

Child Abuse and Neglect Reporting Procedures

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Mandated Reporting: An Introduction to the Law and its Implementation

In 1974 Congress enacted P.L. 93-247, the Child Abuse Prevention and Treatment Act (C.A.P.T.A.). C.A.P.T.A. is a federal initiative to fund child abuse prevention and treatment programs, with a focus on community-based interventions. The law requires that states implement mandatory reporting laws in order to qualify for these federal funds. In response, all 50 states and the District of Columbia have implemented mandatory reporting laws. The National Center on Child Abuse and Neglect (2002, April) reported that in the year 2000 three million referrals concerning the welfare of approximately five million children were made to CPS agencies throughout the United States. While this number is significant, several studies have established that mandated reporters do not report all suspected cases of child maltreatment to CPS (Abrahams, Casey, & Daro, 1992; Brosig & Kalishman, 1992; Crenshaw, Crenshaw, & Lichtenberg, 1995, King, Reece, Bendel, & Patel, 1998; Zellman, 1990). Much of this underreporting can be attributed to the confusion that exists among mandatory reporters regarding what constitutes a reportable incident (Foreman & Bernett, 2000).

Definitions of child abuse vary by state with most addressing "harm or intended harm" to a child. Some states, however, define child abuse somewhat more narrowly, calling for "serious harm or serious threat of harm." Additionally, states generally have separate definitions for physical abuse, sexual abuse, sexual exploitation, and emotional abuse. Some states also include abandonment in their definition of child neglect. Most state statutes include exemptions for certain cases such as parental refusal of medical treatment for a child due to religious reasons and child rearing practices such as corporal punishment and other cultural practices (National Clearing House of Child Abuse and Neglect Information, 2002). A table has been developed by the National Clearing House on Child Abuse and Neglect Information to provide a brief summary of state definitions regarding child abuse and neglect which is available on-line at:
<http://www.calib.com/nccanch/pubs/sag/define.cfm>

Some common concerns addressed

Mandatory reporting statutes have led to an increase in child abuse reporting since their implementation in the 1970s (King, Reese, Bendel, & Patel, 1998). However, research indicates that underreporting of child abuse and neglect is prevalent. One study (Sedlak, 1989) estimated that between forty and fifty percent of physical abuse cases go unreported by mandated reporters. There are several reasons why a clinician may feel uncomfortable making a child abuse report. The following section will address some of the more common concerns.

Damage to the Therapeutic Relationship

In addition to the confusion that exists regarding the circumstances under which a report must be made, many professionals also have concerns regarding the effect that a report can have on the therapeutic relationship (Badger, 1989; King et al., 1998; Watson & Levine, 1989). Much of the literature examining this concern has focused on the perceived break in the therapeutic relationship that occurs when a clinician reports something disclosed by a client (Agatsum, 1989; Kalichman, 1999; Uchill, 1978; Zellman, 1990). However, studies by Harper and Irvin (1985), Steinberg, Levine and Doueck (1997), Watson and Levine (1989), and Weinstein, Levine, Kogan, Harkavy-Friedman and Miller (2000) all found that in 75% of abuse reporting cases there was either no change or improvement in the therapeutic relationship following the report as measured by indices related to patient cooperation and self-disclosure. About 25% of the cases ended in terminations.

A recent study examined the factors that contributed to the three levels of therapeutic outcomes (positive change, no-change, negative change) reported by 176 mental health professionals in New York State known to have made a report (Weinstein, Levine, Kogan, Harkavy & Miller, 2001). The authors examined five categories of variables: relationship factors, preservative/restorative efforts, therapist attitude and experience, client characteristics, and situational factors. Of those variables, the following three were found to most directly affect the three outcomes: quality of the therapeutic relationship, length of the time the client had been in treatment prior to the report, and the clinician's comfort level with making the report. Regarding the quality of the therapeutic relationship, clinicians who experienced a positive change or no-change in the therapeutic relationship reported higher scores on the Working Alliance Inventory – C than did clinicians who experienced a negative change. The length of time a client had been in treatment was also found to be significant, with positive change and no-change outcomes associated with clients having been in treatment for a longer period of time before the report than those clients who experienced a negative change outcome. It is important to note that the most significant variable, the quality of the therapeutic relationship, is potentially modifiable by the clinician.

Weinstein et al. (2001) associated positive outcomes in making child abuse reports with:

- informing the client before the report is made
- informing the client oneself instead of having a supervisor do so
- explaining the reason for making the report in terms of one's own clinical assessment rather than attributing it to external impositions

Breaches of Confidentiality

In the APA's *Ethical Principles of Psychologists and Code of Conduct 2002* (effective June, 2003), section 4.01 states that, " Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by

law or established by institutional rules or professional or scientific relationship." Further, section 4.05b explains that, "Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose." In fact, most professional associations and governing bodies for the various mental health professions maintain confidentiality as a recognized standard of professional conduct when not conflicting with the law.

It is important to note here that confidentiality is not a legal concept, but rather an ethical mandate. Legal protection is provided by privileged communication statutes under specified conditions. All states have privileged communication statutes, however they vary widely in terms of the information that is protected and the professions eligible for such protected status. All state and federal laws regarding privileged communication recognize mandated reporting of suspected child abuse as an exception. However, in *People v. Stritzinger* (34 Cal. 3d 505, 1983), the California Supreme Court ruled that while mental health professionals are required to waive confidentiality when child abuse is suspected, once the initial report has been made, all subsequent requests for information by police and child protection workers may remain protected under privileged communications statutes (see Caudill & Pope, 1995). It should be stressed once again that privileged communication statutes vary widely and individual clinicians should make every effort to become informed about the laws governing their particular profession in their particular state.

In order to address confidentiality, clinicians should discuss the specific parameters of confidentiality with their clients at the beginning of treatment. Weinstein et al. (2001) state that discussions with clients regarding confidentiality should include developmentally appropriate examples of behaviors that would require a report. Examples include:

- "Someone touches you where they shouldn't."
- "Someone hurts you."
- "If somebody who takes care of you hurts you."
- "If you tell me that someone is going to hurt you or that you are going to hurt someone else."

**Note: at the end of this document there is a list of children's books that deal with sexual abuse. Clinicians may find it helpful to refer to these books in order to find age appropriate terminology to use with younger children.*

Desire to be Certain about Allegations

Kalichman and colleagues (1989) report that many mental health professionals feel compelled to gain a degree of certainty regarding suspected abuse before making a report. While it is normal to want to be fairly certain about a charge as serious as child abuse before involving outside agencies in the life of a family, most clinicians have not been

trained in the investigative skills required to validate a claim of child abuse. Furthermore, research indicates that children's ability to recall past events can be manipulated by subtle, often inadvertent suggestions (Ceci & Bruck, 1995; Ceci, Loftus, Leichtman & Bruck, 1994). Therefore, while it is appropriate for clinicians to follow up suspicions of abuse or maltreatment for the purposes of evaluation or treatment, clinicians need to be careful not to take on the role of investigator (Kalichman, 1999).

Be Prepared. Most Clinicians Will Have a Report to Make Eventually.

First and foremost, clinicians should know the laws that govern their area. If acting as a staff member in an institution such as a school, some states require that the building administrator be informed of any CPS reports (National Clearing House on Child Neglect and Abuse Information, 2002). In addition, it is important to be aware of any previously established building procedure. Due to the fact that the police may choose to come to the school to interview the child, many building administrators like to be informed ahead of time.

However, mental health professionals should keep in mind that they are mandated reporters. That means that if a clinician notices injuries or if a child discloses information regarding an abusive situation to a clinician, the clinician is legally required to call the authorities. Informing the principal does not negate one's professional obligation. This also means that the administration does not have the right to prevent a clinician from making a report. It is the clinician's ethical and legal responsibility to do so!

In addition, it is important to remember that the person with whom the child first shared the information is legally responsible for making a report. Teachers will, at times, refer the case to the mental health clinicians and ask that they make the report. As mandated reporters, teachers need to be reminded that the person to whom the child disclosed the abuse, or who saw the injuries, is the person who needs to make the report.

Clinicians should make sure to have several copies of the CPS Report form in their office, as a written report must be submitted within 48 hours of making the call. When preparing to make a report, the clinician should limit the level of detail included in the report to an amount that minimizes breaches in confidentiality and maximizes child protection (Melton & Limber, 1989). Different states and localities require different information for an abuse and neglect report.

Know who to call. If the alleged abuser is a **family member or caregiver** of some kind (i.e. teacher, babysitter, etc.) in many states the call must be placed to Child Protective Services (CPS) or local law enforcement. In some states, if the alleged abuser is **not someone who takes care of the child** (a neighbor who is not a babysitter, a stranger, etc.) the call should be placed to the police at 911.

Remember, the clinician's role is not one of investigator. The only information that needs to be gathered is that which is requested in the CPS report form. While further information may be helpful for evaluation or treatment purposes, the clinician should

wait until the report has been made to seek this information in order to avoid jeopardizing the investigation (Kalichman, 1999).

Clinicians should discuss with the child why the call is being made and what information will be shared. In addition, it might be helpful to explain to the child what will most likely take place after the report is made. Informing the child about what can be expected if the police come to talk to them, etc., will help it to seem less scary. Many children associate the police with having done something wrong. It should be stressed that the police will be there to help the child, not because the child did anything wrong. Another important step is for the clinician to present CPS as potentially helpful as well as authoritative, and to stress his or her commitment to provide support throughout the process if a report is ever made.

Typical information requested by CPS includes:

- Name and home address of the child and parent or other individual responsible for care of the child;
- Present location of the child;
- Age of the child;
- Names and ages of other children in the home;
- Nature and extent of injuries or sexual abuse or neglect of the child;
- Information about previous possible physical or sexual abuse or neglect;
- Information which might aid in establishing the cause of the injury or neglect;
- Information which might aid in establishing the identity of the individual(s) responsible for abuse/neglect; and
- If reporting abuse or neglect of a child involving mental injury, a description of the substantial impairment of the child's mental or psychological ability to function that was observed and identified, and why it is believed to be attributable to an act of maltreatment or omission of proper care and attention.

Please refer to the National Clearing House on Child Abuse and Neglect Information <http://www.calib.com/nccanch/pubs/stats02/repoproc.pdf> for information specific to your area or check with your local CPS or Department of Social Services office to find out about reporting requirements.

After the call has been made

The clinician should follow the procedure previously established with the building administrators. If the administration has asked to be notified when a report is made, now is the time to let them know.

It is generally recommended that the clinician inform the child's parent or guardians, especially if the parent or guardian is not suspected of being the perpetrator. In fact, there

is an ethical obligation to inform parents of breaches of confidentiality (Kalichman, 1999). This allows for an environment of openness and honesty, rather than one of secrecy. It is important, however, for the clinician to use his or her professional judgement when determining whether to inform a suspected perpetrator of the need to report. Clinicians should not inform the parent or guardian if they feel that such an action could lead to further abuse (Besharov, 1990).

It is generally required that a written report be sent to Child Protective Services within 48 hours of making the call. Some areas will require that a copy of the report be sent to other locations as well. For example, some school districts require that copies of all CPS reports be mailed to the District office. Clinicians should check with their local DSS and School District officials for requirements in their area. They may also want to note the addresses and fax numbers below or in some other convenient location in order to have the information at hand.

Internet Resources on Child Abuse

American Professional Society on the Abuse of Children <http://www.apsac.org/>
National Clearing House on Child Abuse and Neglect Information.
<http://www.calib.com/nccanch/>
Child Abuse Prevention Network <http://child-abuse.com/>
Child Lures Prevention <http://www.childlures.org/>
Child Trauma Academy <http://www.childtrauma.org/>
Children Institute International <http://www.childrensinstitute.org/>
Prevent Child Abuse America <http://www.preventchildabuse.org/>

Children's Books

Girard, L. W. (1992). *My body is private*. Morton Grove, IL: Albert Whitman & Co.
Kleven, S. (1998). *The right touch*. Bellevue, WA: Illumination Arts.
Spelman, C. (1997). *Your body belongs to you*. Morton Grove, IL: Albert Whitman & Co.

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