's been effective to report with the parent there - calling CAS and putting the phone on speaker … so that the client can hear exactly what I’m reporting … I think it is effective because it makes a disempowering situation less powerless - clients are part of process.

(P396)

Some respondents explained they encourage clients to self-report, “I have found from experience that Children’s Aid is far more receptive and helpful to parents who ask for help themselves” (P288). Some respondents report suspected child maltreatment in conjunction with the client and find this process to be beneficial to maintaining the alliance. One respondent noted:

Offering the family or client the opportunity to participate in the reporting process … Often it is being open and honest about the reporting that allows families the perspective that you are not out to get them but interested in maintaining safety and support for everyone involved. (P537)

Finally, some social workers gave the family options around making the report. One respondent noted:

I work with the family to decide how best to make the report … they can make the call themselves and I will follow-up or we can make the call together. This gives the family some control over the process. (P274)
Information Strategies

Respondents utilized a plethora of information strategies to maintain the therapeutic alliance. Some respondents revisited the signed consent form which was signed and explained when counselling commenced. One respondent noted “I … remind them that we discussed my obligation to report prior to commencing a counselling relationship, and they signed the terms of counselling to that effect” (P147).

Social workers noted that providing information on CAS can be helpful. One respondent noted “prior to contacting CAS, clearly describing the process of consultation with CAS, including the understanding that my consultation with CAS will result in CAS deciding whether a full report, with identifying information, is required” (P231). Respondents noted explaining the role of the CAS in terms of protecting children was important information to share with parents. One respondent shared “explaining the role of CAS: as a supporter of families in need, who are there to ensure children in our society are well taken care of” (P514).

Respondents noted that outlining the process of a CAS investigation was important information to share with clients. Providing this information served to allay parents’ automatic fear that their child will be removed from the home. One respondent noted:

We can discuss general expectations about what will happen when the report is made; such as interviews, and CAS having the job to make sure everyone is safe. It may not necessarily mean that the child will leave the home etc. Discussing the client's apprehensions and giving them information or refuting ill-conceived beliefs about abuse and what it really is. (P468)

One respondent explained that sharing this information can strengthen the alliance by noting “being able to explain what is happening, or what will happen, can reduce fears and help position
me as supportive of the family” (P297). Respondents noted that explaining the benefit of involvement with the CAS was useful in maintaining the alliance. One respondent noted “try to suggest to the family that CAS may be able to help them to deal with their obvious parenting struggles. I think this helps to see the CAS in a helping role rather than a punitive one” (P402). Some respondents point out specific services offered by the CAS. One respondent shared “frame CAS as a support, as an advocate, can provide in-home support if required for behavioural issues” (P198).

Respondents noted the importance of collaborating with CAS to assist in maintaining the alliance. One respondent commented “being kept in the loop by CAS so that I can help support the family … Being able to explain what is happening, or what will happen, can reduce fears and help position me as supportive of the family” (P297).

Finally, offering psycho-education to the family was seen as paramount to assist families and maintain the alliance. One respondent described a theoretical approach to educating the family, “I also use family systems theory to help decrease families shame and to increase their understanding of the impact of intergenerational trauma and loss on the emergence (and / or continuing patterns of) child maltreatment” (P96). Another respondent noted exploring parental disciplinary history:

Often it is a time to help them reflect on their childhoods and look at how they were parented as children and the impact that had (most of these cases the parents experienced abuse and are repeating the pattern of family violence) this is an opportunity for learning and making changes. (P490)
Affect Regulation Strategies

Many respondents wrote about the intense emotions experienced by the social worker and the client(s) after reporting to the CAS. One respondent explained the importance of social worker affect regulation by “exploring … counter transference with colleagues and supervisors” (P192) in an effort to manage the social worker’s intense affective reaction. Respondents noted the importance of calmness when moving forward with the family, “I stay calm, validate feelings, ask what the experience with CAS was like for them, ask how I can help now … how can we work together now, how can we work together with CAS to support the family” (P73).

Following the report to the CAS, social workers noted the importance of assisting with the family’s affect regulation in a variety of ways, for example, maintaining contact with the family assists in helping manage negative emotions. One respondent explained this in terms of feelings of non-judgment and abandonment:

Families seem to be better able to accept a referral to a CAS when they perceive the worker to continue to care for them and be interested in their well-being … I think they also appreciate not being abandoned by the individual during the period that the CAS is involved. (P563)

Respondents noted that offering to support the family during or following the CAS investigation is helpful to maintaining the alliance and can assist with intense fears concerning the investigation. Respondents noted the increased trust in using this strategy, “reassuring them that I will not abandon them in the process. I think these strategies have been effective, as it builds trust and models a more appropriate way to deal with intense feelings” (P257) and that it promotes faith in the parents “following up with support is a good idea … to assist the parents so
that they do not feel that they are up against CAS alone but it is to assist them so that they can become better parents” (P229).

Respondents also spoke about allowing the family time to process their reactions to the report, “validation of their feelings is very important. This helps the client(s) to realize that their feelings are normal … to be expected … their feelings are not so much directed to me but to the situation” (P54). Some respondents commented on specific feelings, “accepting the family’s feelings, especially their anger,” (P90) “validating and exploring feelings of shame / blame” (P192) and “validate their fear in particular of CAS” (P157). One respondent made an interesting comment concerning validating the parental role “before reporting it has been helpful to validate the parents’ challenges / struggles which lead to the abusive incident, normalize their frustration” (P230).

Another strategy to maintain the alliance was to meet with the CAS worker and the family together to promote support and transparency. One respondent noted “offering to meet with CAS with the family where possible - demonstrates transparency with the family and they are able to see my non-judgmental stance through my engagement with CAS” (P184). Other respondents found it helpful to directly acknowledge the impact of reporting on the relationship. One respondent shared that not hiding the impact on the relationship was important, “explaining the … concern about impact, being open about the fact that it does affect the relationship” (P462).

**Advocacy Strategies**

Respondents noted using various advocacy strategies to maintain the relationship with the family and to pinpoint the reality of how the child was being treated. One particular advocacy strategy was to express concern for child’s safety and well-being as often the child does not have a “voice” per se and needs the social worker to speak on his or her behalf. One respondent noted:
I am transparent with clients about concerns … safety, both emotional and physical, comes first, as without this in place, therapeutic work can be superficial. I am clear with clients on this and the mutual flow of discussion and concerns as this can potentially help move the therapeutic relationship forward. (P531)

Another advocacy strategy was to reinforce parenting skills and strengths. One respondent noted “reinforce the belief that family members want to do ‘better’, belief that they are capable of doing so and engaging with this” (P540) while another respondent shared “identifying strengths they have shown in handling difficult situations” (P505). Respondents tried to unite with the clients’ desire to be good parents. One respondent noted “joining with the family’s intent to be the best parents they can be and remaining involved as a partner offers them a corrective experience about professionals and communicates our belief in their ability to do better” (P553). Another respondent emphasized being non-judgmental “I have found that if the therapeutic relationship is strong or longstanding and if I am clear about not judging the parents (after all, many are doing their best in desperate circumstances), they will continue to work with me” (P332).

Finally, respondents took advocacy one step further when many spoke about advocating on behalf of the family with CAS. One respondent noted “I try very hard to reassure them that the fact they are seeking help speaks volumes about their strength as a family and that this message would be stressed with the intake CAS worker” (P560) Respondents maintain that informing the CAS of the family’s strengths assists in maintaining the therapeutic alliance with the family.

Resource Strategies

Respondents spoke about utilizing community supports to assist families after reporting suspected child maltreatment. One respondent explained “continuing to support in other concrete
ways (i.e., food, school etc),” (P114) was a means of providing the necessities the family may not currently possess. Respondents noted turning to professional supports was crucial in assisting families as well as themselves in the aftermath of reporting. One respondent noted “it is extremely hard to maintain the alliance - best thing is a team approach, where others are involved as well, and can support the family with their feelings if they are too upset with me to do this” (P171). Working together as a team provided support for both the family as well as the reporting social worker.

**Factors Affecting Social Workers’ Reporting Decisions**

Although not directly elicited within the qualitative questions, many respondents reflected on the positive and negative factors concerning their local CAS which impacts their reporting decisions. Table 35 presents a summary of the factors which impact respondents’ decision-making.

Table 35.

*Positive and Negative Factors which Impact Respondents’ Decision-making*

<table>
<thead>
<tr>
<th>Positive Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Offer Anonymous Consultation</td>
</tr>
<tr>
<td>• Assistance Around Informing the Family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Negative Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of Information</td>
</tr>
<tr>
<td>• Selective Therapeutic Support</td>
</tr>
<tr>
<td>• Lack of Involvement in Cases of Domestic Violence</td>
</tr>
<tr>
<td>• Punitive Focus Versus Prevention Focus</td>
</tr>
<tr>
<td>• Lack of Follow-up</td>
</tr>
<tr>
<td>• Lack of Collaboration and Systemic Focus</td>
</tr>
<tr>
<td>• Negative Experiences with Individual CAS Workers</td>
</tr>
<tr>
<td>• Use of Stigmatizing Language</td>
</tr>
</tbody>
</table>
Positive Factors

Some respondents commented on the fact that their local CAS offers anonymous consultation with social workers to determine if a suspicion requires reporting. One respondent noted “I have learned to contact the Children’s Aid Society and frame questions to them anonymously to obtain their feedback about whether or not cases warrant reporting … This improves my confidence about the process” (P473). Another respondent explained:

Making a call to CAS to run a ‘hypothetical’ situation by them … they were able to help me process whether this warranted needing to make a report or not. So for situations where it was not required, I felt then assured that my concern was checked out. (P503)

Following substantiation, one respondent received assistance around informing the family that a report is required, “CAS was also very helpful regarding reporting the abuse and the ways to handle informing the family” (P550).

Negative Factors

Many respondents shared experiences with the CAS which were less than satisfactory. One respondent decried the lack of information and selective therapeutic support while sharing the following:

CAS will simply NOT share information with external agencies / care providers despite their wanting information. Example, they will send to the hospital clients for ‘assessment’ and not state WHY? Also it is sometimes felt that they will work with certain families ‘hoping’ they might change, despite evidence clearly to the contrary. (P464)

Another respondent commented specifically on CAS’s lack of involvement in cases of domestic violence:
Many times, CAS will not become involved if parents are separated and there has been domestic violence in the family - their response is: we do not get involved in separation and divorce issues even though the issue being reported is one of children's welfare on access visits with father. Other times, CAS is ineffective in dealing with issues of domestic violence in the family by dealing with mother in a punitive manner. (P498)

One respondent commented on the *punitive focus versus prevention focus* of the CAS:

“Because CAS often are solely child protection focused, but do not include in that the child's need for a family … CAS seems to cast their nets too far these days, with no recourse for clients” (P555). Another respondent explained “due to the ineffectiveness of our local CAS (punitive, no focus whatsoever on family system and prevention), I would prefer to continue working with a family rather than cut ties of a therapeutic relationship” (P444).

Another respondent expressed concern around the *lack of follow up* they have witnessed in their local CAS. One respondent shared “I have been very concerned … that the CAS has needed a great deal of pressure to follow up on even more significant cases of abuse in less than 7 days even with significant follow up on my part” (P150). Another respondent shared “I have … had some disappointing contact with CAS where I have felt that they have not followed up sufficiently with families even after I have communicated my concerns” (P559).

Some respondents commented on the *lack of collaboration and systemic focus* which they perceive as necessary during the investigation process. One respondent shared:

Some CAS agencies do not hire BSW / MSW but hire people with BAs, or Diplomas, which seem to affect effectiveness of their response and work with the family. Many workers do not seem to think systemically, do not connect families to counselling, doctors or consult with schools. (P460)
Another respondent explained:

The challenge in working with CAS is there has been a decreased emphasis on working collaboratively and case conferencing on mutual cases … There is not enough done to ensure this continuity in treatment and providing consistent messages between both agencies. Clients are often left confused by having so many different workers on a case and what their roles are at the onset, continuing through to longer term cases where ongoing communication between agencies is vital. The onus is often left to the individual clinician and the willingness of the CAS worker to work together. (P500)

Some respondents commented on negative experiences with individual CAS workers. One respondent shared “I personally have had difficulty as a professional trying to maintain relationships with CAS workers ... it has been my experience that often times this is a one way, power, relationship” (P470). Another respondent shared the following: “very serious cases often get dismissed and other not so high risk cases get overreacted to. The quality of the response and care the client and family get is very dependant on the social worker you get” (P512). However, one respondent explained “my experiences with CAS … have been very dependent on the worker. I have had both positive and negative experiences” (P455).

One respondent noted a CAS worker’s use of stigmatizing language:

When I have reported to X Children’s Aid Society … I have had very negative experiences, where CAS staff has spoken of the concern with very stigmatizing language, which has significantly increased my concern about the service the family will receive. (P184)
Summary

Respondent narratives around the impact of reporting suspected child maltreatment, the strategies to maintain the alliance and the positive and negative factors that influence respondents’ decision-making surfaced through the inclusion of open-ended, qualitative questions into the survey methodology. The categories within each theme support the quantitative findings as well as highlight additional avenues for future exploration and research that illuminates factors affecting reporting of suspected child maltreatment and how the alliance is maintained.

The final chapter of this dissertation presents the interpretations and implications of the quantitative and qualitative findings. The findings are explored within the field of social work research and social work practice. In addition, a revised conceptual framework is presented in light of the findings.
CHAPTER SEVEN: INTERPRETATIONS AND IMPLICATIONS OF THE FINDINGS

Introduction

The final chapter offers interpretations and implications of the quantitative and qualitative findings from the study. The research questions are reviewed and findings discussed in light of the theoretical and empirical literature reviews in chapters 2 and 3. The chapter then presents a revised conceptual framework based on the findings and compares this model to Brosig and Kalichman’s (1992) original framework as well as the framework presented in chapter 3. The chapter concludes with an exploration of the limitations of the study and the implications for future research as well as social work practice. As the findings for the second research question concerning the interaction between the legal, clinician, situational, and professional factors were not significant, they will not be discussed.

Research Questions and Discussion

The first research question explored the factors that predict a social worker’s decision to report or not report suspected child maltreatment. Results showed that Regulatory Body Requirements is a highly significant predictor (p < .01) of the likelihood of reporting suspected child maltreatment across all vignettes and groups. Respondents with higher Regulatory Body Requirements scores on the survey indicating they did not agree they had either an ethical obligation to the College of Social Workers and Social Service Workers (CSWSSW) or a legal obligation to the Ontario provincial mandatory reporting laws were less likely to report the vignette to the CAS. This finding is consistent with studies that have shown that knowledge of mandatory reporting legislation does not guarantee compliance (Green & Hansen, 1989; Kalichman et al., 1989; Swoboda et al., 1978). It is possible that these respondents may be more conservative in their views on mandatory reporting laws or may be conservative in their views
within the context of these specific vignettes. When examining respondents’ top three factors influencing decision-making to report suspected child maltreatment, the duty to report (n = 126) and the legal obligation to report (n=161) were the second highest ranking factors. This last finding is consistent with Beck and Ogloff (1995) who found that the legal obligation to report influenced clinicians’ reporting decisions.

In light of literature on decision-making in medicine, respondents who placed value in the duty to report based on their legal obligation may exhibit a vigilant decision-making pattern. As previously noted, such decision making involves an organized, thorough information search and consideration of alternatives prior to making a decision, often leading to high quality decisions (Janis & Mann, 1977). Respondents who rated highly the duty and legal obligation to report may seek guidance from provincial mandatory reporting legislation as well as the OCSWSSW code of ethics prior to making their decision. In addition, this pattern of decision-making may be similar to an evidence-based perspective which de-emphasizes the use of intuition while stressing the examination of evidence (Evidence Based Medicine Working Group, 1992).

Respondents who espouse the duty to report and legal obligation to report may also reflect, from the field of psychology, Kitchener’s (1984) intuitive level of decision-making. When faced with deciding the most ethical course of action, the intuitive level involves the beliefs, knowledge and assumptions found in professional ethical codes of conduct which forms the basis of clinicians’ ethical actions. Similarly Woody (1990), in the marriage and family therapy decision-making literature, proposes that professional codes of ethics including rules, norms and principles offer the clinician a logical method for ethical decision-making based on universal principles.
Consultation / Supervision is a significant predictor (p < .05) of the likelihood of reporting suspected child maltreatment in Vignette 1, Groups 1 and 2 (recantation / confirmation of abuse); Vignette 2, Group 1 (maltreatment by immigrant parents); and Vignette 3, Group 2 (child discloses maltreatment). Respondents with higher Consultation / Supervision scores on the survey indicating they did not agree with the need to consult with others or seek supervision were more likely to report suspected child maltreatment in these vignettes and groups; however, it is possible that for these respondents the most appropriate course of action in these particular vignettes was readily apparent so they did not see the need for consultation or supervision. It is also noteworthy that these respondents appeared to be more confident in their decision-making with vulnerable groups (e.g., child of immigrant parents in Vignette 2 and a hospitalized child in Vignette 3). It is possible that a higher degree of certainty in respondent decision-making correlates with a higher degree of perceived client vulnerability. When examining respondents’ top three factors influencing decision-making to report suspected child maltreatment, the opinion of colleagues (n = 373) was the number one factor. This finding is consistent with Weinstein et al. (2000) who found that 90.3% of respondents consulted with at least one source prior to reporting, including supervisors, colleagues, or the CPS Hotline. This suggests that making a report to CAS does not become routine despite a clinician’s level of experience.

In examining this finding in relation to the psychology literature, turning to colleagues when rendering important clinical decisions gives credence to the fact that decision-making does not occur in an emotional vacuum (Finucane et al., 2003; Loewenstein et al., 2001). Respondents who consult with others prior to contacting the CAS may recognize that emotions such as fear, anger, judgment, anxiety, or compassion can affect the decision-making process either positively or negatively by changing priorities or distorting thinking (O’Sullivan, 1999). As noted earlier, it
is essential that clinicians demonstrate awareness of their decision-making processes including the impact of these emotions. By turning to colleagues, these respondents may be practicing sound affect regulation prior to rendering a decision.

Neuroscience literature may help further explain the high number of respondents who seek the opinion of colleagues. Baylis (2006) purports that affiliation and social bonding is fundamental to neurological development and growth. Supportive relationships also contribute to the release of oxytocin, a neuro-peptide directly involved in social bonding and down regulation of the stress response system (Bloom, Nelson, & Lazerson, 2001; Rosenzweig, Leiman, & Breedlove, 1999; Taylor et al., 2000). Social bonding helps soothe and down regulates the hypothalamic-pituitary-adrenal axis (HPA) axis through the effects of oxytocin, and leads to reduced fearfulness (Panksepp, 1998; Taylor et al., 2000). Consequently, contact with a supportive person, such as a social work colleague, during the decision-making process to report or not report suspected child maltreatment may help modulate the stress of the decision-making, the fear around the reaction of the family, and the physiological arousal by stimulating the release of oxytocin (McEwen, 2002; Taylor et al., 2000; Uvnas-Moberg, 1998).

Siegel (2009) notes that decision-making and intervening in human problems, such as child maltreatment, are now being understood as a complex process which incorporates both a rational and emotional component, underscoring Damasio’s (2000) earlier observation that emotion is the edifice of reason. This perspective emphasizes implicit (i.e., unconscious), and explicit (i.e., conscious), mental processing (MacFadden & Schoech, 2010). The vast majority of individuals’ mental lives involve unconscious activity which reflects implicit mental processing. The human brain is geared toward survival and is finely attuned to the emotion of fear. Information flows into the thalamus and is simultaneously forwarded to either the amygdala
(Low Road response) or to the cortex which engages memory and thought (High Road response) (MacFadden & Schoech, 2010). Decision-making ability is centered in the frontal lobe of the brain and depends on the integration of the frontal lobe with the emotional limbic system. Professionals rendering decisions concerning suspicions of child maltreatment require a level of awareness, conscious thought and reflection to counterbalance the biases inherent in the Low Road processing.

Finally, the social work literature also helps explain the role of consulting with colleagues. Gambrill and Shlonsky (2000) note a host of personal and environmental based factors which may bias decision-making, and consultation with colleagues may limit the impact of these factors and reflect a conversational decision-making approach (Jankowski & Ivey, 2001). Sharing a suspicion of child maltreatment with a colleague may expand a social worker’s perspective as to the most appropriate course of action.

Of interest was that Circumstances Around Disclosure was not a significant predictor in respondents’ decision-making within any of the vignettes. This finding differs from Kalichman et al. (1989) and Kalichman and Craig (1991) who found that the perception of perpetrator behaviour (i.e., a father admits to child maltreatment and the perpetrator is non-compliant in admitting culpability), was a significant factor in respondents’ decision-making. In addition, Attitude Towards CAS was not significant in the Chi-Square and Correlation Analyses and thus was not included as a predictor in the logistic regression; however, respondents’ qualitative comments displayed a wide range of positive and negative opinions regarding the CAS.

The third research question concerns the factors that predict the likelihood of social workers undertaking specific steps and actions to maintain the therapeutic alliance once they report suspected child maltreatment. In examining what factors predict social workers’ specific
efforts to maintain the therapeutic alliance once they report suspected child maltreatment, as well as what factors predict social workers’ amount of effort (likelihood of taking specific steps or actions) to maintain the therapeutic alliance, multiple logistic regression analyses revealed that respondents working in Community Related Practice (i.e., community mental health; case management, and university / college social work), were more likely to maintain the alliance by offering additional sessions, speaking to clients via telephone, meeting clients in their home and helping clients prepare for the CAS visit. In essence, respondents working in Community Related Practice make a variety of efforts to maintain the alliance and appear to have a greater comfort level with home visits. Seeing clients in their home environment may also allow these respondents to witness the structural issues often disguised as maltreatment such as poverty, low income housing, and poor neighbourhoods (Merritt, 2009). It is possible that witnessing these structural issues propels these respondents to maintain the alliance.

Results also highlighted that respondents working in Medical Related Practice were less likely to meet with clients in their home. However, respondents in this area of social work practice were also more likely to validate clients’ emotions and help clients prepare for the CAS visit. It is possible that due to time restrictions, client volumes, and an emphasis on discharge planning, respondents working in this area of practice do not have the time to meet with clients outside of the medical setting while validating clients’ emotions and speaking with clients about the CAS visit are both strategies which can be performed within a medical setting.

In examining the previous two findings, it appears that the occupational environment plays a role in social workers’ efforts to maintain the alliance. It is possible that some environments where social work is practiced are more restrictive or offer more latitude than others. For example, within medical settings social work services may be offered solely within
business hours whereas in community settings, social work services may include evening and weekend hours as well as the opportunity to see clients in their home environment. This may restrict what social workers can do to reach out to clients to maintain the alliance.

With regards to the predictor Gender, results show a gender based difference between men and women with regards to their efforts to maintain the alliance. Specifically, female respondents were more likely to offer additional sessions, speak to clients via telephone, validate clients’ emotions, explain the reasons behind mandatory reporting, and help prepare clients for the CAS visit. This is not to say that male respondents did not make efforts to maintain the alliance but that the efforts did not reach statistical significance. Biology could potentially play a role in this finding. Qualitative findings highlighted that a report to CAS is often a period of stress for both the family and the social worker. There are two kinds of stress response, the historical “fight or flight” (Cannon, 1932) and the more recently described “tend and befriend” (Taylor et al., 2000). Taylor et al. (2000) propose that females respond to stressful situations by protecting themselves through nurturing behaviour, the “tend” part of the model and forming alliances with a larger social group, particularly among women, the “befriend” part of the model.

The “tend / befriend” response builds on the brain’s attachment / caregiving system which counteracts the metabolic activity associated with the traditional fight or flight stress response such as increased heart rate, blood pressure and cortisol levels, and leads to nurturing and affiliative behaviour. Taylor et al. (2000) speculate that women may have developed a completely different system for coping with stress in large part because their responses evolved in the context of being the primary caregiver of their children. From research into the neuro-endocrine responses for fight or flight, Taylor et al. (2000) document that, although women do show the same immediate hormonal and sympathetic nervous system response to acute stress,
other factors intervene to make fight or flight less likely in females. In terms of the fight response, while male aggression appears to be regulated by hormones such as testosterone, and linked to sympathetic reactivity and hostility, female aggression appears to be more cerebral in nature and moderated by social circumstances, learning, culture and the situation. Taylor et al. (2000) note that when stressed, females prefer being with others, especially other females and women are much more likely than men to seek out and use social support in all types of stressful situations, including health-related concerns, relationship problems and work-related conflicts.

The second hypothesis as to the differential finding between men and women centres on the tri-partite model of the alliance: bond, tasks, and goals (Bordin, 1979). If the “bond” part of the model equates more with the emotional connection or attachment with the client while the “tasks and goals” equate more with the intervention to produce change or the outcome of therapy, it is noteworthy that many of the steps or actions female respondents perform (e.g., offering additional sessions, speaking to clients via telephone, and validating clients’ emotions), are akin to the attachment or “bond” aspect. It is possible that the male respondents aligned more with the tasks and goals parts of the model.

The gender difference in the findings also speaks to Gilligan’s (1982) qualitative work on how men and women make decisions based on morality. A male approach to morality centres on people having certain basic rights, and respecting the rights of others. She theorizes male morality as having a “justice orientation” whereas a female approach to morality centres on people having responsibilities towards and caring for others. From this perspective, alliance repair strategies of offering additional sessions, speaking to clients via telephone, and validating clients’ emotions, promotes Gilligan’s idea of women caring for their clients, akin to the attachment or “bond” aspect of the alliance.
In examining the predictor Reporting History, respondents who agreed that their reporting history influenced their decision in the vignette were more likely to speak to clients via telephone and were more likely to meet clients in their home to retain the alliance but were less likely to explain the reasons behind mandatory reporting. This finding is consistent with the Steinberg et al. (1997) study which found that the more a therapist had reported in the past, the more likely the client terminated prematurely. Thus, having experience with reporting was not predictive of a better outcome regarding the alliance. It is possible that these respondents in the present study had a similar experience as the respondents in the Steinberg et al. (1997) study and thus, took steps to prevent premature termination.

Findings showed that respondents who disagreed with the need for Consultation / Supervision around their reporting decision were less likely to speak to clients via telephone, validate clients’ emotions, explain the reasons for reporting numerous times, explain the reasons behind mandatory reporting, and apologize for the impact of reporting. As noted earlier in the chapter, respondents who did not see the need to consult with a colleague or supervisor were also more likely to report suspected child maltreatment in these vignettes and groups. It appears that confidence in their decision-making leads to more likelihood of reporting and to less likelihood of maintaining the alliance. It is possible that due to their certainty that maltreatment is occurring, respondents believed the responsibility is now on the CAS to take investigative action which, in turn, causes them to withdraw from the client. However, more likelihood of withdrawing from clients has clinical repercussions as the time following the report to CAS is often when clients need the support of the social worker the most. It is important that social workers continue to reach out to clients during the reporting and investigative process, even if those efforts are rejected by clients.
In examining the predictor Comfort with Conflict, respondents who felt comfortable discussing their concerns with parents / caregivers were more likely to offer additional sessions, validate clients’ emotions, help clients prepare for the CAS visit, explain the reasons behind mandatory reporting, and explain their reasons for reporting numerous times. Respondents who felt less comfortable discussing their concerns with parents / caregivers were less likely to apologize for the impact of reporting. It is understandable that respondents who feel comfortable discussing their concerns with parents / caregivers are more likely to reach out to them to maintain the alliance. However, the reality of clinical practice is that social workers will not feel comfortable discussing concerns around mandatory reporting with all clients. This finding points to the central role of affect regulation as a means to regulate one’s internal psychobiological state while staying attuned to the client.

The fourth research question centres on the strategies to maintain the therapeutic alliance after social workers report suspected child maltreatment. Across vignettes and groups, descriptive statistics indicate that very few respondents (1% - 6%) believed there were no further steps or actions required to repair the alliance. Roughly 80% of respondents would offer clients additional sessions while 60% - 70% of respondents would speak to clients via telephone. Fewer respondents (14% - 27%) indicated they would be willing to meet with clients in their home. About 90% of respondents would validate clients’ emotions and 50% - 60% would explain the reasons behind mandatory reporting as well as help clients prepare for the CAS visit. A high number of respondents (90% - 95%) indicated they would explain their reasons for reporting. Fewer respondents (25% - 35%) indicated they would apologize for the impact of reporting.

As these numbers testify, respondents view the alliance as an integral component of treatment and make a range of efforts to maintain the alliance when it has been ruptured. Given
the variety of treatment modalities inherent in a sample size of 480, these numbers also testify that the therapeutic alliance is integral across treatment modalities and is viewed as a powerful predictor of outcome independent of clinician adherence to specific therapeutic approaches (Bickman et al., 2004; Chatoor & Krupnick, 2001; Horvath & Bedi, 2002; Karver et al., 2006; Luborsky, 2000; Martin et al., 2000; Sexton et al., 2005).

Respondents appeared to feel comfortable meeting clients on a face to face basis within an office setting while fewer respondents were willing to conduct a home visit. This may be due to the high number of female respondents in the survey. Respondents felt comfortable validating clients’ emotions and explaining the objectives of mandatory reporting; however, fewer respondents indicated their willingness to explain their own reasons for reporting. This may be due to respondents’ belief that by explaining their own reasons they have to shoulder client blame. A minority of respondents (5% - 10%) indicated they would take other steps and actions such as offering psycho-education around child maltreatment, offering information or resources, or playing an advocacy role with CAS; however, this stands in contrast to the qualitative findings where the majority of respondents noted offering psycho-education as well as information or resources to clients. Weinstein et al. (2000) found that many clinicians engaged in additional activities following the report with the most frequent activities being telephoning the client (41.9%) and offering an extra session (27.8%). The least frequent activity was making a home visit (10.6%) which is consistent with the present study. Levine et al. (1991, 1995) found that clinicians also performed additional activities which included giving extra sessions, making home visits or telephoning the client, as a means of preserving the relationship.

In examining respondents’ qualitative comments regarding the impact of reporting, findings showed predominantly negative emotions (anger, anxiety) and reactions (denial, blame)
on the part of the client along with negative impacts on the clinical relationship and clinical work (loss of trust, family withdraws from treatment, impact on communication). These reactions are in keeping with Stage 1 (Attending to the Rupture Marker) of Safran et al.’s (1990) model of alliance ruptures. As noted earlier, Safran et al. (1990) dichotomized rupture markers into either those of withdrawal or confrontation (Harper 1989a, 1989b). In withdrawal rupture markers, the patient withdraws or partially disengages from the therapist, his or her own emotions, or an aspect of the therapeutic process. In confrontation rupture markers, the patient directly indicates anger, resentment, or dissatisfaction with the therapist or therapeutic process. From a clinical perspective, social workers need to prepare themselves cognitively and affectively for negative emotions and reactions from clients regarding a report.

However, it is possible that the negative feelings and reactions displayed by clients could mask more positive feelings, for example, clients could feel anxious or angry about the report; however, the underlying feeling could be one of shame at their behaviour towards their child or relief that they will receive help. From a clinical perspective, social workers should understand the distinction between primary and secondary emotions (Fosha, 2000; Greenberg, 2002). Clients facing a report to the CAS may experience primary emotions such as shame or embarrassment which is covered by anger and anxiety used as a defence against these more primary internal processes. Secondary emotions such as anger should be explored to uncover the primary emotions (Greenberg, 2002). Some respondents also noted positive client reactions which included families understanding the need for the report, the relationship being strengthened and families continuing in treatment.

Findings from neuroscience may shed light on the dichotomy of clients’ reactions to a report to CAS. Returning to LeDoux’s (1996) distinction between the Low Road reaction, which
is characterized by a quick, nonconscious, reactive system, and the High Road reaction, characterized by a more considered, thoughtful system, the low, limbic road enables humans to assess danger and protect themselves whereas the high, neocortical road provides flexibility, thoughtfulness, and choice. When a social worker informs a family that a report will go to the CAS, neurologically, this information is sent to the amygdala that will assess the information for danger, and typically lead to a fight or flight response. It is possible that those clients who react negatively to this information and who sever the relationship may experience a Low Road reaction, possibly due to fears of the removal of their child. Clients who continue in treatment and who understand the reason for the report may experience a High Road reaction. The neocortex, or High Road allows clients to pause and consider their options and to think before reacting impulsively. In examining the Low Road and High Road reactions from a clinical perspective, it may be helpful for social workers to understand the biological difference between these two reactions and how an initial Low Road reaction could lead to a High Road reaction given time and discussion over concerns regarding the child. Social workers can prepare themselves to respond to those clients who evince a Low Road reaction in an effort to assist clients to self-regulate.

In examining clients’ negative reactions from the perspective of attachment, some authors view the relationship between a client and therapist as a secondary attachment experience, within which corrective emotional experiences can occur (D’Elia, 2001). When clients present with hope for relief from high levels of arousal, therapists can serve as a secondary attachment figure attending to the clients’ need for reassurance and a sense of relief from their state of arousal (Baylis, 2006). Within the therapeutic relationship a corrective emotional experience can take place (Siegel, 1999). Similar to attachment theory’s original application to the caregiver-child
relationship, therapists who are sensitively attuned, and responsive to their clients’ needs, can generate a secure attachment. Within the early stages of treatment, therapists are charged with establishing a secure base for clients to begin the process of exploring difficult aspects of themselves and their relationships (Stalker & Hazelton, 2008).

When confidentiality cannot be maintained and a report goes to the CAS, it is possible that the secondary attachment held between client and social worker is ruptured, particularly with clients with insecure attachments from childhood. From this perspective, it is not only the rupture of the alliance but the rupture of the attachment experience and the loss of a secure, “holding environment” (Winnicott, 1962). However, by remaining sensitively attuned and responsive to the clients’ negative reactions regarding the report, as opposed to emotionally withdrawing, social workers can facilitate the corrective emotional experience and reformulate the secure “holding environment.” In this regard, social workers can emulate how parents can provide a corrective repair experience during attachment ruptures with their children.

Qualitative findings also showed a range of strategies social workers use to salvage the therapeutic alliance (i.e., reporting options, providing information, affect regulation, advocacy and providing resources), as well as prevention strategies prior to the disclosure of reportable material. In examining the strategies themselves, some strategies may be considered more content focused (providing information and resources) while others are more process focused (managing clients’ affect regulation). The process of managing clients’ affect regulation through validation or empathic statements is congruent with Stage 4 (Self-Assertion) of Safran’s et al. (1996) model where the therapist intervenes by validating or empathizing with the patient’s experience.
Social workers try to foster and protect the alliance through various means such as building a therapeutic alliance prior to the disclosure of child maltreatment, explaining confidentiality at the start of therapy, asking clients to signed informed consent statements, and returning to the signed consent statement when reportable material surfaces to remind clients of the original agreement.

The strategy of building a strong therapeutic alliance prior to the disclosure of child maltreatment is consistent with studies which have reported that the presence of a strong, existing therapeutic alliance can mitigate the effects of a report to CAS (Harper & Irvin, 1985; Levine et al., 1995; Steinberg et al., 1997; Weinstein et al., 2001). The strategy of explaining the limits of confidentiality at the start of therapy and asking clients to sign informed consent statements is consistent with the Steinberg et al. (1997) study which showed that having explicit informed consent procedures can mitigate the effects of a report to CAS. Many social workers in this study used various reporting options such as discussing the duty to report with the family, involving the family in the reporting process, or giving the family options around making the report. This finding is consistent with studies (Crenshaw & Lichtenberg, 1993; Nicolai & Scott, 1994; Steinberg et al., 1997) which showed that the majority of clinicians informed the client about the report before it was made.

Despite clinician concerns over physical harm (Badger, 1989; Baily, 1982; Weinstein et al., 2000) as well as litigation (Cruickshanks & Skellern, 2007; Haines & Turton, 2008; Hansen et al., 1997) no respondent in this study reported a threat of physical violence against his or her person or threat of malpractice, the most serious implication being the ending of the relationship; however, even when the relationship continued, respondents reported negative impacts to trust and communication in terms of how much information is subsequently disclosed by the family.
The high degree of negativity in feelings and reactions often carries over into the clinical relationship and work, implying that the negativity is not simply contained within the emotional life of the individual or the family.

Revised Conceptual Framework

In light of the findings a revised conceptual framework is offered on page 191. In contrast to the Brosig and Kalichman (1992) model on page 62, and the expanded conceptual framework on page 69, where both begin with the decision-making factors, this revised framework begins with the strategies respondents outlined qualitatively to avoid relationship rupture prior to the disclosure of reportable material. Specifically, respondents noted explaining the limits of confidentiality at the start of counselling, asking clients to sign an informed consent statement, and building a therapeutic alliance early within counselling.

From these initial strategies, the framework proceeds to the surfacing of reportable material and then to the decision-making factors. Highlighted in grey within the legal, situational, and professional factors are the significant predictors: Regulatory Body Requirements, Culture, Religion & Ethnicity, Reporting History, and Consultation / Supervision, 4 of the original 10 predictors.

Underneath these decision-making factors, the revised model flows to the “decision-making process” which, in turn, flows to the decision to “report” or “not report.” Following the decision to report are the “strategies to maintain the relationship,” namely reporting, information, affect regulation, advocacy, and resource strategies. Emerging from these strategies is the positive or negative “impact on the relationship.” Respondents noted that the impact can vary depending on the family, thus both sides of the spectrum are represented in the framework: the relationship is maintained and strengthened or the relationship becomes strained and tense.
Figure 3.
Revised Conceptual Framework for Clinician Decision-Making and Maintenance of the Therapeutic Alliance

- **LEGAL FACTORS**
  - Knowledge of the Law
  - Statutory Wording
  - Legal Requirements
  - Regulatory Body Requirement

- **CLINICIAN FACTORS**
  - Personal Disciplinary History
  - Comfort with Conflict
  - Personal Experience with CAS
  - Gender
  - Parenthood
  - Attitude towards the Children’s Aid Society

- **SITUATIONAL FACTORS**
  - Victim Attributes
  - Type of Abuse
  - Severity of Abuse
  - Availability of Evidence
  - Circumstances Around Disclosure
  - Culture, Religion & Ethnicity

- **PROFESSIONAL FACTORS**
  - Years of Experience
  - Training
  - Attitudes and Experience
  - Reporting History
  - Consultation / Supervision
  - Field of Practice

- **RELATIONSHIP FACTORS**
  - Relationship with the Client
  - Concerns about the Impact on the Relationship

- **PROACTIVE STRATEGIES TO AVOID POTENTIAL ALLIANCE RUPTURE**
  - Explain confidentiality and reporting of child maltreatment
  - Ask client to sign informed consent
  - Begin forming alliance

- **SUSPICION OF CHILD MALTREATMENT**

- **DECISION MAKING PROCESS**

- **REPORT**
  - Strategies to Maintain the Relationship
    - Reporting strategies
    - Advocacy strategies
    - Information strategies
    - Resource strategies
    - Affect regulation strategies

- **NOT REPORT**
  - Strategies to Maintain the Relationship
    - Relationship is maintained
    - Relationship is strengthened
    - Family continues in treatment
    - Relationship becomes strained and tense
    - Relationship is severed
    - Family withdraws from treatment
Implications for Social Work Practice

Social workers in every province and territory are governed by mandatory reporting laws. Social work clinicians are thus charged with understanding the content, breadth, and appropriate application of these laws in their decision-making around child maltreatment. And yet, in this study in two vignettes depicting physical and emotional maltreatment, respondents were split between those who would report and those who were unsure or who would not report. While further research is needed to provide more in-depth information about the reasons for such differences, it appears that social work clinicians may benefit from more training about the expectations concerning their duty to report. As well, reflective activities that examine decision-making processes around this clinical dilemma may lead to more uniform interpretation of this obligation. Team meetings, case conferences, supervision groups, and provincial association workshops can provide opportunities for social workers to grapple with and explore the complexity of mandatory reporting.

Similarly, the study demonstrated that respondents value the opinions and perspectives of colleagues in their decision-making around reporting child maltreatment. Consulting with peers offers another perspective on the family’s struggles, provides guidance in ambiguous cases of child maltreatment, validates conflicting feelings around the involvement of the CAS, and reduces feelings of isolation in the reporting process. This finding is consistent with that of other researchers who found clinicians in community settings (McLaughlin, Rothery, Babins-Wagner, & Schleifer, 2010) and in a psychiatric hospital (Bogo, Paterson, Tufford, & King, 2011a, 2011b) sought and valued the advice of peers and co-workers when faced with clinical decision-making and challenging clinical issues. Specifically, clinicians appreciated the shared experience, practice wisdom, values, and perspectives of colleagues and even ranked talking
with a colleague as the most important source of high quality information. Clinicians learn from reflective discussions with colleagues, receive feedback, and manage difficulties. Thus, findings from these three studies clearly demonstrate that social workers, even those not directly involved in a case of potential child maltreatment, play a meaningful role in assisting and guiding their colleagues to appropriate and professional decision-making.

Consistent with the view of the relationship as bi-directional (Bordin, 1979) and one of the most consistent and strongest predictors of treatment success (Horvath, 2001; Horvath & Symonds, 1991; Lambert & Barley, 2001; Martin et al., 2000), it is essential for the client and social worker to remain engaged in the face of a potential rupture. Respondents advocated the use of affect regulation strategies to remain calm, focused and professional when facing client’s anger and blame over the report. Thus, it is important to educate clinicians in what Schore (2010) terms “autonomic affect regulation” or regulating one’s internal psychobiological state. This involves clinicians’ ability to concurrently and accurately monitor their own level of comfort or discomfort in session while staying attuned to the interoceptive and exteroceptive cues of the client. Hanson (2009) equates regulation with a process of restraining oneself and establishing a balance which can be sustained over time in the face of changing environmental input, such as reporting child maltreatment.

By remaining calm and attuned to his or her feelings in the face of a client’s emotional reaction the social worker may help the client to “down regulate”, thus promoting dialogue and the management of client emotions. Schore (1994) and Siegel (1999) note that a reciprocal and attuned relationship allows an individual to use the emotional state of another to regulate their own emotional state both in the present and independently in the future. In addition, the ability to remain emotionally attuned and responsive to the client in the midst of powerful, emotional,
therapeutic content, as opposed to seeking factual information, providing cognitive responses, or asking about behavioural strategies, is critical to maintain the alliance (Tsang, Bogo, & George, 2003; Tsang, Bogo, & Lee, 2011). However, to stay within the realm of emotion, affect regulation strategies take on critical importance.

Given the central role of affect regulation and its biological basis, social work clinicians could benefit from an understanding of the recent discoveries in the area of clinical neuroscience (Egan, Neely-Barnes, & Combs-Orme, 2011), including a working knowledge of right and left hemisphere brain functions (Nunn, Hanstock, & Lask, 2008), the role of the amygdala, and how the pre-frontal cortex functions as a regulator of the limbic area (Siegel, 2010). Given the stress of social work interviewing, it may be helpful for clinicians to understand those areas of the brain that are involved in stress regulation, namely the orbital frontal cortex, medial cortex, hippocampus, and hypothalamus / pituitary / adrenal axis (Schore, 2010).

In summary, the study demonstrated a plethora of strategies social workers utilize to repair alliance ruptures. Knowing there are strategies one can take to salvage the alliance can bring a measure of confidence to one’s decision-making. Continuing education opportunities and supervision with knowledgeable social work clinicians can assist both novice and seasoned clinicians to address alliance ruptures when reporting suspected child maltreatment. Neuroscience is also playing an increasingly important role in clinical practice through understanding brain based reactions and the therapeutic relationship as a means of affect regulation. Culture is another clinical area which requires increased attention. Despite the inclusion of a cultural focus to some of the vignettes (i.e., recent immigrants from Bosnia or Southeast Asia), only a minority of respondents suggested alliance repair strategies that demonstrated or incorporated cultural awareness, such as referring a client to cultural specific
resources, consulting with a colleague knowledgeable of the client's culture, explaining mandatory reporting laws as they exist in Ontario, acknowledging possible cultural differences between the client's views of discipline and Canadian mandatory reporting laws, and utilizing the services of a translator. These findings are in tandem with those of Maiter and Stalker (2011) who interviewed 20 South Asian immigrants who had experience with the Ontario child welfare system. Participants in this study expressed their desire for more culturally sensitive services which were inclusive of families. In addition, the CASW (2005) Guidelines for Ethical Practice charges social work clinicians to demonstrate cultural awareness and sensitivity when interacting with clients. In keeping with the Guidelines for Ethical Practice, social work clinicians are advised to gain knowledge of and incorporate alliance repair strategies which acknowledge clients’ cultural reality and demonstrate cultural awareness.

Limitations

There are several limitations to this study. First, it cannot be determined how respondents differed from non-respondents (Sue & Ritter, 2007). In addition, membership in the OASW may not be completely representative of all social workers in Ontario. Second, given that respondents were predominantly Caucasian females who completed their degrees in Canada and that the survey was restricted to social workers registered online with the OASW in one geographic area, this limits generalizability. Third, the overall response rate is 22% which is slightly below the accepted response rate for web-based surveys of 30% (Sue & Ritter, 2007) and lower than surveys with similar content (Delaronde et al., 2000; King et al., 1998; Tilden et al., 1994; Weinstein et al. 2001; Zellman, 1990a). Fourth, vignette research may not reflect what the social worker does in actual practice (Brosig & Kalichman, 1992). Fifth, it was not possible to conduct a constant comparative analysis of the qualitative responses because the same questions were
administered each time (Glaser & Strauss, 1967). Sixth, the process of randomization of members to either Group 1 or Group 2 of the manipulated vignettes did not meet the standards for true randomization.

**Implications for Future Research**

The depth and breadth of this study’s findings point to the need for specific research on both decision-making around the mandatory reporting of child maltreatment and strategies to maintain the therapeutic alliance. Within the realm of decision-making, the study findings showed that the predictors Regulatory Body Requirements and Consultation / Supervision comprise two of the significant factors social workers consider in deciding to report suspected child maltreatment. Given the largely quantitative focus of this dissertation and that the study centred on three hypothetical vignettes, a follow-up study with focus groups or individual interviews with study participants is needed to further probe how these two factors contribute to social workers’ decision-making in a diversity of clinical situations. Regarding alliance processes, in-depth qualitative exploratory interviews will allow for further examination of the issues social workers encounter and the steps and actions they take to maintain the therapeutic alliance. Examining differences with respect to gender of the worker and area of practice may yield further insights.

More than one quarter of respondents (n = 161) reported undergoing training in child maltreatment at the university level. It is imperative to examine the pedagogical aspects of this training as this preparation provides the foundation for social workers in their conceptualization of and practice with cases of child maltreatment. Future research can examine what pedagogical methods (i.e., lecture, case studies, vignettes, simulation, and readings), lead to effective decision making and alliance behaviour. Examining the effectiveness of pedagogical methods in training
social workers to work with child maltreatment is consistent with the competency based assessment framework in the United States Educational Policy and Accreditation Standards (EPAS) (Council on Social Work Education, 2008) and builds upon an existing program of research utilizing the Objective Structured Clinical Examination (OSCE) to assess social work student performance and reflection. The OSCE adapted for social work examines the conceptual quality of meta-competence along with the skills utilized in procedural competence (Bogo et al., 2012; Bogo et al., 2011; Bogo, Regehr, Katz, Logie, & Mylopoulos, 2011). In this regard, the OSCE can illuminate how the pedagogical training related to risk assessment and reporting of child maltreatment translates into students’ conceptual understanding and skills utilization when working with potential child maltreatment.

Findings also showed that 191 respondents rated their overall experience with the CAS as “neutral,” “negative,” or “very negative” while 260 respondents rated their overall CAS experience as either “positive” or “very positive.” Qualitative results showed social workers also reported both positive and negative factors associated with the CAS as well as with individual CAS workers. Given the dichotomy of these findings, future research must delineate the positive and negative aspects of these experiences to determine what processes lead to effective collaborative relationships between Ontario Children’s Aid Societies and community social workers. As noted in chapter 1, social work is practiced in settings heavily populated with children and families. Consequently, social workers may be the first mental health professionals to be privy to potential cases of child maltreatment and to determine the need for reporting to the CAS. It is vital that the relationship between Children’s Aid Societies and social work clinicians is strong and trustworthy.
The study investigated the specific strategies social workers employ to maintain the therapeutic alliance following a report to the CAS solely from the perspective of the social worker. However, previous research has identified that the client’s perspective of the alliance supersedes that of the therapist with regards to the outcome of treatment (Horvath, 2001; Horvath & Symonds, 1991; Martin et al., 2000). An investigation into clients’ perspectives will build upon a thoughtful article by De Boer and Coady (2007) who examined the perspectives of clients formerly involved in the CAS system. In this study, clients noted that child welfare workers who stated agency expectations clearly; who did not threaten or judge; who listened, respected, and empathized with their concerns; and who recognized their strengths, formed strong relationships with their workers. Many of these same actions are reported by the respondents in this study; however, what is missing are clients’ perspectives on the degree of helpfulness of specific strategies (prevention, reporting, information, affect regulation, advocacy, and resource) social workers employ to maintain the alliance following the report to CAS.

Finally, this study examined social workers’ decision-making from the perspective of a first time report. Re-reporting, however, is a reality of clinical practice, where reportable material may re-surface at a later point in treatment and place social workers in the disquieting position of deciding to potentially re-report a family to CAS (Drake, Jonson-Reid, Sapokaite; 2006; Jonson-Reid, Emery, Drake, & Stahlschmidt, 2010). It is important to understand social workers’ decision-making processes when faced with the prospect of re-reporting a family to CAS.

Concluding Thoughts

This dissertation aimed to delineate the factors that guide Ontario social workers’ decision-making when rendering decisions on the mandatory reporting of child maltreatment and to understand how social workers maintain the therapeutic alliance with children and families
following the decision to report suspected child maltreatment. The importance of examining this clinical social work issue cannot be understated. Child maltreatment can lead to deleterious physical, emotional, and psychological effects impacting both present and future functioning. The harsh reality of child maltreatment, coupled with the staggering financial costs of child welfare investigations, contributes to the urgency of this study.

The decision to report suspected child maltreatment may be a highly upsetting experience for social workers who may feel many negative and conflicting emotions during and following the reporting process. Social workers need assistance with affect regulation in order to be fully present and attuned to the family. Consulting with colleagues, seeking supervision, collaborating with CAS, and acknowledging their ethical and legal duties are means whereby social workers can seek the support they need in this process. We can assume that with such support, social workers can then work more intensively and thoughtfully with the client.

Social workers also recognize the predominantly negative emotions and reactions clients experience in the face of a report to CAS. In order for the report to be a therapeutically meaningful experience for the client, social workers reach out to the client in a variety of ways to maintain the alliance thus underscoring the importance of the relationship. By utilizing an array of alliance repair strategies, social workers can assist clients to see the need for the report and how the report may improve their situation.

This study has raised several important questions that require additional exploration. Future research focusing on the perspectives of the family, with particular emphasis on the opinions of children regarding the reporting process, will lead to evidenced based practices around appropriate intervention with clients in a way that will be useful to them and protect children.
As noted earlier, attention to the problems of children and families is congruent with the traditional mission and values of social work (Barksy, 2010; Reamer, 1994a, 1994b), particularly Value 1: Respect for the Inherent Dignity and Worth of Persons (CASW, 2005). As the treatment of children and families in need will always constitute a core social work specialization, social workers are poised to contribute greatly to the discussion on the mandatory reporting of child maltreatment.
REFERENCES


Child and Family Services Act, R. S. O. 1990, Chapter C11.


Raue, P. J., & Goldfried, M. R. (1994). The therapeutic alliance in cognitive-behavior therapy. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research and


## Appendix 1

Summary of Canadian and American Mandatory Reporting Laws Pertaining to Child Maltreatment

<table>
<thead>
<tr>
<th>Canada</th>
<th>Source</th>
<th>Law</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Columbia</td>
<td>Child, Family and Community Services Act, 1996</td>
<td>Duty to Report Need for Protection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) A person who has reason to believe that a child needs protection under section 13 must promptly report the matter to a director or a person designated by a director. (2) Subsection (1) applies even if the information on which the belief is based is privileged, except as a result of a solicitor-client relationship or is confidential and its disclosure is prohibited under another Act. (3) A person who contravenes subsection (1) commits an offence. (4) A person who knowingly reports to a director, or a person designated by a director, false information that a child needs protection commits an offence. (5) No action for damages may be brought against a person for reporting information under this section unless the person knowingly reported false information. (6) A person commits an offence under this section is liable to a fine of up to $10,000 or to imprisonment for up to 6 months, or to both. (7) The limitation period governing the commencement of a proceeding under the Offence Act does not apply to a proceeding relating to an offence under this section.</td>
</tr>
<tr>
<td>Alberta</td>
<td>Child Welfare Act, 2000</td>
<td>Reporting a Child in Need</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) Any person who has reasonable and probable grounds to believe that a child is in need of intervention shall forthwith report the matter to a director. (1.1) A referral received pursuant to section 35 of the <em>Youth Criminal Justice Act</em> (Canada) is deemed to be a report made under subsection (1). (2) Subsection (1) applies notwithstanding that the information on which the belief is founded is confidential and its disclosure is prohibited under any other Act. (3) This section does not apply to information that is privileged as a result of a solicitor-client relationship. (4) No action lies against a person reporting pursuant to this section, including a person who reports information referred to in subsection (3), unless the reporting is done maliciously or without reasonable and probable grounds for the belief. (5) Notwithstanding and in addition to any other penalty provided by this Act, if a director has reasonable and probable grounds to believe that a person has not complied with subsection (1) and that person is registered under an Act regulating a profession or occupation prescribed in the regulations, the director shall advise the appropriate governing body of that profession or occupation of the failure to comply. (6) Any person who fails to comply with subsection (1) is guilty of an offence and liable to a fine of not more than $2000 and in default of payment to imprisonment for a term of not more than 6 months. RSA 2000 cC-12 s4; 2003 c16 s</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) Subsection (1) applies notwithstanding any claim of confidentiality or professional privilege other than: solicitor-client privilege; or (b) Crown privilege.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3) No action shall be commenced against a person with respect to making a report pursuant to subsection (1) except with leave of the court of Queen’s bench.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4) Every peace officer who has reasonable grounds to believe that a child is in need of protection shall immediately report the information to an officer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1989-90 cC-7.2 s12; 1996 c11 s2</td>
</tr>
<tr>
<td>Manitoba</td>
<td>Child and Family Services Act, 1985</td>
<td>Reporting a Child in Need of Protection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18(1) Subject to subsection (1.1), where a person has information that leads the person reasonably to believe that a child is or might be in need of protection as provided in section 17, the person shall forthwith report the information to an agency or to a parent or guardian of the child.</td>
</tr>
</tbody>
</table>
child.

**Reporting to agency only**

18(1.1) Where a person under subsection (1)
(a) does not know the identity of the parent or guardian of the child;
(b) has information that leads the person reasonably to believe that the parent or guardian
(i) is responsible for causing the child to be in need of protection, or
(ii) is unable or unwilling to provide adequate protection to the child in the circumstances; or
(c) has information that leads the person reasonably to believe that the child is or might be suffering abuse by a parent or guardian of the child or by a person having care, custody, control or charge of the child;

subsection (1) does not apply and the person shall forthwith report the information to an agency.

**Duty to report**

18(2) Notwithstanding the provisions of any other Act, subsection (1) applies even where the person has acquired the information through the discharge of professional duties or within a confidential relationship, but nothing in this subsection abrogates any privilege that may exist because of the relationship between a solicitor and the solicitor's client.

S.M. 1989-90, c.3, s.4; S.M. 1996, c.4, s.3

**Protection of informant**

18.1(1) No action lies against a person for providing information in good faith and in compliance with section 18.

Identity of informant

18.1(2) No person shall, except as required in the course of a judicial proceeding, disclose to the family of a child reported in need of protection the identity of the informant under section 18 without the written consent of the informant.

**No interference or harassment**

18.1(3) No person shall interfere with or harass an informant under section 18.

S.M. 1989-90, c.3, s.5

**Reports regarding professionals, etc.**

18.2(1) Where the director has reasonable grounds to believe that a person has caused a child to be in need of protection or has failed to report information in accordance with section 18, the director may report the matter to the body or person that governs the professional status of the person or certifies, licenses, or otherwise authorizes or permits the person to carry on his or her work or occupation.

**Requirement to investigate**

18.2(2) A body or person who receives a report under subsection (1) shall
(a) investigate the matter to determine whether any professional status review or disciplinary proceedings should be commenced against the person; and
(b) on conclusion of the investigation and any proceedings, advise the director of the determination under clause (a), the reasons for the determination, and, if applicable, the results of any professional status review or disciplinary proceedings.

S.M. 1989-90, c.3, s.5; S.M. 1997, c.48, s.7

---

**Ontario Child and Family Services Act, 2002**

**Ongoing Duty to Report**

(2) A person who has additional reasonable grounds to suspect one of the matters set out in subsection (1) shall make a further report under subsection (1) even if he or she has made previous reports with respect to the same child. 1999, c.2, s.22(1)

(3) A person who has a duty to report a matter under subsection (1) and (2) shall make the report directly to the society and shall not rely on any other person to report on his or her behalf. 1999, c.2, s. 22(1).

(4) A person referred to in subsection (5) is guilty of an offence, if, (a) he or she contravenes subsection (1) or (2) by not reporting a suspicion; and (b) the information on which it was based was obtained in the course of his or her professional or official duties. 1999, c.2, s.22(2)

(5) Subsection (4) applies to every person who performs professional or official duties with respect to children including
(a) health care professional, including a physician, nurse, dentist, pharmacist, and psychologist;
(b) a teacher, school principal, social workers, family counsellor, operator or employee of a day nursery and youth and recreation work;
(b.1) a religious official, including a priest, a rabbi, and a member of the clergy;
(b.2) a mediator and an arbitrator;
© a peace officer and a coroner;  
(d) a solicitor; and  
(e) a service provider and an employee of a service provider. 1999, c.2, s. 22(3); 2006, c.1, s.2  
(6) In clause (5) (b), "youth and recreation worker" does not include a volunteer. 1999, c.2, s. 22(3).  
(6.1) A director, officer or employee of a corporation who authorizes, permits or concurs in a contravention of an offence under subsection (4) by an employee of the corporation is guilty of an offence. 1999, c.2, s. 22(3).  
(6.2) A person convicted of an offence under subsection 94) or (6.1) is liable to a fine of not more than $1000. 1999, c.2, s.22(3).  
(7) This section applies although the information reported may be confidential or privileged, and no action for making the report shall be instituted against a person who acts in accordance with this section unless the person acts maliciously or without reasonable grounds for the suspicion. R.S.O. 1990, c. C.11, s. 72 (7); 1999, c.2, s. 22(4).  
(8) Nothing in this section abrogates any privilege that may exist between a solicitor and his or her client. R.S.O. 1990, c. C.11, s. 72(8).

| Quebec | Youth Protection Act, 2007 | Duty to Report. | 39. Every professional who, by the very nature of his profession, provides care or any other form of assistance to children and who, in the practice of his profession, has reasonable grounds to believe that the security or development of a child is or may be considered to be in danger within the meaning of section 38 or 38.1, must bring the situation to the attention of the director without delay. The same obligation is incumbent upon any employee of an institution, any teacher, any person working in a childcare establishment or any policeman who, in the performance of his duties, has reasonable grounds to believe that the security or development of a child is or may be considered to be in danger within the meaning of the said provisions.  
Duty to report.  
Any person, other than a person referred to in the first paragraph, who has reasonable grounds to believe that the security or development of a child is considered to be in danger within the meaning of subparagraph d and e of the second paragraph of section 38 must bring the situation to the attention of the director without delay.  
Other cases.  
Any person, other than a person referred to in the first paragraph, who has reasonable grounds to believe that the security or development of a child is or may be considered to be in danger within the meaning of subparagraph a, b, c or f of the second paragraph of section 38 or within the meaning of section 38.1 may bring the situation to the attention of the director.  
Applicability.  
The first and second paragraphs apply even to those persons who are bound by professional secrecy, except to an advocate who, in the practice of his profession, receives information concerning a situation described in section 38 or 38.1.  
1977, c. 20, s. 39; 1981, c. 2, s. 9; 1984, c. 4, s. 19; 1992, c. 21, s. 375; 1994, c. 35, s. 25; 2006, c. 34, s. 16.

| Nova Scotia | Children and Family Services, 2002 | Duty to Report | 23 (1) Every person who has information, whether or not it is confidential or privileged, indicating that a child is in need of protective services shall forthwith report that information to an agency.  
(2) No action lies against a person by reason of that person reporting information pursuant to subsection (1), unless the reporting of that information is done falsely and maliciously.  
(3) Every person who contravenes subsection (1) is guilty of an offence and upon summary conviction is liable to a fine of not more than two thousand dollars or to imprisonment for a period not exceeding six months or to both.  
(4) No proceedings shall be instituted pursuant to subsection (3) more than two years after the contravention occurred.  
(5) Every person who falsely and maliciously reports information to an agency indicating that a child is in need of protective services is guilty of an offence and upon summary conviction is liable to a fine of not more than two thousand dollars or to imprisonment for a period not exceeding six months or to both.  
1990, c. 5, s. 23; 1996, c. 10, s. 2.  
Duty of professionals and officials to report  
24 (1) In this Section, "suffer abuse", when used in reference to a child, means be in need of protective services within the meaning of clause (a), (c), (e), (f), (h), (i) or (j) of subsection (2) of Section 22.  
(2) Notwithstanding any other Act, every person who performs professional or official duties with respect to a child, including  
(a) a health care professional, including a physician, nurse, dentist, pharmacist or psychologist;  
(b) a teacher, school principal, social worker, family counsellor, member of the clergy, operator or employee of a day-care facility;  
(c) a peace officer or a medical examiner;
(d) an operator or employee of a child-caring facility or child-care service;
(e) a youth or recreation worker,

who, in the course of that person's professional or official duties, has reasonable grounds to suspect that a child is or may be suffering or may have suffered abuse shall forthwith report the suspicion and the information upon which it is based to an agency.

(3) This Section applies whether or not the information reported is confidential or privileged.

(4) Nothing in this Section affects the obligation of a person referred to in subsection (2) to report information pursuant to Section 23.

(5) No action lies against a person by reason of that person reporting information pursuant to subsection (2), unless the reporting is done falsely and maliciously.

(6) Every person who contravenes subsection (2) is guilty of an offence and upon summary conviction is liable to a fine of not more than five thousand dollars or to imprisonment for a period not exceeding one year or to both.

(7) No proceedings shall be instigated pursuant to subsection (6) more than two years after the contravention occurred.

(8) Every person who falsely and maliciously reports information to an agency indicating that a child is or may be suffering or may have suffered abuse is guilty of an offence and upon summary conviction is liable to a fine of not more than two thousand dollars or to imprisonment for a period not exceeding six months or to both.

1990, c. 5, s. 24; 1996, c. 10, s. 3.

New Brunswick Family Services Act, 1983

<table>
<thead>
<tr>
<th>Protection Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>30(1) Any person who has information causing him to suspect that a child has been abandoned, deserted, physically or emotionally neglected, physically or sexually ill-treated or otherwise abused shall inform the Minister of the situation without delay.</td>
</tr>
<tr>
<td>30(2) This section applies notwithstanding that the person has acquired the information through the discharge of his duties or within a confidential relationship, but nothing in this subsection abrogates any privilege that may exist because of the relationship between a solicitor and the solicitor’s client.</td>
</tr>
<tr>
<td>30(3) A professional person who acquires information in the discharge of the professional person’s responsibilities that reasonably ought to cause the professional person to suspect that a child has been abandoned, deserted, physically or emotionally neglected, physically or sexually ill-treated or otherwise abused but who does not inform the Minister of the situation without delay commits an offence.</td>
</tr>
<tr>
<td>30(3.1) Proceedings with respect to an offence under subsection (3) may be instituted at any time within six years after the time when the subject matter of the proceedings arose.</td>
</tr>
<tr>
<td>30(4) Where the Minister has reasonable grounds to suspect that a professional person has committed an offence under subsection (3), the Minister may, regardless of any action the Minister may take with respect to prosecution, require any professional society, association or other organization authorized under the laws of the Province to regulate the professional activities of the person to cause an investigation to be made into the matter.</td>
</tr>
<tr>
<td>30(5) No action lies, in relation to the giving of information under this section, against a person who in good faith complies therewith.</td>
</tr>
<tr>
<td>30(5.01) No action shall be commenced against a person in relation to the giving of information to the Minister under this section except with leave of the court.</td>
</tr>
<tr>
<td>30(5.02) An application for leave shall be commenced by a Notice of Application served on the respondent and the Minister in accordance with the Rules of Court.</td>
</tr>
<tr>
<td>30(5.03) On an application for leave, leave shall be granted only if the applicant establishes, by affidavit or otherwise, a prima facie case that the person who gave the information to the Minister did not give the information in good faith.</td>
</tr>
<tr>
<td>30(5.04) If leave is not granted, the court may order the applicant to pay all or any portion of the costs of the application.</td>
</tr>
<tr>
<td>30(5.05) An action against a person in relation to the giving of information to the Minister under this section is a nullity if the action is commenced without the leave of the court.</td>
</tr>
<tr>
<td>30(5.1) A person who wilfully gives false information under this section commits an offence.</td>
</tr>
<tr>
<td>30(6) Except in the course of judicial proceedings, no person shall reveal the identity of a person who has given information under this section without that person’s written consent.</td>
</tr>
<tr>
<td>30(7) Any person who violates subsection (6) commits an offence.</td>
</tr>
<tr>
<td>30(8) Upon completion of any investigation undertaken by the Minister as a result of any information provided by any person, the Minister may so advise the person who provided the information, and shall inform (a) the parent; (b) any person identified during the investigation as a person neglecting or ill-treating the child; and (c) the child, if in the opinion of the Minister he is capable of understanding, as to the findings and conclusions drawn by the Minister.</td>
</tr>
<tr>
<td>Province</td>
</tr>
<tr>
<td>----------</td>
</tr>
</tbody>
</table>
| Prince Edward Island | Child Protection Act, 2003 | 30(8.1) Notwithstanding subsection (8), the Minister shall not inform any person referred to in paragraphs (8)(a) to (c) of the findings and conclusion drawn by the Minister if 
(a) in the opinion of the Minister, the giving of the information would have the effect of putting the child’s well-being at risk,
(b) in the opinion of the Minister, the giving of the information may impede any criminal investigation related to the neglect or ill-treatment of the child, or
(c) in the case of a person identified during an investigation as neglecting or ill-treating the child, the person has not been contacted as part of the Minister’s investigation.
30(9) Notwithstanding the Evidence Act, a spouse may be compelled to testify as a witness in the course of judicial proceedings brought against his spouse under this Act with respect to abuse or neglect of a child or an adult.
30(10) For the purposes of this section “professional person” means a physician, nurse, dentist or other health or mental health professional, an administrator of a hospital facility, a school principal, school teacher or other teaching professional, a social work administrator, social worker or other social service professional, a child care worker in any day care centre or child caring institution, a police or law enforcement officer, a psychologist, a guidance counsellor, or a recreational services administrator or worker, and includes any other person who by virtue of his employment or occupation has a responsibility to discharge a duty of care towards a child.
1992, c.52, s.11; 1994, c.7, s.1; 1995, c.43, s.1; 1997, c.2, s.4; 1998, c.40, s.1; 1999, c.32, s.5.

<table>
<thead>
<tr>
<th>Province</th>
<th>Act</th>
<th>Duty to Report</th>
</tr>
</thead>
</table>
| Newfoundland and Labrador | Child, Youth and Family Services Act | 22(1) Notwithstanding any other Act, every person who has knowledge, or has reasonable grounds to suspect that a child is in need of protection shall without delay, report or cause to be reported the circumstances to the Director, or to a peace officer who shall report the information to the Director, and provide to the Director such additional information as is known or available to the person.
2(2) Subsection (1) applies notwithstanding the confidential nature of the information on which the report is based, but nothing in this section abrogates any solicitor-client privilege.
3(3) Subject to subsection (5), no person shall reveal or be compelled to reveal the identity of a person who has made a report or provided information respecting a child pursuant to subsection (1).
4(4) Subject to subsection (5), a person who makes a report or provides information pursuant to subsection (1) or who does anything to assist in an investigation carried out by the Director is liable to any civil action in respect of providing such information or assistance.
5(5) Subsections (3) and (4) do not apply where a person knowingly makes a report or provides information which is false or misleading.
2000(2nd), c.3, s.22.

<table>
<thead>
<tr>
<th>Province</th>
<th>Act</th>
<th>Duty to Report and Investigation of Report</th>
</tr>
</thead>
</table>
| North West | Child and Youth Services Act | 15. (1) Where a person has information that a child is or may be in need of protective intervention, the person shall immediately report the matter to a director, social worker or a peace officer.
(2) Where a person makes a report under subsection (1), the person shall report all the information in his or her possession.
(3) Where a report is made to a peace officer under subsection (1), the peace officer shall, as soon as possible after receiving the report, inform a director or social worker.
(4) This section applies, notwithstanding the provisions of another Act, to a person referred to in subsection (5) who, in the course of his or her professional duties, has reasonable grounds to suspect that a child is or may be in need of protective intervention.
(5) Subsection (4) applies to every person who performs professional or official duties with respect to a child, including,
(a) a health care professional;
(b) a teacher, school principal, social worker, family counsellor, member of the clergy or religious leader, operator or employee of a child care service and a youth and recreation worker;
(c) a peace officer; and
(d) a solicitor.
(6) This section applies notwithstanding that the information is confidential or privileged, and an action does not lie against the informant unless the making of the report is done maliciously or without reasonable cause.
(7) A person shall not interfere with or harass a person who gives information under this section.
(8) A person who contravenes this section is guilty of an offence and is liable on summary conviction to a fine not exceeding $10,000 or to imprisonment for a term not exceeding 6 months, or to both a fine and imprisonment.
Notwithstanding section 7 of the Provincial Offences Act, an information or complaint under this section may be laid or made within 3 years from the day when the matter of the information or complaint arose.
1998 cC-12.1 s15.
Territories Family Services Act

8(1) A person who has information of the need of protection of a child shall, without delay, report the matter

(a) to a child Protection Worker; or
(b) if a child Protection work is not available, to a peace officer or an authorized person.

8(2) For greater certainty, a person may not delegate the duty to report a matter under subsection 9(1) to another person.

8(3) Subsection (1) applies

(a) notwithstanding any other Act; and
(b) notwithstanding that the information is confidential or privileged.

8(4) No action shall be commenced against a person for reporting information in accordance with this section unless it is done maliciously.

8(5) Nothing in this section shall abrogate any privilege that may exist between a solicitor and the solicitor’s client.

8(6) Every person who contravenes subsection 9(1) is guilty of an offence and liable on summary conviction to a fine not exceeding $5,000, to imprisonment for a term not exceeding six months or to both.

S.N.W.T. 2002, c. 14, s.7

Yukon Children’s Act, 2002

117(1) A person who has reasonable grounds to believe that a child may be a child in need of protection may report the information on which the person bases that belief to the director, an agent of the director, or a peace officer.

117(2) No legal action of any kind, including professional disciplinary proceedings, may be taken against a person who reports information under subsection 9(1) because of so reporting, unless the reporting was done maliciously and falsely.

117(3) Any person who maliciously and falsely reports to a peace officer, the director, an agent of the director, or to any other person facts from which the inference that a child may be in need of protection may reasonably be drawn commits an offence and is liable on summary conviction to a fine of up to $5,000 or imprisonment for as long as six months, or both.

R.S., c.22, s.115

Nunavut Child and Family Services Act

8(1) A person who has information of the need of protection of a child shall, without delay, report the matter

(c) to a child Protection Worker; or
(d) if a child Protection work is not available, to a peace officer or an authorized person.

8(2) For greater certainty, a person may not delegate the duty to report a matter under subsection 9(1) to another person.

8(3) Subsection (1) applies

(c) notwithstanding any other Act; and
(d) notwithstanding that the information is confidential or privileged.

8(4) No action shall be commenced against a person for reporting information in accordance with this section unless it is done maliciously.

8(5) Nothing in this section shall abrogate any privilege that may exist between a solicitor and the solicitor’s client.

8(6) Every person who contravenes subsection 9(1) is guilty of an offence and liable on summary conviction to a fine not exceeding $5,000, to imprisonment for a term not exceeding six months or to both.

S.N.W.T. 2002, c. 14, s.7

United States


Alabama

Professionals Required to Report Citation: Ala. Code § 26-14-3
The following persons are required to report:

Doctors, medical examiners, dentists, nurses, or pharmacists
School teachers or officials
Law enforcement officials
Daycare workers or social workers
Members of the clergy
Any other person called upon to render aid or medical assistance to a child

Reporting by Other Persons
Citation: Ala. Code § 26-14-4
Any other person who has reasonable cause to suspect that a child is being abused or neglected may report.

Standards for Making a Report
Citation: Ala. Code § 26-14-3
A report must be made when the child is known or suspected of being a victim of abuse or neglect.

Privileged Communications
Citation: Ala. Code §§ 26-14-3; 26-14-10
Only the clergy-penitent and attorney-client privileges are permitted.

Inclusion of Reporter’s Name in Report
### Alaska

**Professionals Required to Report**  
Citation: Alaska Stat. §§ 47.17.020; 47.17.023  
The following persons are required to report:  
- Health practitioners or administrative officers of institutions  
- School teachers and administrators or child care providers  
- Paid employees of domestic violence and sexual assault programs, crisis intervention and prevention programs, or organizations that provide counseling or treatment to individuals seeking to control their use of drugs or alcohol  
- Peace officers or officers of the Department of Corrections  
- Persons who process or produce visual or printed matter, either privately or commercially  
- Members of a child fatality review team or the multidisciplinary child protection team  

**Reporting by Other Persons**  
Citation: Alaska Stat. § 47.17.020  
Mandated reporters may report cases that come to their attention in their nonoccupational capacities.  
Any other person who has reasonable cause to suspect that a child has been harmed may report.  

**Standards for Making a Report**  
Citation: Alaska Stat. §§ 47.17.020; 47.17.023  
A report must be made when:  
- In the performance of his or her occupational duties, a reporter has reasonable cause to suspect that a child has suffered harm as a result of abuse or neglect.  
- A person has reasonable cause to suspect that visual or printed matter depicts a child engaged in the unlawful exploitation of a minor.  

**Privileged Communications**  
Citation: Alaska Stat. § 47.17.060  
Neither the physician-patient nor the husband-wife privilege is recognized.  

**Inclusion of Reporter’s Name in Report**  
Not addressed in statutes reviewed.  

**Disclosure of Reporter Identity**  
Not addressed in statutes reviewed.

### Arizona

**Mandatory Reporters of Child Abuse and Neglect**  
**Professionals Required to Report**  
Citation: Rev. Stat. § 13-3620  
The following persons are mandated reporters:  
- Physicians, physician's assistants, optometrists, dentists, behavioral health professionals, nurses, psychologists, counselors or social workers  
- Peace officers, members of the clergy, priests, or Christian Science practitioners  
- Parents, stepparents, or guardians  
- School personnel or domestic violence victim advocates  
- Any other person who has responsibility for the care or treatment of minors  

**Reporting by Other Persons**  
Citation: Rev. Stat. § 13-3620  
Any other person who reasonably believes that a minor is a victim of abuse or neglect may report.  

**Standards for Making a Report**  
Citation: Rev. Stat. § 13-3620  
A report is required when the reporter reasonably believes that a minor is a victim of abuse or neglect.  

**Privileged Communications**  
Citation: Rev. Stat. § 13-3620  
Only the attorney-client and the clergy-penitent privileges are recognized.  

**Inclusion of Reporter’s Name in Report**  
Not addressed in statutes reviewed.  

**Disclosure of Reporter Identity**  
Not addressed in statutes reviewed.

### Arkansas

**Professionals Required to Report**  
Citation: Ann. Code § 12-12-507  
The following persons are mandated reporters:  
- Physicians, surgeons, osteopaths, resident interns, coroners, dentists, dental hygienists, nurses, or medical personnel  
- Teachers, school officials or counselors, daycare center workers  
- Child care workers, foster care workers  
- Social workers, foster parents, or department employees  
- Mental health professionals  
- Domestic violence shelter employees or volunteers  
- Employees of a child advocacy center  
- Law enforcement personnel, peace officers, prosecuting attorneys, domestic abuse advocates, judges  
- Court Appointed Special Advocate (CASA) program staff or volunteers  
- Juvenile intake or probation officers  
- Members of the clergy, including ministers, priests, rabbis, accredited Christian Science practitioners, or other similar functionary of a religious organization  

**Disclosure of Reporter Identity**  
Not addressed in statutes reviewed.
### California

**Professionals Required to Report**
- Citation: Penal Code §§ 11166; 11165.7
- Mandated reporters include any of the following:
  - Teachers, teacher's assistants, administrative officers, certificated pupil personnel employees of any public or private school
  - Administrators and employees of public or private day camps, youth centers, youth recreation programs, or youth organizations
  - Employees of child care institutions, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities
  - Social workers, probation officers, or parole officers
  - Any person who is an administrator or a counselor in a child abuse prevention program in any public or private school
  - District attorney investigators, peace officers, firefighers except for volunteer firefighters
  - Physicians, surgeons, psychiatrists, psychologists, dentists, licensed nurses, dental hygienists, optometrists, marriage counselors, family and child counselors, clinical social workers
  - Emergency medical technicians I or II or paramedics
  - State or county public health employees
  - Coroners or medical examiners
  - Commercial film and photographic print processors
  - Child visitation monitors
  - Animal control officers or humane society officers
  - Clergy members, which includes priests, ministers, rabbis, religious practitioners, or similar functionary of a church, temple, or recognized denomination or organization
  - Any custodian of records of a clergy member
  - Employees of any police department, county sheriff's department, county probation department, or county welfare department
  - Employees or volunteers of Court Appointed Special Advocate programs

**Reporting by Other Persons**
- Citation: Penal Code § 11166
- Any other person who reasonably suspects that a child is a victim of abuse or neglect may report.

**Standards for Making a Report**
- Citation: Penal Code §§ 11166; 11165.7
- A report is required when:
  - A mandated reporter, in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a child whom the reporter knows or reasonably suspects is the victim of abuse or neglect.
  - Commercial film and photographic print processors have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child under age 16 engaged in an act of sexual conduct.

**Privileged Communications**
- Citation: Penal Code § 11166
- Only the clergy-penitent privilege is permitted.

**Inclusion of Reporter's Name in Report**
- Citation: Penal Code § 11167
- Reports of mandated reporters shall include:
  - The name, business address, and telephone number of the mandated reporter
  - The capacity that makes the person a mandated reporter

**Disclosure of Reporter Identity**
- Citation: Penal Code § 11167
- The identity of the reporter shall be confidential, and shall be disclosed only:
  - To agencies investigating the report
  - When the person waives confidentiality
  - By court order

### Colorado

**Professionals Required to Report**
- Citation: Rev. Stat. § 19-3-304
- Persons required to report include:
  - Physicians, surgeons, physicians in training, child health associates, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, nurses, hospital personnel, dental hygienists, physical therapists, pharmacists, registered dieticians
  - Public or private school officials or employees
Social workers, Christian Science practitioners, mental health professionals, psychologists, professional counselors, marriage and family therapists
Veterinarians, peace officers, firefighters, or victim's advocates
Commercial film and photographic print processors
Counselors, marriage and family therapists, or psychotherapists
Clergy members, including priests, rabbis, duly ordained, commissioned, or licensed ministers of a church, members of religious orders, or recognized leaders of any religious bodies
Workers in the State Department of Human Services
Juvenile parole and probation officers
Child and family investigators
Officers and agents of the State Bureau of Animal Protection and animal control officers

### Reporting by Other Persons

**Citation:** Rev. Stat. § 19-3-304

Any other person may report known or suspected child abuse or neglect.

### Standards for Making a Report

**Citation:** Rev. Stat. § 19-3-304

A report is required when:

- A mandated reporter has reasonable cause to know or suspect child abuse or neglect.
- A reporter has observed a child being subjected to circumstances or conditions that would reasonably result in abuse or neglect.
- Commercial film and photographic print processors have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child engaged in an act of sexual conduct.

### Privileged Communications

**Citation:** Rev. Stat. §§ 19-3-304; 19-3-311

The clergy-penitent privilege is permitted.
The physician-patient, psychologist-client, and husband-wife privileges are not allowed as grounds for failing to report.

### Inclusion of Reporter's Name in Report

**Citation:** Rev. Stat. § 19-3-307

The report shall include the name, address, and occupation of the person making the report.

### Disclosure of Reporter Identity

**Citation:** Rev. Stat. § 19-1-307

The identity of the reporter shall be protected.

---

### Connecticut

#### Professionals Required to Report

**Citation:** Gen. Stat. § 17a-101

The following persons are required to report:

- Physicians or surgeons, nurses, medical examiners, dentists, dental hygienists, physician assistants, pharmacists, or physical therapists
- Psychologists or other mental health professionals
- School teachers, principals, guidance counselors, or coaches
- Social workers
- Police officers, juvenile or adult probation officers, or parole officers
- Members of the clergy
- Alcohol and drug counselors, marital and family therapists, professional counselors, sexual assault counselors, or battered women's counselors
- Emergency medical services providers
- Any person paid to care for a child in any public or private facility, child daycare center, group daycare home, or family daycare home that is licensed by the State
- Employees of the Department of Children and Families and the Department of Public Health who are responsible for the licensing of child daycare centers, group daycare homes, family daycare homes, or youth camps
- The Child Advocate and any employee of the Office of Child Advocate

**Citation:** Gen. Stat. § 17a-103

Any mandated reporter acting outside his or her professional capacity, or any other person having reasonable cause to suspect that a child is being abused or neglected, may report.

### Standards for Making a Report

**Citation:** Gen. Stat. § 17a-101a

A report is required when, in the ordinary course of his or her employment or profession, a reporter has reasonable cause to suspect or believe that a child has been abused or neglected.

### Privileged Communications

Not addressed in statutes reviewed.

### Inclusion of Reporter's Name in Report

**Citation:** Gen. Stat. §§ 17a-101d; 17a-103

The commissioner shall use his or her best efforts to obtain the name and address of the reporter.

### Disclosure of Reporter Identity

**Citation:** Gen. Stat. § 17a-28

The name of an individual reporting child abuse or neglect shall not be disclosed without his or her written consent, except to:

- An employee of the department responsible for child protective services or the abuse registry
- A law enforcement officer
- An appropriate State's attorney
- An appropriate assistant attorney general
- A judge of the Superior Court and all necessary parties in a court proceeding pursuant to § 46b-129 or a criminal prosecution involving child abuse or neglect
- A State child care licensing agency, executive director of any institution, school, or facility, or superintendent of schools
- Information identifying an individual who reported abuse or neglect of a person, including any tape recording of an oral report, shall not be released to the
subject of the report unless, upon application to the Superior Court by such person and served on the Commissioner of Children and Families, a judge determines, after in camera inspection of relevant records and a hearing, that there is reasonable cause to believe the reporter knowingly made a false report or that other interests of justice require such release.

Delaware

Professionals Required to Report
Citation: Ann. Code tit. 16, § 903
The following persons are required to report:
Physicians, dentists, interns, residents, osteopaths, nurses, or medical examiners
School employees
Social workers or psychologists
Reporting by Other Persons
Citation: Ann. Code tit. 16, § 903
Any person who knows or in good faith suspects child abuse or neglect shall make a report.

Standards for Making a Report
Citation: Ann. Code tit. 16, § 903
A report is required when the reporter knows or in good faith suspects child abuse or neglect.

District of Columbia

Mandatory Reporters of Child Abuse and Neglect
Professionals Required to Report
Citation: Ann. Code § 4-1321.02
Persons required to report include:
Child and Family Services Agency employees, agents, and contractors
Physicians, psychologists, medical examiners, dentists, chiropractors, registered nurses, licensed practical nurses, or persons involved in the care and treatment of patients
Law enforcement officers
School officials, teachers, or athletic coaches
Department of Parks and Recreation employees, public housing resident managers, social service workers, or daycare workers
Domestic violence counselors or mental health professionals
Reporting by Other Persons
Citation: Ann. Code § 4-1321.02
Any other person who knows or has reason to suspect that a child is being abused or neglected may report.

Standards for Making a Report
Citation: Ann. Code § 4-1321.02
A report is required when:
A mandated reporter knows or has reasonable cause to suspect that a child known to him or her in his or her official capacity has been or is in danger of being abused or neglected.
A licensed health professional or a law enforcement officer, except an undercover officer whose identity or investigation might be jeopardized, has reasonable cause to believe that a child is abused as a result of inadequate care, control, or subsistence in the home environment due to exposure to drug-related activity.
A mandated reporter knows or has reasonable cause to suspect that a child has been, or is in immediate danger of being, the victim of sexual abuse; the child was encouraged, commanded, or permitted to become a prostitute; or the child has an injury caused by a bullet, knife, or other sharp object that has been caused by other than accidental means.

Privileged Communications
Citation: Ann. Code § 4-1321.05
Neither the husband-wife nor the physician-patient privilege is permitted.

Inclusion of Reporter’s Name in Report
Citation: Ann. Code § 4-1321.03
Mandated reporters are required to provide their name, occupation, and contact information.

Disclosure of Reporter Identity
Citation: Ann. Code § 4-1302.03
The Child Protection Register staff shall not release any information that identifies the source of a report or the witnesses to the incident referred to in a report to the alleged perpetrator of the abuse, the child's parent or guardian, or a child-placing agency investigating a foster or adoptive placement, unless said staff first obtains permission from the source of the report or from the witnesses named in the report.

Florida

Mandatory Reporters of Child Abuse and Neglect
Professionals Required to Report
Citation: Ann. Stat. § 39.201
The following persons are mandated reporters:
Physicians, osteopaths, medical examiners, chiropractors, nurses, or hospital personnel
Other health or mental health professionals
Practitioners who rely solely on spiritual means for healing
School teachers or other school officials or personnel
Social workers, daycare center workers, or other professional child care, foster care, residential, or institutional workers
Law enforcement officers or judges

Reporting by Other Persons
Citation: Ann. Stat. § 39.201
Any person who knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected shall report.

Standards for Making a Report
Citation: Ann. Stat. § 39.201
A report is required when:
- A person knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected.
- A person knows that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care.

Privileged Communications
Citation: Ann. Stat. § 39.204
Only the attorney-client and clergy-penitent privileges are permitted.

Inclusion of Reporter’s Name in Report
Citation: Ann. Stat. § 39.201
Professionals who are mandated reporters are required to provide their names to hotline staff.

Disclosure of Reporter Identity
Citation: Ann. Stat. §§ 39.201; 39.202
The names of reporters shall be entered into the record of the report, but shall be held confidential. The name of the reporter may not be released to any person other than employees of the department responsible for child protective services, the central abuse hotline, law enforcement, the child protection team, or the appropriate State attorney, without the written consent of the person reporting.

This does not prohibit the subpoenaing of a person reporting child abuse, abandonment, or neglect when deemed necessary by the court, the State attorney, or the department, provided the fact that such person made the report is not disclosed.

Georgia

Professionals Required to Report
Citation: Ann. Code §§ 19-7-5; 16-12-100
The following persons are required to report:
- Physicians, hospital and medical personnel, podiatrists, dentists, or nurses
- School teachers, administrators, guidance counselors, school social workers, or psychologists
- Psychologists, counselors, social workers, or marriage and family therapists
- Child welfare agency personnel (including any child-caring institution, child-placing agency, maternity home, family daycare home, group daycare home, and daycare center), child-counseling personnel, or child service organization personnel
- Law enforcement personnel
- Persons who process or produce visual or printed matter

Reporting by Other Persons
Citation: Ann. Code § 19-7-5
Any other person who has reasonable cause to believe that a child has been abused may report.

Standards for Making a Report
Citation: Ann. Code §§ 19-7-5; 16-12-100
A report is required when:
- A person has reason to believe that a child has been abused.
- A person observes a child being subjected to conditions or circumstances that would reasonably result in abuse, abandonment, or neglect.

Privileged Communications
Citation: Ann. Code § 19-7-5
No privileged communications are permitted for mandatory reporters.

Inclusion of Reporter’s Name in Report
Not addressed in statutes reviewed.

Disclosure of Reporter Identity
Citation: Ann. Code § 49-5-41
Any release of records shall protect the identity of any person reporting child abuse.

Idaho

Professionals Required to Report
Citation: Idaho Code § 16-1605
The following persons are required to report:
- Physicians, residents on hospital staffs, interns, nurses, or coroners
- School teachers or daycare personnel
- Social workers or law enforcement personnel
- Other persons

Reporting by Other Persons
Citation: Idaho Code § 16-1605
Any person who has reason to believe that a child has been abused, abandoned, or neglected is required to report.

Standards for Making a Report
Citation: Idaho Code § 16-1605
A report is required when:
- A person has reason to believe that a child has been abused, abandoned, or neglected.
- A person observes a child being subjected to conditions or circumstances that would reasonably result in abuse, abandonment, or neglect.

Privileged Communications
Citation: Idaho Code §§ 16-1605; 16-1606
Any privilege between a husband and wife and any professional and client, except for the clergy-penitent or attorney-client privilege, shall not be grounds for failure to report.

Inclusion of Reporter’s Name in Report
Not addressed in statutes reviewed.

Disclosure of Reporter Identity
### Illinois

**Professionals Required to Report**

*Citation: Comp. Stat. Ch. 325, § 5/4; Ch. 720, § 5/11-20.2*

The following persons are required to report:

- Physicians, residents, interns, hospital administrators and personnel, surgeons, dentists, dental hygienists, osteopaths, chiropractors, podiatrists, physician assistants, or substance abuse treatment personnel
- Funeral home directors or employees, coroners, or medical examiners
- Emergency medical technicians, acupuncturists, or crisis line or hotline personnel
- School administrators and school employees, educational advocates, or truant officers
- Members of a school board or the Chicago Board of Education
- Members of the governing body of a private school
- Social workers, social services administrators, or domestic violence program personnel
- Nurses, genetic counselors, respiratory care practitioners, advanced practice nurses, home health aides, directors or staff assistants of nursery schools or child care centers, or recreational program or facility personnel
- Law enforcement officers or probation officers
- Licensed professional counselors, psychologists, or psychiatrists
- Field personnel of the Department of Healthcare and Family Services, Juvenile Justice, Public Health, Human Services, Corrections, Human Rights, or Children and Family Services
- Supervisors and administrators of general assistance under the Illinois Public Aid Code
- Foster parents, homemakers, or child care workers
- Members of the clergy
- Commercial film and photographic print processors

**Reporting by Other Persons**

*Citation: Comp. Stat. Ch. 325, § 5/4*

Any other person who has reasonable cause to believe that a child is abused or neglected may report.

**Standards for Making a Report**

*Citation: Comp. Stat. Ch. 325, § 5/4; Ch. 720, § 5/11-20.2*

A report is required when:

- A reporter has reasonable cause to believe that a child known to him or her in his or her professional capacity may be abused or neglected.
- Commercial film and photographic print processors have knowledge of or observe any film, photograph, videotape, negative, or slide that depicts a child engaged in any sexual conduct.

**Privileged Communications**

*Citation: Comp. Stat. Ch. 325, § 5/4; Ch. 735, § 5/8-803*

The privileged quality of communication between any professional person required to report and his or her patient or client shall not apply to situations involving abused or neglected children and shall not constitute grounds for failure to report.

A member of the clergy shall not be compelled to disclose a confession or admission made to him or her as part of the discipline of the religion.

**Inclusion of Reporter’s Name in Report**

*Citation: Comp. Stat. Ch. 325, § 5/7.9*

The report shall include the name, occupation, and contact information of the person making the report.

**Disclosure of Reporter Identity**

*Citation: Comp. Stat. Ch. 325, § 5/11.1a*

Any disclosure of information shall not identify the person making the report.

### Indiana

**Professionals Required to Report**

*Citation: Ann. Code § 31-33-5-2*

Mandatory reporters include any staff member of a medical or other public or private institution, school, facility, or agency.

**Reporting by Other Persons**

*Citation: Ann. Code § 31-33-5-1*

Any person who has reason to believe that a child is a victim of abuse or neglect must report.

**Standards for Making a Report**

*Citation: Ann. Code §§ 31-33-5-1; 31-33-5-2*

A report is required when any person has reason to believe that a child is a victim of abuse or neglect.

**Privileged Communications**

*Citation: Ann. Code § 31-32-11-1*

The following privileges are not permitted, and shall not be grounds for failing to report:

- Husband-wife privilege
- Health care provider-patient privilege
- Therapist-client privilege between a certified social worker, certified clinical social worker, or certified marriage and family therapist and a client of any of these professionals
- Any privilege between a school counselor or psychologist and a student

**Inclusion of Reporter’s Name in Report**

*Citation: Ann. Code § 31-33-7-4*

The written report must include the name and contact information for the person making the report.

**Disclosure of Reporter Identity**

*Citation: Ann. Code § 31-33-18-2*

The report shall be made available to the person about whom a report has been made, with protection for the identity of:

- Any person reporting known or suspected child abuse or neglect
- Any other person if the person or agency making the information available finds that disclosure of the information would be likely to endanger the life or safety of the person
- The report may also be made available to each parent, guardian, custodian, or other person responsible for the welfare of a child named in a report, with protection for the identity of reporters and other appropriate individuals.
Iowa

**Professionals Required to Report**

**Citation:** Ann. Stat. §§ 232.69; 728.14

The following persons are required to report:

- Health practitioners
- Social workers or psychologists
- School employees, certified paraeducators, coaches, or instructors employed by community colleges
- Employees or operators of health care facilities, child care centers, Head Start programs, family development and self-sufficiency grant programs, substance abuse programs or facilities, juvenile detention or juvenile shelter care facilities, foster care facilities, or mental health centers
- Employees of Department of Human services institutions
- Peace officers, counselors, or mental health professionals
- Commercial film and photographic print processors

**Reporting by Other Persons**

**Citation:** Ann. Stat. § 232.69

Any other person who believes that a child has been abused may report.

**Standards for Making a Report**

**Citation:** Ann. Stat. §§ 232.69; 728.14

A report is required when:

- A reporter, in the scope of his or her professional practice or employment responsibilities, reasonably believes that a child has been abused.
- A commercial film and photographic print processor has knowledge of or observes a film, photograph, videotape, negative, or slide that depicts a minor engaged in a prohibited sexual act or in the simulation of a prohibited sexual act.

**Privileged Communications**

**Citation:** Ann. Stat. § 232.74

The husband-wife or health practitioner-patient privilege does not apply to evidence regarding abuse to a child.

**Inclusion of Reporter’s Name in Report**

**Citation:** Ann. Stat. § 232.70

The report shall contain the name and address of the person making the report.

**Disclosure of Reporter Identity**

**Citation:** Ann. Stat. § 232.71B

The department shall not reveal the identity of the reporter to the subject of the report.

Kansas

**Professionals Required to Report**

**Citation:** Ann. Stat. § 38-2223

*Effective January 1, 2007*

The following persons are required to report:

- Persons providing medical care or treatment, including persons licensed to practice the healing arts, dentistry, and optometry; persons engaged in postgraduate training programs approved by the State Board of Healing Arts; licensed professional or practical nurses; and chief administrative officers of medical care facilities
- Persons licensed by the State to provide mental health services, including psychologists, clinical psychotherapists, social workers, marriage and family therapists, professional counselors, and registered alcohol and drug abuse counselors
- Teachers, school administrators, or other employees of an educational institution that the child is attending
- Licensed child care providers or their employees at the place where the child care services are being provided to the child
- Firefighters, emergency medical services personnel, law enforcement officers, juvenile intake and assessment workers, court services officers, community corrections officers, case managers, and mediators

**Reporting by Other Persons**

**Citation:** Ann. Stat. § 38-2223

*Effective March 28, 2007*

Any person who has reason to suspect that a child may be a child in need of care may report.

**Standards for Making a Report**

**Citation:** Ann. Stat. § 38-2223

A report is required when a reporter has reason to suspect that a child has been harmed as a result of physical, mental, or emotional abuse or neglect or sexual abuse.

**Privileged Communications**

**Citation:** Ann. Stat. § 38-2249

*Effective March 28, 2007*

In all proceedings under this code, the rules of evidence of the code of civil procedure shall apply, except that no evidence relating to the condition of a child shall be excluded solely on the ground that the matter is or may be the subject of a physician-patient privilege, psychologist-client privilege, or social worker-client privilege.

**Inclusion of Reporter’s Name in Report**

Not addressed in statutes reviewed.

**Disclosure of Reporter Identity**

**Citation:** Ann. Stat. § 38-2213

Information authorized to be disclosed in this subsection shall not contain information that identifies a reporter of a child alleged or adjudicated to be a child in need of care.

Kentucky

**Professionals Required to Report**

**Citation:** Rev. Stat. § 620.030

All persons are required to report, including, but not limited to:

- Physicians, osteopathic physicians, nurses, coroners, medical examiners, residents, interns, chiropractors, dentists, optometrists, emergency medical technicians, paramedics, or health professionals
- Teachers, school personnel, or child-caring personnel
- Social workers or mental health professionals
- Peace officers

**Reporting by Other Persons**
Maine

Professionals Required to Report
Citation: Rev. Stat. tit. 22, § 4011-A
Mandatory reporters include:
allopathic and osteopathic physicians, emergency medical services persons, medical examiners, podiatrists, physicians' assistants, dentists, dental hygienists and assistants, chiropractors, nurses, home health aides, medical or social service workers
Teachers, guidance counselors, school officials, children's summer camp administrators or counselors, or child care personnel
Social workers, psychologists, or mental health professionals
Court Appointed Special Advocates, guardians ad litem, homemakers, law enforcement officials, fire inspectors, municipal code enforcement officials, or chairs of licensing boards that have jurisdiction over mandated reporters
Commercial film and photographic print processors
Clergy members acquiring the information as a result of clerical professional work except for information received during confidential communications
Humane agents employed by the Department of Agriculture, Food, and Rural Resources

Reporting by Other Persons
Citation: Rev. Stat. tit. 22, § 4011-A
Any other person who knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected may report.

Standards for Making a Report
Citation: Rev. Stat. tit. 22, § 4011-A
An animal control officer may report to the department when that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected.

Louisiana

Professionals Required to Report
Citation: Children's Code art. 603(13)
Mandatory reporters include any of the following individuals performing their occupational duties:
Health practitioners, including physicians, surgeons, physical therapists, dentists, residents, interns, hospital staff members, podiatrists, chiropractors, licensed nurses, nursing aides, dental hygienists, emergency medical technicians, paramedics, optometrists, medical examiners, or coroners
Mental health/social service practitioners including psychiatrists, psychologists, marriage or family counselors, social workers, members of the clergy, aides, or other individuals who provide counseling services to a child or his or her family
Members of the clergy, including priests, rabbis, duly ordained clerical deacons or ministers, or Christian Science practitioners
Teachers, child care providers, teacher's aides, instructional aides, school principal's aides, school staff members, foster home parents, group home or other child care institutional staff members, personnel of residential home facilities, or licensed or unlicensed daycare providers
Police officers or law enforcement officials
Commercial film and photographic print processors
Mediators
Parenting coordinators

Reporting by Other Persons
Citation: Children's Code art. 609
Any other person who has cause to believe that a child's health is endangered as a result of abuse or neglect may report.

Standards for Making a Report
Citation: Children's Code art. 609; 610
A report is required when:
A reporter has cause to believe that a child's health is endangered as a result of abuse or neglect.
A commercial film or photographic print processor has knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child, whom he or she knows or should know is under age 17, that constitutes child pornography.

Privileged Communications
Citation: Children's Code art. 603; 609
A clergy member is not required to report a confidential communication from a person to a member of the clergy who, in the course of the discipline or practice of that church, denomination, or organization, is authorized or accustomed to hearing confidential communications, and under the discipline or tenets of the church, denomination, or organization has a duty to keep such communications confidential.
Neither the husband-wife nor any professional-client/patient privilege, except the attorney-client and clergy-penitent privilege, shall be a ground for refusing to report.

Disclosure of Reporter Identity
Citation: Rev. Stat. § 620.050
The identity of the reporter shall not be disclosed except:
To law enforcement officials, the agency investigating the report, or to a multidisciplinary team
Under court order, after a court has found reason to believe the reporter knowingly made a false report

Citation: Rev. Stat. § 620.030
Any person who knows or has reasonable cause to believe that a child is dependent, neglected, or abused shall immediately report.

Citation: Rev. Stat. § 620.030
A report is required when a person knows or has reasonable cause to believe that a child is dependent, neglected, or abused.

Privileged Communications
Citation: Rev. Stat. § 620.050
Neither the husband-wife nor any professional-client/patient privilege, except the attorney-client and clergy-penitent privilege, shall be a ground for refusing to report.

Inclusion of Reporter’s Name in Report
Not addressed in statutes reviewed.

Disclosure of Reporter Identity
Citation: Rev. Stat. § 620.050
The identity of the reporter shall not be disclosed except:
To law enforcement officials, the agency investigating the report, or to a multidisciplinary team
Under court order, after a court has found reason to believe the reporter knowingly made a false report

Citation: Rev. Stat. § 620.030
Any person who knows or has reasonable cause to believe that a child is dependent, neglected, or abused shall report.

Citation: Rev. Stat. § 620.030
A report is required when a person knows or has reasonable cause to believe that a child is dependent, neglected, or abused.

Privileged Communications
Citation: Rev. Stat. § 620.050
Neither the husband-wife nor any professional-client/patient privilege, except the attorney-client and clergy-penitent privilege, shall be a ground for refusing to report.

Disclosure of Reporter Identity
Citation: Rev. Stat. § 620.050
The identity of the reporter shall not be disclosed except:
To law enforcement officials, the agency investigating the report, or to a multidisciplinary team
Under court order, after a court has found reason to believe the reporter knowingly made a false report

Citation: Rev. Stat. tit. 22, § 4011-A
Any other person who knows or has reasonable cause to believe that a child has been or is likely to be abused or neglected may report.

Citation: Rev. Stat. tit. 22, § 4011-A
Any other person who knows or has reasonable cause to believe that a child has been or is likely to be abused or neglected may report.

Citation: Rev. Stat. tit. 22, §§ 4011-A; 4011-B
Any other person who knows or has reasonable cause to believe that a child has been or is likely to be abused or neglected may report.
A report is required when:
The person knows or has reasonable cause to suspect that a child is or is likely to be abused or neglected.
A health-care provider involved in the delivery or care of an infant knows or has reasonable cause to suspect the infant has been born affected by illegal substance abuse or is suffering from withdrawal symptoms resulting from prenatal drug exposure.

**Privileged Communications**
Citation: Rev. Stat. tit. 22, §§ 4011-A; 4015
A member of the clergy may claim privilege when information is received during a confidential communication.
The husband-wife and physician and psychotherapist-patient privileges cannot be invoked as a reason not to report.

**Inclusion of Reporter’s Name in Report**
Citation: Rev. Stat. tit. 22, § 4012
The report shall include the name, occupation, and contact information for the person making the report.

**Disclosure of Reporter Identity**
Citation: Rev. Stat. tit. 22, § 4008
The department will protect the identity of reporters and other persons as appropriate when disclosing information in the records to a child named in a report, the child's parent, custodian, or caretaker, or a party to a child protection proceeding.

---

**Maryland**

<table>
<thead>
<tr>
<th>Professionals Required to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citation: Fam. Law § 5-704</td>
</tr>
<tr>
<td>Persons required to report include:</td>
</tr>
<tr>
<td>Health practitioners</td>
</tr>
<tr>
<td>Educators or human service workers</td>
</tr>
<tr>
<td>Police officers</td>
</tr>
</tbody>
</table>

**Reporting by Other Persons**
Citation: Fam. Law § 5-705
Any other person who has reason to believe that a child has been subjected to abuse or neglect must report.

**Standards for Making a Report**
Citation: Fam. Law §§ 5-704; 5-705
A report is required when, acting in a professional capacity, the person has reason to believe that a child has been subjected to abuse or neglect.

**Privileged Communications**
Citation: Fam. Law § 5-705
Only the attorney-client and clergy-penitent privileges are permitted.

**Disclosure of Reporter Identity**
Not addressed in statutes reviewed.

---

**Massachusetts**

<table>
<thead>
<tr>
<th>Professionals Required to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citation: Gen. Laws ch. 119, § 51A</td>
</tr>
<tr>
<td>Mandatory reporters include:</td>
</tr>
<tr>
<td>Physicians, hospital personnel, medical examiners, emergency medical technicians, dentists, nurses, chiropractors, optometrists, or psychiatrists Teachers, educational administrators, daycare workers or persons paid to care for or work with children in facilities that provide daycare or residential services, family daycare systems and child care food programs, or school attendance officers</td>
</tr>
<tr>
<td>Psychologists, social workers, licensed allied mental health and human services professionals, drug and alcoholism counselors, clinical social workers, or guidance or family counselors</td>
</tr>
<tr>
<td>Probation officers, clerk or magistrates of district courts, parole officers, foster parents, firefighters, or police officers</td>
</tr>
<tr>
<td>Priests, rabbis, clergy members, ministers, leaders of any church or religious body, accredited Christian Science practitioners, persons performing official duties on behalf of a church or religious body, leader of any church or religious body, or persons employed by a church or religious body to supervise, educate, coach, train, or counsel a child on a regular basis</td>
</tr>
</tbody>
</table>

**Reporting by Other Persons**
Citation: Gen. Laws ch. 119, § 51A
Any other person who has reasonable cause to believe that a child is suffering from abuse or neglect may report.

**Standards for Making a Report**
Citation: Gen. Laws ch. 119, § 51A
A report is required when the reporter, in his or her professional capacity, has reasonable cause to believe that a child is suffering injury from abuse or neglect that inflicts harm or a substantial risk of harm.

**Privileged Communications**
Citation: Gen. Laws ch. 119, § 51A
A clergy member shall report all cases of abuse, but need not report information gained in a confession or other confidential communication. Any other privilege relating to confidential communications shall not prohibit the filing of a report.

**Inclusion of Reporter’s Name in Report**
Citation: Gen. Laws ch. 119, § 51A
A report shall include the name of the reporter.

**Disclosure of Reporter Identity**
Not addressed in statutes reviewed.

---

**Michigan**

<table>
<thead>
<tr>
<th>Professionals Required to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citation: Comp. Laws § 722.623</td>
</tr>
<tr>
<td>Mandatory reporters include:</td>
</tr>
<tr>
<td>Physicians, physician assistants, dentists, dental hygienists, medical examiners, nurses, persons licensed to provide emergency medical care, or audiologists School administrators, counselors, or teachers</td>
</tr>
<tr>
<td>Regulated child care providers</td>
</tr>
<tr>
<td>Psychologists, marriage and family therapists, licensed professional counselors, social workers, or social work technicians Law enforcement officers</td>
</tr>
</tbody>
</table>

**Privileged Communications**
Citation: Comp. Laws § 722.623
A clergy member shall report all cases of abuse, but need not report information gained in a confession or other confidential communication. Any other privilege relating to confidential communications shall not prohibit the filing of a report.

**Inclusion of Reporter’s Name in Report**
Citation: Comp. Laws § 722.623
A report shall include the name of the reporter.

**Disclosure of Reporter Identity**
Not addressed in statutes reviewed.
<table>
<thead>
<tr>
<th>State</th>
<th>Professionals Required to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>Mandatory reporters include: A professional or professional's delegate who is engaged in the practice of the healing arts, hospital administration, psychological or psychiatric treatment, child care, education, social services, correctional supervision, probation or correctional services, or law enforcement</td>
</tr>
<tr>
<td></td>
<td>A member of the clergy who received the information while engaged in ministerial duties</td>
</tr>
<tr>
<td>Mississippi</td>
<td>The following professionals are required to report: Physicians, dentists, interns, residents, or nurses Public or private school employees or child care givers Psychologists, social workers, family protection workers, or family protection specialists Attorneys, ministers, or law enforcement officers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>Reporting by Other Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>Any other person may voluntarily report if the person knows, has reason to believe, or suspects that a child is being neglected or subjected to sexual or physical abuse.</td>
</tr>
<tr>
<td>Mississippi</td>
<td>All other persons who have reasonable cause to suspect that a child is abused or neglected must report.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>Standards for Making a Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>A report is required when a reporter knows or has reason to believe that a child is being neglected or sexually or physically abused or has been neglected or physically or sexually abused within the preceding 3 years.</td>
</tr>
<tr>
<td>Mississippi</td>
<td>A report is required when a reporter has reasonable cause to suspect child abuse or neglect.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>Privileged Communications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>A member of the clergy is not required by this subdivision to report information that is otherwise privileged under § 595.02, subdivision 1, paragraph (c). No evidence relating to the neglect or abuse of a child or to any prior incidents of neglect or abuse involving any of the same persons accused of neglect or abuse shall be excluded in any proceeding on the grounds of privilege set forth in section 595.02, subdivision 1, paragraph (a) [husband-wife], (d) [medical practitioner-patient], or (g) [mental health professional-client].</td>
</tr>
<tr>
<td>Mississippi</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>Disclosure of Reporter Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>The identity of the reporting person is confidential subject to disclosure only with the consent of that person or by judicial process. The identity of the reporter is protected in any release of information to the subject of the report.</td>
</tr>
<tr>
<td>Mississippi</td>
<td>The identity of the reporting party shall not be disclosed to anyone other than law enforcement officers or prosecutors without an order from the appropriate youth court.</td>
</tr>
</tbody>
</table>

[Effective July 1, 2007] The identity of the reporter shall not be disclosed to an individual under investigation.
<table>
<thead>
<tr>
<th>State</th>
<th>Professionals Required to Report</th>
<th>Citation: Rev. Stat. §§ 210.115; 568.110; 352.400</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missouri</td>
<td>Professionals required to report include: Physicians, medical examiners, coroners, dentists, chiropractors, optometrists, podiatrists, residents, interns, nurses, hospital and clinic personnel, or other health practitioners Daycare center workers or other child care workers, teachers, principals, or other school officials Psychologists, mental health professionals, social workers Ministers including clergypersons, priests, rabbis, Christian Science practitioners, or other persons serving in a similar capacity for any religious organization Juvenile officers, probation, parole officers, peace officers, law enforcement officials, or jail or detention center personnel Other persons with responsibility for the care of children Commercial film and photographic print processors, computer providers, installers, or repair persons, or Internet service providers</td>
<td>Reporting by Other Persons Citation: Rev. Stat. § 210.115 Any other person who has reasonable cause to suspect that a child has been subjected to abuse or neglect may report. Standards for Making a Report Citation: Rev. Stat. §§ 210.115; 568.110 A report is required when: A reporter has reasonable cause to suspect that a child has been subjected to abuse or neglect. A reporter observes a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect. A commercial film and photographic print processor has knowledge of or observes any film, photograph, videotape, negative, slide, or computer-generated image or picture depicting a child engaged in an act of sexual conduct. Privileged Communications Citation: Rev. Stat. § 210.140 Only the attorney-client or clergy-penitent privilege may be grounds for failure to report. Inclusion of Reporter’s Name in Report Citation: Rev. Stat. § 210.130 The report must include the name, address, occupation, and contact information for the person making the report. Disclosure of Reporter Identity Citation: Rev. Stat. § 210.150 The names or other identifying information of reporters shall not be furnished to any child, parent, guardian, or alleged perpetrator named in the report.</td>
</tr>
<tr>
<td>Montana</td>
<td>Professionals Required to Report Citation: Ann. Code § 41-3-201 Professionals required to report include: Physicians, residents, interns, members of hospital staffs, nurses, osteopaths, chiropractors, podiatrists, medical examiners, coroners, dentists, optometrists, or any other health professionals School teachers, other school officials, employees who work during regular school hours, operators or employees of any registered or licensed daycare or substitute care facility, or any other operators or employees of child care facilities Mental health professionals or social workers Religious healers Foster care, residential, or institutional workers Members of clergy, as defined in § 15-6-2-1(2)(a): The term &quot;clergy&quot; means: An ordained minister, priest, or rabbi A commissioned or licensed minister of a church or church denomination that ordains ministers if the person has the authority to perform substantially all the religious duties of the church or denomination A member of a religious order who has taken a vow of poverty A Christian Science practitioner Guardians ad litem or court-appointed advocates authorized to investigate a report Peace officers or other law enforcement officials</td>
<td>Reporting by Other Persons Citation: Ann. Code § 41-3-201 Any other person who knows or has reasonable cause to suspect that a child is abused or neglected may report. Standards for Making a Report Citation: Ann. Code § 41-3-201 A report is required when: A reporter knows or has reasonable cause to suspect, as a result of information received in his or her professional or official capacity, that a child is abused or neglected. A health-care professional involved in the delivery or care of an infant knows that the infant is affected by a dangerous drug. Privileged Communications Citation: Ann. Code § 41-3-201 A person listed as a mandated reporter may not refuse to make a report as required in this section on the grounds of a physician-patient or similar privilege. A member of the clergy or priest is not required to make a report under this section if the communication is required to be confidential by canon law, church doctrine, or established church practice. Inclusion of Reporter’s Name in Report Not addressed in statutes reviewed. Disclosure of Reporter Identity Citation: Ann. Code § 41-3-205 The identity of the reporter shall not be disclosed in any release of information to the subject of the report.</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Professionals Required to Report Citation: Rev. Stat. § 28-711 Professionals required to report include:</td>
<td></td>
</tr>
</tbody>
</table>
Physicians, medical institutions, or nurses
School employees
Social workers
**Reporting by Other Persons**
Citation: Rev. Stat. § 28-711
All other persons who have reasonable cause to believe that a child has been subjected to abuse or neglect must report.

**Standards for Making a Report**
Citation: Rev. Stat. § 28-711
A report is required when:
A reporter has reasonable cause to believe that a child has been subjected to abuse or neglect.
A reporter observes a child being subjected to conditions or circumstances that reasonably would result in abuse or neglect.

**Privileged Communications**
Citation: Rev. Stat. § 28-714
The physician-patient, counselor-client, and husband-wife privileges shall not be grounds for failing to report.

**Inclusion of Reporter’s Name in Report**
Citation: Rev. Stat. § 28-711
The initial oral report shall include the reporter’s name and address.

**Disclosure of Reporter Identity**
Citation: Rev. Stat. § 28-719
The name and address of the reporter shall not be included in any release of information.

---

<table>
<thead>
<tr>
<th>Nevada</th>
</tr>
</thead>
</table>

**Professionals Required to Report**
Citation: Rev. Stat. § 432B.220
Mandatory reporters include:
- Physicians, dentists, dental hygienists, chiropractors, optometrists, podiatrists, medical examiners, residents, interns, nurses, or physician assistants
- Emergency medical technicians, other persons providing medical services, or hospital personnel
- Coroners
- School administrators, teachers, counselors, or librarians
- Any persons who maintain or are employed by facilities or establishments that provide care for children, children's camps, or other facilities, institutions, or agencies furnishing care to children
- Psychiatrists, psychologists, marriage and family therapists, clinical professional counselors, clinical alcohol and drug abuse counselors, alcohol or drug abuse counselors, athletic trainers, or social workers
- Members of the clergy, practitioners of Christian Science, or religious healers, unless they have acquired the knowledge of the abuse or neglect from the offenders during confessions
- Persons licensed to conduct foster homes
- Officers or employees of law enforcement agencies or adult or juvenile probation officers
- Attorneys, unless they have acquired the knowledge of the abuse or neglect from clients who are, or may be, accused of the abuse or neglect
- Any person who is employed by or serves as a volunteer for an approved youth shelter
- Any adult person who is employed by an entity that provides organized activities for children
- Any person who maintains, is employed by, or serves as a volunteer for an agency or service that advises persons regarding abuse or neglect of a child and refers them to services

**Reporting by Other Persons**
Citation: Rev. Stat. § 432B.220
Any other person may report.

**Standards for Making a Report**
Citation: Rev. Stat. § 432B.220
A report is required when:
- A reporter, in his or her professional capacity, knows or has reason to believe that a child is abused or neglected.
- A reporter has reasonable cause to believe that a child has died as a result of abuse or neglect.
- A medical services provider who delivers or provides medical services to a newborn infant and in his or her professional or occupational capacity, knows or has reasonable cause to believe that the newborn infant has been affected by prenatal illegal substance abuse or has withdrawal symptoms resulting from prenatal drug exposure.

**Privileged Communications**
Citation: Rev. Stat. §§ 432B.220; 432B.250
The clergy-penitent privilege applies when the knowledge is gained during religious confession.
The attorney-client privilege applies when the knowledge is acquired from a client who is or may be accused of abuse.
Any other person who is required to report may not invoke privilege for failure to make a report.

**Inclusion of Reporter’s Name in Report**
Not addressed in statutes reviewed.

**Disclosure of Reporter Identity**
Citation: Rev. Stat. § 432B.290
The identity of the reporter is kept confidential.

---

<table>
<thead>
<tr>
<th>New Hampshire</th>
</tr>
</thead>
</table>

**Professionals Required to Report**
Citation: Rev. Stat. § 169-C:29
The following professionals are required to report:
- Physicians, surgeons, county medical examiners, psychiatrists, residents, interns, dentists, osteopaths, optometrists, chiropractors, nurses, hospital personnel,
or Christian Science practitioners
- Teachers, school officials, nurses, or counselors
- Daycare workers or any other child or foster care workers
- Social workers
- Psychologists or therapists
### New Jersey

**Professionals Required to Report**  
Not addressed in statutes reviewed.  

**Reporting by Other Persons**  
Citation: Ann. Stat. § 9:6-8.10  
Any person having reasonable cause to believe that a child has been subjected to child abuse or neglect or acts of child abuse shall report.  

**Standards for Making a Report**  
Citation: Ann. Stat. § 9:6-8.10  
A report is required when a person has reasonable cause to believe that a child has been subjected to abuse or neglect.  

**Privileged Communications**  
Not addressed in statutes reviewed.  

**Inclusion of Reporter’s Name in Report**  
Not addressed in statutes reviewed.  

**Disclosure of Reporter Identity**  
Citation: Ann. Stat. § 9:6-8.10a  
The identity of the reporter shall not be made public.  
Any information that could endanger any person shall not be released.

### New Mexico

**Professionals Required to Report**  
Citation: Ann. Stat. § 32A-4-3  
Professionals required to report include:  
- Physicians, residents, or interns  
- Law enforcement officers or judges  
- Nurses  
- Teachers or school officials  
- Social workers  
- Members of the clergy  

**Reporting by Other Persons**  
Citation: Ann. Stat. § 32A-4-3  
Every person who knows or has a reasonable suspicion that a child is an abused or neglected child shall report the matter immediately.  

**Standards for Making a Report**  
Citation: Ann. Stat. § 32A-4-3  
A report is required when a person knows or has a reasonable suspicion that a child is abused or neglected.  

**Privileged Communications**  
Citation: Ann. Stat. §§ 32A-4-3; 32A-4-5  
A clergy member need not report any information that is privileged.  
The report or its contents or any other facts related thereto or to the condition of the child who is the subject of the report shall not be excluded on the ground that the matter is or may be the subject of a physician-patient privilege or similar privilege or rule against disclosure.  

**Inclusion of Reporter’s Name in Report**  
Not addressed in statutes reviewed.  

**Disclosure of Reporter Identity**  
Citation: Ann. Stat. § 32A-4-33  
Any release of information to a parent, guardian, or legal custodian shall not include identifying information about the reporter.

### New York

**Professionals Required to Report**  
Citation: Soc. Serv. Law § 413  
[Effective October 1, 2007]  
The following persons and officials are required to report:  
- Physicians, physician assistants, surgeons, medical examiners, coroners, dentists, dental hygienists, osteopaths, optometrists, chiropractors, podiatrists, residents, interns, psychologists, registered nurses, social workers, or emergency medical technicians  
- Licensed creative arts therapists, marriage and family therapists, mental health counselors, or psychoanalysts  
- Hospital personnel or Christian Science practitioners  
- School officials, including but not limited to, teachers, guidance counselors, school psychologists, school social workers, school nurses, or administrators  
- Social services workers, daycare center workers, providers of family or group family daycare, or employees or volunteers in a residential care facility or any other child care or foster care worker  
- Mental health professionals, substance abuse counselors, or alcoholism counselors  
- Peace officers, police officers, district attorneys or assistant district attorneys, investigators employed in the office of a district attorney, or other law enforcement officials
<table>
<thead>
<tr>
<th>State</th>
<th>Professionals Required to Report</th>
<th>Citation</th>
<th>Standards for Making a Report</th>
<th>Privileged Communications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anyone other person who has reasonable cause to suspect that a child is abused or maltreated may report.</td>
<td>Soc. Serv. Law § 414</td>
<td>A report is required when the reporter has reasonable cause to suspect:</td>
<td></td>
</tr>
<tr>
<td>North Carolina</td>
<td>Any other person who has cause to suspect abuse or neglect shall report.</td>
<td>Gen. Stat. § 7B-301</td>
<td>A child coming before him or her in his or her professional or official capacity is an abused or maltreated child.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reporting by Other Persons</td>
<td></td>
<td>The parent, guardian, custodian, or other person legally responsible for the child comes before the reporter and states from personal knowledge facts, conditions, or circumstances that, if correct, would render the child an abused or maltreated child.</td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td>The following professionals are required to report:</td>
<td>Cent. Code § 50-25.1-03</td>
<td>A report is required when a reporter has knowledge of or reasonable cause to suspect that a child is abused or neglected if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physicians, nurses, dentists, optometrists, medical examiners or coroners, or any other medical or mental health professionals</td>
<td></td>
<td></td>
<td>A member of the clergy is not required to report such circumstances if the knowledge or suspicion is derived from information received in the capacity of spiritual adviser.</td>
</tr>
<tr>
<td></td>
<td>Religious practitioners of the healing arts</td>
<td></td>
<td></td>
<td>Any privilege of communication between husband and wife or between any professional person and the person’s patient or client, except between attorney and client, cannot be used as grounds for failing to report.</td>
</tr>
<tr>
<td></td>
<td>Schoolteachers, administrators, or school counselors</td>
<td></td>
<td></td>
<td>Inclusion of Reporter’s Name in Report</td>
</tr>
<tr>
<td></td>
<td>Addiction counselors, social workers, child care workers, or foster parents</td>
<td></td>
<td></td>
<td>The report must include the name, address, and telephone number of the reporter.</td>
</tr>
<tr>
<td></td>
<td>Police or law enforcement officers, juvenile court personnel, probation officers, division of juvenile services employees</td>
<td></td>
<td></td>
<td>Disclosure of Reporter Identity</td>
</tr>
<tr>
<td></td>
<td>Members of the clergy</td>
<td></td>
<td></td>
<td>The department shall hold the identity of the reporter in strictest confidence.</td>
</tr>
<tr>
<td>Ohio</td>
<td>Mandatory reporters include:</td>
<td>Rev. Code § 2151.421</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attorneys</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physicians, interns, residents, dentists, podiatrists, nurses, or other health care professionals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionals Required to Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oklahoma</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Professionals Required to Report</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citation: Rev. Code § 2151.421</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A report is required when a mandated person is acting in an official or professional capacity and knows or suspects that a child has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Privileged Communications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citation: Rev. Code § 2151.421</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The attorney-client or physician-patient privilege is waived if the client or patient is a child who is suffering or faces the threat of suffering any physical or mental injury.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The physician-patient privilege shall not be a ground for excluding evidence regarding a child's injuries, abuse, or neglect, or the cause of the injuries, abuse, or neglect in any judicial proceeding resulting from a report.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons performing the duties of an assessor or third party employed by a public children services agency to assist in providing child or family related services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting by Other Persons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citation: Rev. Code § 2151.421</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other person who suspects that a child has suffered or faces a threat of suffering from abuse or neglect may report.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standards for Making a Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citation: Rev. Code § 2151.421</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A report is required when a mandated person is acting in an official or professional capacity and knows or suspects that a child has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Privileged Communications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citation: Rev. Code § 2151.421</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The attorney-client or physician-patient privilege is waived if the client or patient is a child who is suffering or faces the threat of suffering any physical or mental injury.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The physician-patient privilege shall not be a ground for excluding evidence regarding a child's injuries, abuse, or neglect, or the cause of the injuries, abuse, or neglect in any judicial proceeding resulting from a report.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The cleric could not testify with respect to that communication in a civil or criminal proceeding.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inclusion of Reporter’s Name in Report</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not addressed in statutes reviewed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosure of Reporter Identity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citation: Rev. Code § 2151.421</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The information provided in a report made pursuant to this section and the name of the person who made the report shall not be released for use, and shall not be used, as evidence in any civil action or proceeding brought against the person who made the report.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professionals Required to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oregon</strong></td>
</tr>
<tr>
<td><strong>Professionals Required to Report</strong></td>
</tr>
<tr>
<td>Citation: Rev. Stat. §§ 419B.005; 419B.010</td>
</tr>
<tr>
<td>A public or private official is mandated to report. Public or private officials include:</td>
</tr>
<tr>
<td>Physicians, interns, or residents</td>
</tr>
<tr>
<td>Dentists</td>
</tr>
<tr>
<td>School employees Licensed practical nurses or registered nurses</td>
</tr>
</tbody>
</table>
| Employees of the Department of Human Services, State Commission on Children and Families, Child Care Division of the Employment Department, the Oregon Youth Authority, a county health department, a community mental health and developmental disabilities program, a county juvenile department, a
Licensed child-caring agency, or an alcohol and drug treatment program
Peace officers
Psychologists
Members of the clergy
Licensed clinical social workers
Optometrists
Chiropractors
Certified providers of foster care or their employees
Attorneys
Naturopathic physicians
Licensed professional counselors or marriage and family therapists
Firefighters or emergency medical technicians
Court appointed special advocates
Registered or certified child care providers
Members of the Legislative Assembly

**Reporting by Other Persons**

Citation: Rev. Stat. § 419B.015
Any person may voluntarily make a report.

**Standards for Making a Report**

Citation: Rev. Stat. § 419B.010
A report is required when any public or private official has reasonable cause to believe that any child with whom the official comes in contact has suffered abuse.

**Privileged Communications**

Citation: Rev. Stat. § 419B.010
A psychiatrist, psychologist, member of the clergy, or attorney shall not be required to report if such communication is privileged under law.

An attorney is not required to make a report of information communicated to the attorney in the course of representing a client, if disclosure of the information would be detrimental to the client.

**Inclusion of Reporter’s Name in Report**

Not addressed in statutes reviewed.

**Disclosure of Reporter Identity**

Citation: Rev. Stat. § 419B.015
The name, address, and other identifying information about the person who made the report may not be disclosed.

---

**Pennsylvania**

**Professionals Required to Report**

Citation: Cons. Stat. ch. 23, § 6311

*Effective May 29, 2007*

Persons required to report include, but are not limited to; Licensed physicians, osteopaths, medical examiners, coroners, funeral directors, dentists, optometrists, chiropractors, podiatrists, interns, registered nurses, licensed practical nurses, or hospital personnel engaged in the admission, examination, care, or treatment of persons Christian Science practitioners or members of the clergy

School administrators, school teachers, school nurses, social services workers, daycare center workers, or any other child care or foster care workers

Mental health professionals

Peace officers or law enforcement officials

**Reporting by Other Persons**

Citation: Cons. Stat. ch. 23, § 6312
Any person who has reason to suspect that a child is abused or neglected may report.

**Standards for Making a Report**

Citation: Cons. Stat. ch. 23, § 6311

*Effective May 29, 2007*

A report is required when a person, who in the course of employment, occupation, or practice of a profession, comes into contact with children, has reasonable cause to suspect, on the basis of medical, professional, or other training and experience, that a child is a victim of child abuse.

**Privileged Communications**

Citation: Cons. Stat. ch. 23, § 6311

*Effective May 29, 2007*

Except with respect to confidential communications made to a member of the clergy that are protected under 42 Pa.C.S. § 5943 (relating to confidential communications to clergymen), and except with respect to confidential communications made to an attorney that are protected by 42 Pa.C.S. §§ 5916 or 5928 (relating to confidential communications to an attorney), the privileged communication between any professional person required to report and the patient or client of that person shall not apply to situations involving child abuse and shall not constitute grounds for failure to report as required by this chapter.

**Inclusion of Reporter’s Name in Report**

Citation: Cons. Stat. ch. 23, § 6313
Mandated reporters must make a written report that includes their name and contact information.

**Disclosure of Reporter Identity**

Citation: Cons. Stat. ch. 23, § 6340
The release of the identity of the mandated reporter is prohibited unless the secretary finds that the release will not be detrimental to the safety of the reporter.

---

**Rhode Island**

**Professionals Required to Report**

Citation: Gen. Laws § 40-11-6
Any physician or duly certified registered nurse practitioner is required to report.

**Reporting by Other Persons**

Citation: Gen. Laws § 40-11-3(a)
Any person who has reasonable cause to know or suspect that a child has been abused or neglected must report.

**Standards for Making a Report**

Citation: Gen. Laws §§ 40-11-3(a); 40-11-6
A report is required when:
A person has reasonable cause to know or suspect that a child has been abused or neglected.
<table>
<thead>
<tr>
<th>State</th>
<th>Professionals Required to Report</th>
<th>Citation: Ann. Code § 20-7-510</th>
<th>The following professionals are required to report:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physicians, nurses, dentists, optometrists, medical examiners, or coroners</td>
<td></td>
<td>Physicians, nurses, dentists, optometrists, medical examiners, or coroners</td>
</tr>
<tr>
<td></td>
<td>Any other medical, emergency medical services, or allied health professionals</td>
<td></td>
<td>Any other medical, emergency medical services, or allied health professionals</td>
</tr>
<tr>
<td></td>
<td>School teachers or counselors, principals, or assistant principals</td>
<td></td>
<td>School teachers or counselors, principals, or assistant principals</td>
</tr>
<tr>
<td></td>
<td>Child care workers in any child care centers or foster care facilities</td>
<td></td>
<td>Child care workers in any child care centers or foster care facilities</td>
</tr>
<tr>
<td></td>
<td>Mental health professionals, social or public assistance workers, or substance abuse treatment staff</td>
<td></td>
<td>Mental health professionals, social or public assistance workers, or substance abuse treatment staff</td>
</tr>
<tr>
<td></td>
<td>Members of the clergy including Christian Science practitioners or religious healers</td>
<td></td>
<td>Members of the clergy including Christian Science practitioners or religious healers</td>
</tr>
<tr>
<td></td>
<td>Police or law enforcement officers, judges, funeral home directors or employees</td>
<td></td>
<td>Police or law enforcement officers, judges, funeral home directors or employees</td>
</tr>
<tr>
<td></td>
<td>Persons responsible for processing films or computer technicians</td>
<td></td>
<td>Persons responsible for processing films or computer technicians</td>
</tr>
<tr>
<td></td>
<td>Reporting by Other Persons</td>
<td>Citation: Ann. Code § 20-7-510</td>
<td>Any other person who has reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse and neglect may report.</td>
</tr>
<tr>
<td></td>
<td>Standards for Making a Report</td>
<td>Citation: Ann. Code § 20-7-510</td>
<td>A report is required when a reporter, in his or her professional capacity, receives information that gives him or her reason to believe that a child has been or may be abused or neglected.</td>
</tr>
<tr>
<td></td>
<td>Privileged Communications</td>
<td>Citation: Ann. Code § 20-7-540</td>
<td>The privileged quality of communication between husband and wife and any professional person and his patient or client, except that between attorney and client or clergy member, including Christian Science Practitioner or religious healer, and penitent, does not constitute grounds for failure to report.</td>
</tr>
<tr>
<td></td>
<td>Inclusion of Reporter’s Name in Report</td>
<td>Citation: Ann. Code § 20-7-510</td>
<td>Not addressed in statutes reviewed.</td>
</tr>
<tr>
<td></td>
<td>Disclosure of Reporter Identity</td>
<td>Citation: Ann. Code § 20-7-510</td>
<td>The identity of the person making a report pursuant to this section must be kept confidential by the agency or department receiving the report and must not be disclosed.</td>
</tr>
</tbody>
</table>

**South Carolina**

<table>
<thead>
<tr>
<th>Professionals Required to Report</th>
<th>Citation: Codified Laws § 26-8A-3</th>
<th>Mandatory reporters include:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Physicians, dentists, osteopaths, chiropractors, optometrists, nurses, coroners</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Teachers, school counselors or officials, child welfare providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental health professionals or counselors, psychologists, social workers, chemical dependency counselors, employees or volunteers of domestic abuse shelters, or religious healing practitioners</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parole or court services officers or law enforcement officers Any safety-sensitive position (as defined in § 23-3-64), including any law enforcement officer authorized to carry firearms and any custody staff employed by any agency responsible for the rehabilitation or treatment of any adjudicated adult or juvenile</td>
</tr>
<tr>
<td></td>
<td>Reporting by Other Persons</td>
<td>Citation: Codified Laws § 26-8A-3</td>
</tr>
<tr>
<td></td>
<td>Standards for Making a Report</td>
<td>Citation: Codified Laws § 26-8A-3</td>
</tr>
<tr>
<td></td>
<td>Privileged Communications</td>
<td>Citation: Codified Laws § 26-8A-15</td>
</tr>
<tr>
<td></td>
<td>Inclusion of Reporter’s Name in Report</td>
<td>Not addressed in statutes reviewed.</td>
</tr>
<tr>
<td></td>
<td>Disclosure of Reporter Identity</td>
<td>Citation: Codified Laws § 26-8A-11.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Within 30 days, the subject of the report requests disclosure of the reporter's identity.</td>
</tr>
</tbody>
</table>

A hearing is held to determine whether the report was made with malice and without reasonable foundation and that release of the name will not endanger the life or safety of the reporter.
<table>
<thead>
<tr>
<th>Tennessee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals Required to Report</td>
</tr>
<tr>
<td>Citation: Ann. Code §§ 37-1-403; 37-1-605</td>
</tr>
<tr>
<td>Persons required to report include:</td>
</tr>
<tr>
<td>Physicians, osteopaths, medical examiners, chiropractors, nurses, hospital personnel, or other health or mental health professionals</td>
</tr>
<tr>
<td>School teachers, other school officials or personnel, daycare center workers, or other professional child care, foster care, residential, or institutional workers</td>
</tr>
<tr>
<td>Social workers</td>
</tr>
<tr>
<td>Practitioners who rely solely on spiritual means for healing</td>
</tr>
<tr>
<td>Judges or law enforcement officers</td>
</tr>
<tr>
<td>Neighbors, relatives, or friends</td>
</tr>
<tr>
<td>Other persons</td>
</tr>
<tr>
<td>Reporting by Other Persons</td>
</tr>
<tr>
<td>Citation: Ann. Code §§ 37-1-403; 37-1-605</td>
</tr>
<tr>
<td>Any person who has knowledge that a child has been harmed by abuse or neglect must report.</td>
</tr>
<tr>
<td>Standards for Making a Report</td>
</tr>
<tr>
<td>Citation: Ann. Code §§ 37-1-403; 37-1-605</td>
</tr>
<tr>
<td>A report is required when:</td>
</tr>
<tr>
<td>A person has knowledge that a child has been harmed by abuse or neglect.</td>
</tr>
<tr>
<td>A person is called upon to render aid to any child who is suffering from an injury that reasonably appears to have been caused by abuse.</td>
</tr>
<tr>
<td>A person knows or has reasonable cause to suspect that a child has been sexually abused.</td>
</tr>
<tr>
<td>A physician diagnoses or treats any sexually transmitted disease in a child age 13 or younger.</td>
</tr>
<tr>
<td>Privileged Communications</td>
</tr>
<tr>
<td>Citation: Ann. Code § 37-1-411</td>
</tr>
<tr>
<td>The following privileges may not be claimed:</td>
</tr>
<tr>
<td>Husband-wife</td>
</tr>
<tr>
<td>Psychiatrist-patient or psychologist-patient</td>
</tr>
<tr>
<td>Inclusion of Reporter’s Name in Report</td>
</tr>
<tr>
<td>Not addressed in statutes reviewed.</td>
</tr>
<tr>
<td>Disclosure of Reporter Identity</td>
</tr>
<tr>
<td>Citation: Ann. Code § 37-1-409</td>
</tr>
<tr>
<td>Except as may be ordered by the juvenile court, the name of any person reporting child abuse or neglect shall not be released to any person, other than employees of the department or other child protection team members responsible for child protective services, the abuse registry, or the appropriate district attorney general upon subpoena of the Tennessee Bureau of Investigation, without the written consent of the person reporting.</td>
</tr>
<tr>
<td>The reporter's identity shall be irrelevant to any civil proceeding and shall, therefore, not be subject to disclosure by order of any court. This shall not prohibit the subpoenaing of a person reporting child abuse when deemed necessary by the district attorney general or the department to protect a child who is the subject of a report; provided, that the fact that such person made the report is not disclosed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals Required to Report</td>
</tr>
<tr>
<td>Citation: Fam. Code § 261.101</td>
</tr>
<tr>
<td>Persons required to report include:</td>
</tr>
<tr>
<td>A professional, for purposes of the reporting laws, is an individual who is licensed or certified by the State or who is an employee of a facility licensed, certified, or operated by the State and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children.</td>
</tr>
<tr>
<td>Professionals include:</td>
</tr>
<tr>
<td>Teachers or daycare employees</td>
</tr>
<tr>
<td>Nurses, doctors, or employees of a clinic or health-care facility that provides reproductive services</td>
</tr>
<tr>
<td>Juvenile probation officers or juvenile detention or correctional officers</td>
</tr>
<tr>
<td>Reporting by Other Persons</td>
</tr>
<tr>
<td>Citation: Fam. Code § 261.101</td>
</tr>
<tr>
<td>A person who has cause to believe that a child has been adversely affected by abuse or neglect shall immediately make a report.</td>
</tr>
<tr>
<td>Standards for Making a Report</td>
</tr>
<tr>
<td>Citation: Fam. Code § 261.101</td>
</tr>
<tr>
<td>A report is required when a person has cause to believe that a child has been adversely affected by abuse or neglect.</td>
</tr>
<tr>
<td>Privileged Communications</td>
</tr>
<tr>
<td>Citation: Fam. Code § 261.101</td>
</tr>
<tr>
<td>The requirement to report applies without exception to an individual whose personal communications may otherwise be privileged, including an attorney, a member of the clergy, a medical practitioner, a social worker, a mental health professional, and an employee of a clinic or health-care facility that provides reproductive services.</td>
</tr>
<tr>
<td>Inclusion of Reporter’s Name in Report</td>
</tr>
<tr>
<td>Not addressed in statutes reviewed.</td>
</tr>
<tr>
<td>Disclosure of Reporter Identity</td>
</tr>
<tr>
<td>Citation: Fam. Code §§ 261.101; 261.201</td>
</tr>
<tr>
<td>Unless waived in writing by the person making the report, the identity of an individual making a report is confidential and may be disclosed only:</td>
</tr>
<tr>
<td>As provided by § 261.201</td>
</tr>
<tr>
<td>To a law enforcement officer for the purposes of conducting a criminal investigation of the report</td>
</tr>
<tr>
<td>A report of alleged or suspected abuse or neglect and the identity of the person making the report are confidential. A court may order the disclosure of such confidential information, if after a hearing and an in camera review of the requested information, the court determines that the disclosure is:</td>
</tr>
<tr>
<td>Essential to the administration of justice</td>
</tr>
<tr>
<td>Not likely to endanger the life or safety of a child who is the subject of the report, a person who made the report, or any other person who participates in an investigation of reported abuse or neglect or who provides care for the child</td>
</tr>
</tbody>
</table>
| The Texas Youth Commission shall release a report of alleged or suspected abuse if the report relates to abuse or neglect involving a child committed to the commission. The commission shall edit any report disclosed under this section to protect the identity of:
<table>
<thead>
<tr>
<th>State</th>
<th>Professionals Required to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utah</td>
<td>Citation: Ann. Code § 62A-4a-403</td>
</tr>
<tr>
<td></td>
<td>Any person licensed under the Medical Practice Act or the Nurse Practice Act is required to report.</td>
</tr>
<tr>
<td></td>
<td>Reporting by Other Persons</td>
</tr>
<tr>
<td></td>
<td>Citation: Ann. Code § 62A-4a-403</td>
</tr>
<tr>
<td></td>
<td>Any person who has reason to believe that a child has been subjected to abuse or neglect must report.</td>
</tr>
<tr>
<td></td>
<td>Standards for Making a Report</td>
</tr>
<tr>
<td></td>
<td>Citation: Ann. Code § 62A-4a-403</td>
</tr>
<tr>
<td></td>
<td>A report is required when:</td>
</tr>
<tr>
<td></td>
<td>A person has reason to believe that a child has been subjected to abuse or neglect.</td>
</tr>
<tr>
<td></td>
<td>A person observes a child being subjected to conditions or circumstances that would reasonably result in sexual abuse, physical abuse, or neglect.</td>
</tr>
<tr>
<td></td>
<td>Privileged Communications</td>
</tr>
<tr>
<td></td>
<td>Citation: Ann. Code §§ 62A-4a-403; 62A-4a-412(5)</td>
</tr>
<tr>
<td></td>
<td>The requirement to report does not apply to clergy, without the consent of the person making the confession, with regard to any confession made to the clergy in their professional character in the course of discipline enjoined by the church.</td>
</tr>
<tr>
<td></td>
<td>The physician-patient privilege is not a ground for excluding evidence regarding a child's injuries or the cause of those injuries, in any proceeding resulting from a report made in good faith pursuant to this part.</td>
</tr>
<tr>
<td></td>
<td>Inclusion of Reporter’s Name in Report</td>
</tr>
<tr>
<td></td>
<td>Not addressed in statutes reviewed.</td>
</tr>
<tr>
<td></td>
<td>Disclosure of Reporter Identity</td>
</tr>
<tr>
<td></td>
<td>Citation: Ann. Code § 62A-4a-412(3)(b)</td>
</tr>
<tr>
<td></td>
<td>The name and contact information of the reporter shall be deleted prior to any release of records to the subject of the report.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vermont</th>
<th>Professionals Required to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Citation: Ann. Stat. tit. 33, § 4913</td>
</tr>
<tr>
<td></td>
<td>The following professionals are required to report:</td>
</tr>
<tr>
<td></td>
<td>Physicians, surgeons, osteopaths, chiropractors, physician's assistants, hospital administrators, nurses, medical examiners, dentists, psychologists, or other health care providers</td>
</tr>
<tr>
<td></td>
<td>School superintendents, school teachers, school librarians, child care workers, school principals, school guidance counselors, mental health professionals, or social workers</td>
</tr>
<tr>
<td></td>
<td>Probation officers, police officers, camp owners, camp administrators or counselors</td>
</tr>
<tr>
<td></td>
<td>Members of the clergy</td>
</tr>
<tr>
<td></td>
<td>Reporting by Other Persons</td>
</tr>
<tr>
<td></td>
<td>Citation: Ann. Stat. tit. 33, § 4913</td>
</tr>
<tr>
<td></td>
<td>Any other person who has reasonable cause to believe that a child has been abused or neglected may report.</td>
</tr>
<tr>
<td></td>
<td>Standards for Making a Report</td>
</tr>
<tr>
<td></td>
<td>Citation: Ann. Stat. tit. 33, § 4913</td>
</tr>
<tr>
<td></td>
<td>A report is required when a reporter has reasonable cause to believe that a child has been abused or neglected.</td>
</tr>
<tr>
<td></td>
<td>Privileged Communications</td>
</tr>
<tr>
<td></td>
<td>Citation: Ann. Stat. tit. 33, § 4913</td>
</tr>
<tr>
<td></td>
<td>Except as provided below, a person may not refuse to make a report required by this section on the grounds that making the report would violate a privilege or disclose a confidential communication.</td>
</tr>
<tr>
<td></td>
<td>A member of the clergy is not required to report if the knowledge comes from a communication that is required to be kept confidential by religious doctrine.</td>
</tr>
<tr>
<td></td>
<td>Inclusion of Reporter’s Name in Report</td>
</tr>
<tr>
<td></td>
<td>Citation: Ann. Stat. tit. 33, § 4914</td>
</tr>
<tr>
<td></td>
<td>Reports shall contain the name and address or other contact information of the reporter.</td>
</tr>
<tr>
<td></td>
<td>Disclosure of Reporter Identity</td>
</tr>
<tr>
<td></td>
<td>Citation: Ann. Stat. tit. 33, § 4913</td>
</tr>
<tr>
<td></td>
<td>The name of and any identifying information about either the person making the report or any person mentioned in the report shall be confidential unless:</td>
</tr>
<tr>
<td></td>
<td>The person making the report specifically allows disclosure.</td>
</tr>
<tr>
<td></td>
<td>A court, after a hearing, finds probable cause to believe that the report was not made in good faith and orders the department to make the name of the reporter available.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Virginia</th>
<th>Professionals Required to Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Citation: Ann. Code § 63.2-1509</td>
</tr>
<tr>
<td></td>
<td>The following professionals are required to report:</td>
</tr>
<tr>
<td></td>
<td>Persons licensed to practice medicine or any of the healing arts</td>
</tr>
<tr>
<td></td>
<td>Hospital residents, interns, or nurses</td>
</tr>
<tr>
<td></td>
<td>Social workers or probation officers</td>
</tr>
<tr>
<td></td>
<td>Teachers or other persons employed in a public or private school, kindergarten, or nursery school</td>
</tr>
<tr>
<td></td>
<td>Persons providing full-time or part-time child care for pay on a regularly planned basis</td>
</tr>
<tr>
<td></td>
<td>Mental health professionals</td>
</tr>
<tr>
<td></td>
<td>Law enforcement officers or mediators</td>
</tr>
<tr>
<td></td>
<td>Any professional staff person, not previously enumerated, employed by a private or State-operated hospital, institution, or facility to which children have been committed or where children have been placed for care and treatment</td>
</tr>
<tr>
<td></td>
<td>Any person associated with or employed by any private organization responsible for the care, custody, or control of children</td>
</tr>
<tr>
<td></td>
<td>Court-appointed special advocates</td>
</tr>
<tr>
<td></td>
<td>Any person, over age 18, who has received training approved by the Department of Social Services for the purposes of recognizing and reporting child abuse</td>
</tr>
</tbody>
</table>
Any person employed by a local department who determines eligibility for public assistance

Reporting by Other Persons
Citation: Ann. Code § 63.2-1510
Any person who suspects that a child is abused or neglected may report.

Standards for Making a Report
Citation: Ann. Code § 63.2-1509
A report is required when, in his or her professional or official capacity, a reporter has reason to suspect that a child is abused or neglected. For purposes of this section, "reason to suspect that a child is abused or neglected" shall include:
A finding made by an attending physician within 7 days of a child's birth that the results of a blood or urine test conducted within 48 hours of the birth of the child indicate the presence of a controlled substance not prescribed for the mother by a physician.
A finding by an attending physician made within 48 hours of a child's birth that the child was born dependent on a controlled substance that was not prescribed by a physician for the mother and has demonstrated withdrawal symptoms.
A diagnosis by an attending physician made within 7 days of a child's birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to in utero exposure to a controlled substance that was not prescribed by a physician for the mother or the child.
A diagnosis by an attending physician made within 7 days of a child's birth that the child has fetal alcohol syndrome attributable to in utero exposure to alcohol.

Privileged Communications
Citation: Ann. Code §§ 63.2-1509; 63.2-1519
[The requirement to report] shall not apply to any regular minister, priest, rabbi, imam, or duly accredited practitioner of any religious organization or denomination usually referred to as a church as it relates to information required by the doctrine of the religious organization or denomination to be kept in a confidential manner.
The physician-patient or husband-wife privilege is not permitted.

Inclusion of Reporter's Name in Report
Not addressed in statutes reviewed.

Disclosure of Reporter Identity
Not addressed in statutes reviewed.

Washington

Professionals Required to Report
Citation: Rev. Code § 26.44.030
The following persons are required to report:
Practitioners, county coroners, or medical examiners
Law enforcement officers
Professional school personnel
Registered or licensed nurses, social service counselors, psychologists, or pharmacists
Employees of the Department of Early Learning
Licensed or certified child care providers or their employees
Employees of the department
Juvenile probation officers
Placement and liaison specialists, responsible living skills program staff, or HOPE center staff
State family and children's ombudsman or any volunteer in the ombudsman's office
Persons who supervise employees or volunteers who train, educate, coach, or counsel children or have regular unsupervised access to children
Department of Corrections Personnel
Any adult with whom a child resides

Reporting by Other Persons
Citation: Rev. Code § 26.44.030
Any person who has reasonable cause to believe that a child has suffered abuse or neglect may report.

Standards for Making a Report
Citation: Rev. Code § 26.44.030
A report is required when:
A reporter has reasonable cause to believe that a child has suffered abuse or neglect.
Any person, in his or her official supervisory capacity with a nonprofit or for-profit organization, has reasonable cause to believe that a child has suffered abuse or neglect caused by a person over whom he or she regularly exercises supervisory authority.
Department of Corrections personnel observe offenders or the children with whom the offenders are in contact, and as a result of these observations have reasonable cause to believe that a child has suffered abuse or neglect.
Any adult has reasonable cause to believe that a child who resides with them has suffered severe abuse.

Privileged Communications
Citation: Rev. Code §§ 26.44.030; 26.44.060
A person who supervises employees or volunteers who train, educate, coach, or counsel children or have regular unsupervised access children shall not be required to report when he or she obtains the information solely as a result of a privileged communication.
Information considered privileged by statute and not directly related to reports required by this section must not be divulged without a valid written waiver of the privilege.
Conduct conforming with reporting requirements shall not be deemed a violation of the confidential communication privilege of §§ 5.60.060 (3) and (4) [pertaining to clergy-penitent and physician-patient privilege], 18.53.200 [pertaining to optometrist-patient privilege], and 18.83.110 [pertaining to psychologist-client privilege].

Inclusion of Reporter's Name in Report
Citation: Rev. Code § 26.44.030
The department shall make reasonable efforts to learn the name, address, and telephone number of the reporter.

Disclosure of Reporter Identity
Citation: Rev. Code § 26.44.030
The department shall provide assurances of appropriate confidentiality of the identification of persons reporting under this section.
<table>
<thead>
<tr>
<th>State</th>
<th>Professionals Required to Report</th>
<th>Citation: Ann. Code § 49-6A-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Virginia</td>
<td>The following professionals are required to report: Medical, dental, or mental health professionals&lt;br&gt;Christian Science practitioners or religious healers&lt;br&gt;School teachers or other school personnel&lt;br&gt;Social service workers or child care or foster care workers&lt;br&gt;Emergency medical services personnel&lt;br&gt;Peace officer, law enforcement officials, or humane officers&lt;br&gt;Members of the clergy&lt;br&gt;Circuit court judges, family court judges, employees of the Division of Juvenile Services, or magistrates</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Reporting by Other Persons</strong></td>
<td>Citation: Ann. Code § 49-6A-2</td>
</tr>
<tr>
<td></td>
<td>Any person who has reasonable cause to suspect that a child is abused or neglected may report.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Standards for Making a Report</strong></td>
<td>Citation: Ann. Code § 49-6A-2</td>
</tr>
<tr>
<td></td>
<td>A reporter has reasonable cause to suspect that a child is abused or neglected. A reporter observes a child being subjected to conditions that are likely to result in abuse or neglect. A reporter believes that a child has suffered serious physical abuse, sexual abuse, or sexual assault.</td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>The following professionals are required to report: Physicians, coroners, medical examiners, nurses, dentists, chiropractors, optometrists, acupuncturists, other medical or mental health professionals, physical therapists, physical therapist assistants, dietitians, occupational therapists, speech-language pathologists, audiologists, or emergency medical technicians&lt;br&gt;School teachers, administrators or counselors, child care workers in daycare centers, group homes, or residential care centers, or daycare providers&lt;br&gt;Alcohol or other drug abuse counselors, marriage and family therapists, professional counselors, or members of the treatment staff employed by or working under contract with a county department or a residential care center for children and youth&lt;br&gt;Social workers, public assistance workers, first responders, police or law enforcement officers, mediators, or court appointed special advocates Members of the clergy or a religious order, including brothers, ministers, monks, nuns, priests, rabbis, or sisters</td>
<td>Citation: Ann. Stat. § 48.981</td>
</tr>
<tr>
<td></td>
<td><strong>Reporting by Other Persons</strong></td>
<td>Citation: Ann. Stat. § 48.981</td>
</tr>
<tr>
<td></td>
<td>Any person, including an attorney, who has reason to suspect that a child has been abused or neglected or who has reason to believe that a child has been threatened with abuse or neglect and that abuse or neglect of the child will occur may report.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Standards for Making a Report</strong></td>
<td>Citation: Ann. Stat. § 48.981</td>
</tr>
<tr>
<td></td>
<td>A reporter, in the course of his or her professional duties, has reasonable cause to suspect that a child has been abused or neglected. A reporter, in the course of his or her professional duties, has reason to believe that a child has been threatened with abuse or neglect or that abuse or neglect will occur.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Privileged Communications</strong></td>
<td>Citation: Ann. Stat. § 48.981</td>
</tr>
<tr>
<td></td>
<td>A member of the clergy is not required to report child abuse information that he or she receives solely through confidential communications made to him or her privately or in a confessional setting if he or she is authorized to hear or is accustomed to hearing such communications and, under the disciplines, tenets, or traditions of his or her religion, has a duty or is expected to keep those communications secret. Those disciplines, tenets, or traditions need not be in writing.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Inclusion of Reporter’s Name in Report</strong></td>
<td>Citation: Ann. Stat. § 48.981</td>
</tr>
<tr>
<td></td>
<td>Not addressed in statutes reviewed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Disclosure of Reporter Identity</strong></td>
<td>Citation: Ann. Stat. § 48.981</td>
</tr>
<tr>
<td></td>
<td>The identity of the reporter shall not be disclosed to the subject of the report.</td>
<td></td>
</tr>
<tr>
<td>Wyoming</td>
<td><strong>Professionals Required to Report</strong></td>
<td>Citation: Ann. Stat. § 14-3-205</td>
</tr>
<tr>
<td></td>
<td>Not addressed in statutes reviewed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Reporting by Other Persons</strong></td>
<td>Citation: Ann. Stat. § 14-3-205</td>
</tr>
<tr>
<td></td>
<td>All persons must report.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Standards for Making a Report</strong></td>
<td>Citation: Ann. Stat. § 14-3-205</td>
</tr>
<tr>
<td></td>
<td>A person knows or has reasonable cause to believe or suspect that a child has been abused or neglected. A person observes any child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Privileged Communications</strong></td>
<td>Citation: Ann. Stat. § 14-3-210</td>
</tr>
</tbody>
</table>
Only the clergy-penitent and attorney-client privileges are permitted.

**Inclusion of Reporter’s Name in Report**

Citation: Ann. Stat. § 14-3-206

The report must include any available photographs, videos, and x-rays with the identification of the person who created the evidence and the date the evidence was created.

**Disclosure of Reporter Identity**

Not addressed in statutes reviewed.
Appendix 2

Survey

Clinician Mandatory Reporting and Maintenance of the Therapeutic Alliance

This survey is intended for social workers who are in direct clinical practice and have a counselling arrangement with their clients or those social workers who have been in direct clinical practice within the past five years. This includes social workers who are in full-time or part-time clinical practice or who have a combination of administrative and direct practice responsibilities. The survey will take 20 minutes of your time and will be comprised of three sections: clinical vignettes, three open-ended questions, and demographic information. If you are unsure about a specific question after having completed it, you may move back to a previous page and revise your responses at any time. When all answers are completed, simply click the “save” key. Please contact me at (416) 524-3010 if you need assistance. Thank you for your participation.

Click here to begin the survey

Section A Your Perspectives on Selected Clinical Vignettes

Please read the following vignette and answer the corresponding statements and questions. For your convenience, the vignette is reproduced for you before each question and statement and is THE SAME VIGNETTE for the first set of questions and statements.

When you have completed the first vignette and corresponding questions and statements you will be prompted when it is time to read a second vignette and answer the same questions and statements. There are three vignettes in total.

Vignette 1 (for Group 1)

You are a social worker at a community mental health centre. You have been seeing a mother and 13-year-old daughter regularly for the past 2 months for the daughter’s noncompliant behaviour. They are recent immigrants from Bosnia. While meeting individually with the daughter she tells you that last week, she entered her parents’ bedroom and saw her father punch her mother in the stomach. The daughter becomes very upset when relating this incident and begins to cry. You invite the mother into the session and the daughter recants her story while the mother vehemently denies the incident. The mother accuses you of fabricating the story to try to break up their family and the two leave the session abruptly.
Vignette 1 (for Group 2)

You are a social worker at a community mental health centre. You have been seeing a mother and 13-year-old daughter regularly for the past 2 months for the daughter’s noncompliant behaviour. They are recent immigrants from Bosnia. While meeting individually with the daughter she tells you that last week, she entered her parents’ bedroom and saw her father punch her mother in the stomach. The daughter becomes very upset when relating this incident and begins to cry. You invite the mother into the session and she confirms the incident; however, she states that this is a family matter, can be handled within the family and leaves the session with the daughter.

A1. I would report this situation to the Children’s Aid Society.

   Strongly Agree
   Agree
   Uncertain
   Disagree
   Strongly Disagree
   No response

A2. I have an ethical obligation under the College of Social Workers and Social Service Workers to report this situation.

   Strongly Agree
   Agree
   Uncertain
   Disagree
   Strongly Disagree
   No response

A3. I have a legal obligation under the Ontario provincial mandatory reporting laws to report this situation.

   Strongly Agree
   Agree
   Uncertain
   Disagree
   Strongly Disagree
A4. In arriving at my decision to report or not report this case, I am comfortable discussing my concerns with these parents / caregivers.

Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response

A5. I would seek the advice of a colleague in deciding whether or not to report this situation.

Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response

A6. I would seek the advice of a supervisor / manager whether or not to report this situation.

Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response

A7. The cultural background of the parents would influence me in my clinical decision to report or not report this case.

Strongly Agree
Agree
Uncertain
Disagree
A8. The circumstances around disclosure (who discloses maltreatment or recantation) are important to me in my clinical decision to report or not report this case.

Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response

A9. My previous experience in calling the Children’s Aid Society influences my decision of the current case.

Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
Not Applicable
No response

A10. I am concerned that the therapeutic alliance with the family would be affected if I chose to report the situation to the Children’s Aid Society.

Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response

A11. Should I decide to file a report with the Children’s Aid Society regarding this case, I would take the following steps to maintain the therapeutic alliance with the family. Select all that apply.
None
Offer additional session(s)
Speak to client(s) via telephone
Meet client(s) in their home
Other, please specify ____________

A12. I would say or do the following things to maintain the therapeutic alliance with the family after I file a report with the Children’s Aid Society. Select all that apply.

None
Validate client(s) emotions
Explain your reasons for reporting numerous times
Help clients prepare for the Children’s Aid Society visit
Explain the reasons behind mandated reporting
Apologize for the impact of reporting
Other, please specify ____________

Please read this SECOND VIGNETTE and answer the corresponding statements and questions. For your convenience, the vignette is reproduced for you before each question and statement and is THE SAME VIGNETTE for the following questions and statements. You will be prompted when it is time to read a third vignette.

Vignette 2 (for Group 1)

You are a social worker in a family counselling centre where you have been seeing a mother and her 3-year-old son regularly for the past 4 months. The father has not attended counselling. The family emigrated from Southeast Asia 4 months ago. You find the mother to have a short temper and she has become angry with you in past sessions if she perceives you as not agreeing with her opinion. While in the interview, the mother reports that her son knocked over a lamp breaking it. The father reportedly hit the son on the buttocks with his hand. You are uncertain if a mark has been left on the child and are uncertain of the child’s well-being given the mother’s temper. With the verbal permission of the mother, you speak to the father on the phone. He acknowledges hitting his son with his hand and indicates his willingness to attend counselling to discuss the incident further. The mother, however, thinks you are overreacting and leaves the session with her son.
Vignette 2 (for Group 2)

You are a social worker in a family counselling centre where you have been seeing a mother and her 3-year-old son regularly for the past 4 months. The father has not attended counselling. The family are 3rd generation Caucasian Canadian. You find the mother to have a short temper and she has become angry with you in past sessions if she perceives you as not agreeing with her opinion. While in the interview, the mother reports that her son knocked over a lamp breaking it. The father reportedly hit the son on the buttocks with his hand. You are uncertain if a mark has been left on the child and are uncertain of the child’s well-being given the mother’s temper. With the verbal permission of the mother, you speak to the father on the phone. He acknowledges hitting his son with his hand and indicates his willingness to attend counselling to discuss the incident further. The mother, however, thinks you are overreacting and leaves the session with her son.

A1. I would report this situation to the Children’s Aid Society.
   Strongly Agree
   Agree
   Uncertain
   Disagree
   Strongly Disagree
   No response

A2. I have an ethical obligation under the College of Social Workers and Social Service Workers to report this situation.
   Strongly Agree
   Agree
   Uncertain
   Disagree
   Strongly Disagree
   No response

A3. I have a legal obligation under the Ontario provincial mandatory reporting laws to report this situation.
   Strongly Agree
   Agree
   Uncertain
A4. In arriving at my decision to report or not report this case, I am comfortable discussing my concerns with these parents/caregivers.

Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response

A5. I would seek the advice of a colleague in deciding whether or not to report this situation.

Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response

A6. I would seek the advice of a supervisor/manager whether or not to report this situation.

Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response

A7. The cultural background of the parents would influence me in my clinical decision to report or not report this case.

Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response

A8. The circumstances around disclosure (who discloses maltreatment or recantation) are important to me in my clinical decision to report or not report this case.

Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response

A9. My overall previous experience in calling the Children’s Aid Society influences my decision of the current case.

Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response

A10. I am concerned that the therapeutic alliance with the family would be affected if I chose to report the situation to the Children’s Aid Society.

Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response
A11. Should I decide to file a report with the Children’s Aid Society regarding this case, I would take the following steps to maintain the therapeutic alliance with the family. Select all that apply.

None
Offer additional session(s)
Speak to client(s) via telephone
Meet client(s) in their home
Other, please specify __________

A12. I would say or do the following things to maintain the therapeutic alliance with the family after I file a report with the Children’s Aid Society. Select all that apply.

None
Validate client(s) emotions
Explain your reasons for reporting numerous times
Help clients prepare for the Children’s Aid Society visit
Explain the reasons behind mandated reporting
Apologize for the impact of reporting
Other, please specify __________

Please read this THIRD VIGNETTE and answer the corresponding statements and questions. For your convenience, the vignette is reproduced for you before each question and statement and is THE SAME VIGNETTE for this set of questions and statements.

Vignette 3 (for Group 1)
You are a social worker in a hospital paediatric unit. Your client is a seven-year-old Caucasian girl hospitalized for the past 7 weeks due to heart problems. One day you hear the girl whining and crying in her hospital room. You notice her parents shut the door to her room, scream at her for 10 minutes and call her “good for nothing.” When the parents leave her room you ask why they screamed at her. The parents explain that this stops their daughter’s whining and is effective with their two younger children.

Vignette 3 (for Group 2)
You are a social worker in a hospital paediatric unit. Your client is a seven-year-old Caucasian girl hospitalized for the past 7 weeks due to heart problems. One day you hear the girl whining and crying in her hospital room. You notice her parents shut the door to her room, scream at her for 10 minutes and call her “good for nothing.” When the parents
leave the unit you ask the daughter why her parents screamed at her. The daughter explains that it stops her whining and is effective with her two younger siblings.

A1. I would report this situation to the Children’s Aid Society.
   Strongly Agree
   Agree
   Uncertain
   Disagree
   Strongly Disagree
   No response

A2. I have an ethical obligation under the College of Social Workers and Social Service Workers to report this situation.
   Strongly Agree
   Agree
   Uncertain
   Disagree
   Strongly Disagree
   No response

A3. I have a legal obligation under the Ontario provincial mandatory reporting laws to report this situation.
   Strongly Agree
   Agree
   Uncertain
   Disagree
   Strongly Disagree
   No response

A4. In arriving at my decision to report or not report this case, I am comfortable discussing my concerns with these parents / caregivers.
   Strongly Agree
   Agree
   Uncertain
A5. I would seek the advice of a colleague in deciding whether or not to report this situation.
   Strongly Agree
   Agree
   Uncertain
   Disagree
   Strongly Disagree
   No response

A6. I would seek the advice of a supervisor / manager whether or not to report this situation.
   Strongly Agree
   Agree
   Uncertain
   Disagree
   Strongly Disagree
   No response

A7. The cultural background of the parents would influence me in my clinical decision to report or not report this case.
   Strongly Agree
   Agree
   Uncertain
   Disagree
   Strongly Disagree
   No response

A8. The circumstances around disclosure (who discloses maltreatment or recantation) are important to me in my clinical decision to report or not report this case.
   Strongly Agree
   Agree
Uncertain
Disagree
Strongly Disagree
No response

A9. My overall previous experience in calling the Children’s Aid Society influences my decision of the current case.
Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response

A10. I am concerned that the therapeutic alliance with the family would be affected if I chose to report the situation to the Children’s Aid Society.
Strongly Agree
Agree
Uncertain
Disagree
Strongly Disagree
No response

A11. Should I decide to file a report with the Children’s Aid Society regarding this case, I would take the following steps to maintain the therapeutic alliance with the family. Select all that apply.
None
Offer additional session(s)
Speak to client(s) via telephone
Meet client(s) in their home
Other, please specify ___________

A12. I would say or do the following things to maintain the therapeutic alliance with the family after I file a report with the Children’s Aid Society. Select all that apply.
None
Validate client(s) emotions
Explain your reasons for reporting numerous times
Help clients prepare for the Children’s Aid Society visit
Explain the reasons behind mandated reporting
Apologize for the impact of reporting
Other, please specify _____________

Section B Your Written Thoughts

Please read and answer the following questions. If any of your written responses are used as sample quotations, all identifying information will be removed. Please indicate at the end of your comments if you do not want your written response used as a sample quotation. Please do not refer to specific case examples.

B1. When faced with a suspicion of child maltreatment, what factors do you include in your decision-making process? Please rank the top three factors.

   Duty to Report
   Fine for Not Reporting
   Ethical obligation to the OASW
   Comfort speaking to parents / caregivers about your concerns
   Type of maltreatment
   The effectiveness of your local Children’s Aid Society
   The opinion of your supervisor / manager
   The opinion of your colleague(s)
   Who in the family discloses the abuse
   Other, please specify _____________

B2. What is the initial impact of reporting suspected child maltreatment on the relationship between you and the family?

B3. What are the strategies you have found to be effective in maintaining the therapeutic alliance with a family after reporting suspected child maltreatment and why do you think they are effective?

Section C Your Background Information

This last section asks some questions about your background that will assist me to better understand your responses.

C1. What was your age on your last birthday?
   20-24
C2. What is your gender?
   Female
   Male
   Transgender

C3. What is your ethnicity? Please select all that apply:
   Caucasian
   Black
   Asian
   Southeast Asian
   First Nations
   Hispanic
   Other, please specify __________

C4. Do you have children (biological / adopted / step-children) of your own?
   YES
   NO

C5. Select your completed degree(s). Select all that apply.
   BSW
   MSW
   PhD

C6. Where did you complete your degree?
   Canada
   United States
   Other, please specify __________

C7. How many years have you practiced as a social worker?

C8. How many years have you practiced as a social worker with children or adolescents and their parents / caregivers?

C9. Select your current social work area of practice.
   hospital social work
elementary / secondary school social work
university / college social work
private practice / Employee Assistance
children’s mental health
community mental health
case management
child welfare / child protection
management / government
family health team
retired
other, please specify ____________

C10. Select your former social work area of practice, if applicable.

hospital social work
elementary / secondary school social work
university / college social work
private practice / Employee Assistance
children’s mental health
community mental health
case management
child welfare / child protection
management / government
family health team
other, please specify ____________
not applicable

C11. If you have received training in child maltreatment, where did you complete this training? Select all that apply.

None
Workshop / Seminar
Workplace In-service
On the Job Training
College Course
University Course
Other, please specify ____________

The following questions ask you about contacting the Children’s Aid Society in instances of mandatory reporting of child maltreatment.

C12. Over the past 12 months, how many times have you contacted the Children’s Aid Society to report suspected child maltreatment?
C13. Over the past 12 months, how many times have you contacted the Children’s Aid Society to consult with them if a case of suspected child maltreatment should be reported?

C14. Have you ever decided to not contact the Children’s Aid Society even though you had a suspicion of child maltreatment? If yes, what were the reasons? Please select from the following options. This question is optional and you are under no obligation to respond. If you choose not to respond to this question, please continue to the next question.

- Not Applicable
- Insufficient evidence
- Believed you could work with the family
- Family demonstrated a willingness to be in treatment
- Concerned about the family terminating treatment

C15. What has been your overall experience in reporting or consulting to the Children’s Aid Society?

- Very positive
- Positive
- Neutral
- Negative
- Very Negative
- I have neither reported nor consulted with the Children’s Aid Society

Section D Final Questions

D1. If you have comments about the content or structure of the survey, please write them here. Please indicate at the end of your comments if you do not want your written response used as a sample quotation.

D2. Thank you for your participation. Because you completed the survey, you can enter a draw for a $150.00 Chapters Indigo gift card. The odds of winning this draw should all respondents complete the survey are 1 out of 2850.

If you would like to enter, please type your first name, email address, and / or daytime telephone number.

Before your survey data are reviewed your name and contact information will be transferred to a secure file and deleted from your survey. This will ensure that your survey responses are anonymous as well as confidential. The draw will be made and the winner notified in December 2010; after which all submitted names and contact information will be destroyed.
Thank you for your time and willingness to respond to the survey. Your participation will help our understanding of child maltreatment in Ontario. If you have any questions, please do not hesitate to contact Lea Tufford at (416) 524-3010 or lea.tufford@utoronto.ca
Appendix 3

Pilot Testing Feedback Form

Name:

**Email Invitation**

Was the email invitation clear and understandable?

Was there anything you believe should have been added?

When you clicked on the URL, did it take you to the page asking for your email address? If not, what happened?

**Information Letter / Consent Form**

Were the information letter / consent form clear and understandable?

Was there anything you believe should have been added?

When you clicked on the “Save and Continue” button did it take you to the survey? If not, what happened?

**Vignettes (Section A)**

Are the vignettes clear and understandable? If not, please write down those portions that are not clear.

Are the statements following the vignettes clear and understandable? If not, please write down those items that are not clear.

Are the response choices clear and understandable? If not, please write down those responses which are not clear, and if possible, what you would prefer.

Were the instructions clearly written and sufficient?

**Open-Ended Questions (Section B)**

Were the questions clear and understandable? If not, please write down those questions which were not clear, and if possible, what you would prefer.

Were the instructions clearly written and sufficient?
**Demographic Questions (Section C)**

Were the demographic questions easy to complete?

Was any information missing which you feel should have been included?

Did any questions feel too intrusive?

**Other Information (Section D)**

Anything you would like to say about this section?

**Email Reminder**

Was the email reminder clear and understandable?

Was there anything you believe should have been added?

**Technical Issues**

How many questions appeared on your screen at one time?

Was the font size easy to read?

Was there any problem moving onto the next question or section of the survey?

Did you have enough room to type your responses to the open-ended questions?

**Length**

How long did the survey take overall?

Was the overall length or any sections too long or too short?

Did you feel like abandoning the survey at any point? If so, where in the survey?

Did you complete it in one sitting or two? Which do you think was easier?

Any other comments?

**Thank you for your help!!**
Appendix 4

Information Letter

Clinician Mandatory Reporting and Maintenance of the Therapeutic Alliance

Date

Dear __________________,

I am a doctoral candidate at the Factor-Inwentash Faculty of Social Work at the University of Toronto and under the supervision of Professor Marion Bogo. You are being asked to participate in a survey to examine social workers’ decision-making factors regarding the reporting of child maltreatment and how they subsequently maintain the therapeutic alliance following a report to the Children’s Aid Society.

Everyday in Ontario social workers make crucial decisions regarding a child’s safety. This applies to social workers in many settings: hospitals, children’s mental health, school boards, employee assistance, and private practice. As a valued member of the Ontario Association of Social Workers (OASW) I need your input to help understand this important clinical issue. If we do not understand the factors which affect social workers’ decisions, children facing safety issues may not receive the help they need and deserve.

As part of this study, it is hoped that the survey will achieve the following objectives:

• To identify the relevant factors social workers take into account when rendering decisions concerning potential child maltreatment.
• To identify the steps social workers take to maintain the therapeutic alliance following a report to the Children’s Aid Society.

Your participation in this study is completely voluntary and will not affect your status with the OASW. This survey will be sent to the 2850 professional members of the OASW. You may withdraw from the study at any time by exiting Survey Wizard. Should you choose to exit the survey any responses you have given will be destroyed. Once data analysis of completed surveys has taken place, it will not be possible to withdraw from the survey. Your participation is very important for professional knowledge regarding child maltreatment.

Confidentiality

The survey takes about 20 minutes and is completely voluntary and confidential. In creating this survey, every attempt has been made to be respectful of your time. Your name will
not be linked to your responses in any way. This study has been approved by the Health Sciences ethics board at the University of Toronto and has been given approval by the OASW. Any information that you provide to the researcher in this study is confidential and will only be seen by the researcher and her doctoral dissertation committee. Surveys will be password protected and maintained online in a secure server at the Factor-Inwentash Faculty of Social Work, University of Toronto, and encrypted on my laptop computer. They will be destroyed seven years after the conclusion of the dissertation in 2017. Only the results of the analysis of the aggregated data will be disseminated.

The Ontario Institute for Studies in Education (OISE) at the University of Toronto created the application entitled Survey Wizard for faculty and doctoral students’ use in research. The application itself and the data it collects are hosted entirely at OISE. The data are stored in an industry-standard database system with the following safeguards against unauthorized access: the database is password-protected, all data transmissions between the application and the database layers are transmitted over a dedicated, isolated network, and the servers and storage systems are located in a physically secured, climate controlled room, where only senior technical and facilities management staff are allowed access. OISE does not own the survey entitled *Clinician Mandatory Reporting and Maintenance of the Therapeutic Alliance* or the data collected from respondents. The data are owned by Lea Tufford who is the licensee of a Survey Wizard account. OISE will not access the survey or the data for any purpose.

Benefits and Risks

Although there are no direct benefits from this study, your information will contribute to the current understanding and knowledge on decision-making as well as the therapeutic alliance, which will enable social workers to respond more effectively to clients in suspected child maltreatment.

You may find reading the child maltreatment vignettes upsetting. Should the vignettes stimulate upsetting thoughts or feelings on these clinical issues you may contact me at the phone number or email address listed below and I will assist you to secure mental health counselling in your immediate or nearby community. Alternatively, you may also choose to speak to your supervisor, colleague or supervision group to discuss your reaction should you feel comfortable with this option and have access to these resources. In addition, you may also access your confidential Employee Assistance Program through your workplace benefits should this option be available to you. This service provides counselling at no cost to employees. You may also choose to contact a local community mental health centre found in your telephone directory.

Compensation

For those respondents who complete the survey, they will be given the option of entering a draw for a $150.00 gift card to Chapters-Indigo. The draw will be made and the winner notified in December 2010.
Publication of Results

The results will be presented at conference presentations, published on the OASW website, presented in the OASW magazine, and presented at the OASW annual meeting. If you have any questions or concerns about the research, would like an update on its status or would like a copy of the results, please contact Lea Tufford at the contact information below. Your confidentiality will be maintained.

You may contact the Office of Research Ethics (ethics.review@utoronto.ca; 416-946-3273) if you have questions about your rights as a research respondent.

You may print off a copy of the information letter and consent form to keep in your own records.

Thank you for your interest in this important topic and this study.

Lea Tufford  Marion Bogo
PhD Candidate  Professor
Factor-Inwentash Faculty of Social Work  Factor-Inwentash Faculty of Social Work
University of Toronto  University of Toronto
246 Bloor Street West  246 Bloor Street West
Toronto, ON M5S 1A1  Toronto ON, M5S 1A1
(416) 524-3010  (416) 978-3263
lea.tufford@utoronto.ca  marion.bogo@utoronto.ca
Appendix 5

E-mail Invitation

From: Lea Tufford

To: Respondents

Subject: Clinician Mandatory Reporting and Maintenance of the Therapeutic Alliance

Dear OASW member,

I am a doctoral candidate at the Factor-Inwentash Faculty of Social Work at the University of Toronto and am asking members of the Ontario Association of Social Workers to participate in a survey about decision-making related to the reporting of suspected child maltreatment to the Children’s Aid Society. The purpose of this study is to examine the factors by which social workers make decisions regarding the reporting of child maltreatment and how they subsequently maintain the therapeutic alliance upon reporting.

Everyday in Ontario social workers make crucial decisions regarding a child’s safety. This applies to social workers in many settings: hospitals, children’s mental health, school boards, employee assistance, and private practice. As a valued member of the OASW I need your input to help understand this important clinical issue. If we do not understand the factors which affect social workers’ decisions, children facing safety issues may not receive the help they need and deserve.

You can help this most important research by completing the survey and giving me your opinions. This survey is intended for social workers who are in direct clinical practice and have a counselling arrangement with their clients or those social workers who have been in direct clinical practice within the past five years. This includes social workers who are in full-time or part-time clinical practice or who have a combination of administrative and direct practice responsibilities. I will make sure the results reach the members of the OASW by posting the results on the OASW website, conducting workshops at the annual meeting and by discussing the results in the OASW magazine.

The survey takes about 20 minutes and is completely voluntary and confidential. In creating this survey, every attempt has been made to be respectful of your time. If you have any questions or concerns about the research or would like an update on its status, please do not
hesitate to contact me. Please add this email address to your approved list of contacts to avoid junk mail.

This survey is completely anonymous but will ask you for your email address. Providing your email address will allow you to complete the survey in two sittings or enable you to return to the survey in the event of a failure of your Internet connection. An email will be sent to your account with a link to return to the survey. Please do not delete this link until your survey is complete and has been submitted. Your email address will in no way identify whether you choose to complete or not complete the survey.

To start the survey, please click on the following link or enter the URL on your browser:


Once at the website, there is an information letter for you to read about the study, a consent form, and instructions for the survey.

In order to complete this study on time, I would appreciate it if you would go to the website and complete the survey within one to two weeks time. If you would prefer to receive this survey via mail please let me know and I will send you the survey through the mail or in a word document via email.

If you have any questions or need help, please e-mail Lea Tufford at lea.tufford@utoronto.ca or contact me at (416) 524-3010.

Thank you,

Lea Tufford, PhD Candidate
Factor-Inwentash Faculty of Social Work
University of Toronto
246 Bloor Street West
Toronto, ON M5S 1A1
Appendix 6

Email Reminder to Participate in Web-Survey

Clinician Mandatory Reporting and Maintenance of the Therapeutic Alliance

Please respond and help shape the future of mandatory reporting of child maltreatment in Ontario.

Thank you if you have already completed the web-survey on mandatory reporting. Your participation is appreciated and valued.

If you have not yet participated, there is still time to complete a web-survey on mandatory reporting that will take about 20 minutes. You will be responding to 3 vignettes and statements about mandatory reporting. In appreciation for your participation, at the end of the survey you will have the option of entering your name in a draw for a $150.00 Indigo gift card from Chapters Indigo. The draw will be made and the winner notified in December 2010. To access the web-survey click on:


Once you have completed and submitted this web-survey, please disregard any other invitations for this web-survey that you might receive.

This research is part of Lea Tufford’s Doctoral studies in Social Work at the University of Toronto. If you have any questions at any time about the study or the procedures, you may contact me at lea.tufford@utoronto.ca or (416) 524-3010.

Thank you in advance,

Lea Tufford, PhD Candidate
Factor-Inwentash Faculty of Social Work
University of Toronto
246 Bloor Street West
Toronto, ON M5S 1A1
Clinician Mandatory Reporting and Maintenance of the Therapeutic Alliance

Please respond and help shape the future of mandatory reporting of child maltreatment in Ontario.

Thank you if you have already completed the web-survey on mandatory reporting. Your participation is appreciated and valued.

If you have not yet participated, there is still time to complete a web-survey on mandatory reporting that will take about 20 minutes. You will be responding to vignettes and statements about mandatory reporting. In appreciation for your participation, at the end of the survey you will have the option of entering your name in a draw for a $150.00 Indigo gift card from Chapters Indigo. The draw will be made and the winner notified in December 2010. To access the web-survey click on:


Once you have completed and submitted this web-survey, please disregard any other invitations for this web-survey that you might receive.

This research is part of Lea Tufford’s Doctoral studies in Social Work at the University of Toronto. If you have any questions at any time about the study or the procedures, you may contact me at lea.tufford@utoronto.ca or (416) 524-3010.

Thank you in advance,

Lea Tufford, PhD Candidate
Factor-Inwentash Faculty of Social Work
University of Toronto
246 Bloor Street West
Toronto, ON M5S 1A1