

Predictors of failure by medical practitioners to report suspected child abuse in Queensland, Australia

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Abstract

Objective: The goal of this investigation was to examine the level of notification of child abuse and neglect and the perceived deterrents to reporting by medical practitioners, who are mandated to report their suspicions but might choose not to do so.

Design: A random sample of medical practitioners was surveyed. About three hundred medical practitioners were approached through the local Division of General Practice. 91 registered medical practitioners in Queensland, Australia, took part in the study.

Results: A quarter of medical practitioners admitted failing to report suspicions, though they were mostly cognisant of their responsibility to report suspected cases of abuse and neglect. Only the belief that the suspected abuse was a single incident and unlikely to happen again predicted non-reporting ($\chi^2 [1, N = 89] = 7.60, p < 0.01$). No gender, age or parent status differences were found between reporters and non-reporters.

Conclusions: Although the rate of non-reporting shows improvement from previous research, it is still at an unacceptable level. The failure to report appears to result not from judgement about the presence or absence of indicators of child abuse and neglect but a threshold that moves individuals to act on their suspicions. Professional development should focus on some of the fallacies which often influence medical practitioners' decisions.

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CHILD ABUSE AND NEGLECT are very serious concerns, in that their consequences are substantial and have been shown to have a pernicious impact upon children in many ways.¹ The impact can be evident across the individual's development, with negative factors being evident immediately, and continuing to emerge during childhood and adulthood, as well as

What is known about the topic?

Medical practitioners are legally required to report suspected child abuse, but studies have shown that Australian doctors do not always report suspected abuse.

What does this paper add?

This paper presents the results of a survey of 91 general practitioners in Queensland, with 26% of the respondents admitting that they had not reported suspected abuse at least once. The reasons for failure to report such abuse resulted not from judgement about the presence of child abuse and neglect but judgement about the likelihood of recurrence.

What are the implications for practitioners?

Rather than improving information on the signs and symptoms of abuse, interventions aimed at increasing responsiveness of medical practitioners need to address the beliefs underlying the behaviour of reporting. Medical practitioners need to consider their personal beliefs and attitudes that influence their decision whether to report or not, in particular, addressing the reality that child abuse and neglect are rarely single incidents. ♦

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intergenerationally. The early recognition of childhood abuse or neglect has been shown to contribute to a decrease in negative outcomes.² As victims and perpetrators of child abuse and neglect typically do not self-report,³ key professionals play a vital role in identifying and reporting abuse or neglect and potentially reducing at least some of the negative consequences of child abuse and neglect.

Governments in Australia and throughout the world recognise the serious nature of abuse and neglect of children and the potentially serious consequences when this is not addressed. As a result, in many Western countries laws have been passed that have established mandatory reporting of suspected incidents of child abuse and neglect as one mechanism for addressing this concern. However, many mandated professionals have been shown to fail to report suspected abuse despite legal requirements to do so.⁴⁻⁸ For example, 43% of general practitioners and paediatric registrars in an Australian sample failed to report suspected abuse or neglect.⁶ In the period 2002–03, medical practitioners accounted for a relatively small percentage of notifications in Australia (2%–3% in most states).⁹

A number of reasons for failing to report suspected child abuse and neglect have been identified from studies examining a variety of groups of individuals, some mandated and others not, for example, nurses, teachers, community members and medical practitioners. The identified reasons for failure to report have included the lack of defined indicators of abuse and a lack of knowledge as to what might constitute child abuse and neglect,^{10,11} a perceived lack of evidence,^{6,8,12,13} uncertainty about reporting requirements and procedures in relation to child abuse and neglect,^{14,15} and knowledge of the family,¹⁶ and the belief that the abuse was a single incident.¹⁰

Factors that have previously been found to influence medical practitioners' judgement include a reluctance to jeopardise the relationship with the child and the family;¹⁷ negative attitudes and beliefs about the effectiveness of

interventions by child protection services;¹⁷ concern about legal ramifications if the allegations were investigated and found to be false, and the time required to attend court if subpoenaed to give evidence.^{17,18} This is the case even though most jurisdictions in Australia and other parts of the world exempt the reporter from liability if they are seen to be acting in good faith.¹⁹

Finlayson and Koocher²⁰ found women were more likely to suspect and report abuse. In contrast, Van Haeringen et al⁶ did not find a gender difference among their sample of medical practitioners. In a study conducted by Korbin and colleagues²¹ the only difference found between men and women was that men were less likely than women to identify a lack of supervision as constituting abuse or neglect.

In a recent study²² of Queensland teachers detecting and reporting child abuse and neglect, it was reported that three quarters of teachers suspected child abuse and neglect at some stage in their career. When asked if they ever made the decision to not report their suspicions, 10% of teachers admitted their failure to report in spite of their suspicions. Unlike medical practitioners, at the time of the study the teachers surveyed did not have any legal obligation to report their suspicions.

Medical practitioners are in a critical position to assess and detect cases of suspected maltreatment due to the regular contact that they may have with individual children. They are thus in a unique position to use their medical expertise to compare a situation with previous behaviours and circumstances and also with peer norms. Medical practitioners have the potential to provide an important comparison when assessing differences among individuals' thresholds to report suspicions. In order to better address the issue of reporting by medical practitioners, it is important to understand how people make judgements in relation to child abuse and neglect and how these judgements influence decisions or actions. The significant role medical practi-

I Respondent characteristics

Characteristic	Number of respondents
Female (no. [%])	39 (45%)
Have own children (no. [%])	64 (72%)
Age range (years)	40–44
Ever made a report (no. [%])	62 (69%)
Made a report in past year (no. [%])	19 (21%)
Ever suspected but not reported (no. [%])	23 (26%)

tioners play in their mandated role to report suspicions suggests an important reason to understand their judgement. The aim of this research is to gain a better understanding of the reporting process and barriers to medical practitioners, who have mandated reporting requirements in Queensland, reporting suspected child abuse and neglect. More specifically this study aims to (1) assess the current level of reporting by medical practitioners, (2) determine if there are demographic differences between reporters and non-reporters, and (3) assess the perceived deterrents to reporting child abuse and neglect. It is hypothesised that self-identified barriers to reporting will include: inadequate knowledge of indicators of abuse and neglect; inadequate knowledge of reporting procedures; lack of visible evidence of abuse and neglect; characteristics of the child and family; and beliefs regarding the consequences of reporting.

Methods

Participants

About three hundred medical practitioners were located and approached through the local Divisions of General Practice. A total of 91 questionnaires were returned, representing a response rate of about 30%.

Materials

A questionnaire was developed for the current study, based on the amalgamation of two instru-

ments used in previous studies: the Educators and Child Abuse Reporting Questionnaire⁸ and questions developed by Hawkins and McCallum.²³ The amalgamated version was used as it covers a number of potential factors identified previously in the literature as well as factors that would be appropriate to mandated medical practitioners. The questionnaire consisted of five-point Likert-type scales, with eight items assessing perceived confidence in identifying and reporting abuse and neglect, 15 items assessing how respondents would behave in various situations in which child abuse or neglect was suspected, 13 items assessing agreement with various statements concerning their beliefs about child abuse and neglect, and 16 items assessing the extent to which various beliefs and attitudes about child abuse and neglect might influence respondents' decisions to report or not report. Additional items included respondent characteristics of gender, age, whether they have children of their own, reporting history and knowledge of reporting procedures and responsibilities.

Procedure

Medical practitioners were approached through the local Division of General Practice. Following approval, staff from the Divisions distributed assessment packages (questionnaire, information sheet, consent form and a reply paid envelope) to GPs at conferences, meetings and individually. Medical practitioners who returned the questionnaires with the signed consent form received a small non-financial incentive.

Statistics

Data were analysed using SPSS for Windows (version 10.1; SPSS Inc, Chicago, Ill, USA). Frequencies were used to determine the demographic and reporting statistics of the sample. One-way analysis of variance (ANOVA) was used to assess any effects of knowledge of responsibilities, and stepwise logistic regression analyses were used to determine the best predictors of not reporting suspected abuse and neglect.²³

Results

Sample characteristics

One medical practitioner returned the questionnaire with more than 10% of items missing and was deleted from the analyses. Five medical practitioners did not record their sex, and were subsequently removed from the analyses assessing gender differences. All other missing values were estimated from participants' existing responses using the SPSS program Missing Value Analysis.* Further demographic characteristics of the sample are presented in Box 1.

Reporting responses and knowledge of reporting responsibilities

Twenty-six percent of doctors admitted not reporting suspected abuse at least once. Characteristics of respondents who suspected abuse or neglect but did not report their suspicions included 35% female, 83% with their own children, and an age range of 45–49 years. There was no significant gender difference between reporters and non-reporters (28% of men v 18% of women did not report; $\chi^2(1) = 0.32, p > 0.05$). This is consistent with earlier findings (eg, Van Haeringen et al⁶).†

The majority of medical practitioners indicated that they had a statutory and a professional or ethical responsibility to report suspected child abuse and neglect ($n = 87$ [97%]). The majority of medical practitioners also believed that they had a responsibility in their workplace and that it was appropriate to report suspicions ($n = 79$ [88%] and $n = 84$ [93%], respectively).

* As Little's MCAR (missing completely at random) test resulted in a non-significant χ^2 , data were deemed to be missing at random (ie, there did not appear to be any systematic pattern to missing values). Accordingly, an expectation maximisation technique was used to impute remaining missing data.²⁴

† As there were fewer than five observations in at least one cell testing the independence of parent status and age across reporters and non-reporters, tests of significance could not be performed.²⁴ ◆

Confidence in identifying and reporting abuse

A mean "confidence" score was created from the eight item scale with higher scores indicating high levels of confidence. Internal consistency was good with a Cronbach's α of 0.90. Medical practitioners reported confidence in identifying and reporting abuse ($M = 3.63, SD = 0.72$).

Factors predicting non-reporting of suspected abuse or neglect

Due to the exploratory nature of the study a stepwise logistic regression analysis was used to develop a model to predict the decision not to report ($n = 23$) or report ($n = 66$) suspected abuse or neglect. Variables measuring confidence in identifying and reporting abuse and reasons influencing the decision to not report were entered into the model to predict these reporting decisions. A one-step model significantly predicted non-reporting of suspected abuse ($\chi^2[1, N = 89] = 7.60; p < 0.01$). One variable was found to predict non-reporting, namely a belief that the abuse or neglect was a "single incident" and unlikely to happen again ($B = 1.35; Bse = 0.51; Wald = 6.87; df = 1; p < 0.01$). Endorsement of this belief correctly predicted 35% of non-reporting by medical practitioners of suspected abuse. Medical practitioners who believed the abuse was a single incident were almost four times more likely to not report their suspicions (odds ratio, 3.85) (Box 2). No other beliefs significantly predicted membership in the group of practitioners who did not report suspected abuse.

Qualitative responses

While the study utilised questionnaire data, a number of respondents provided some qualitative responses. Respondents who had suspected and reported abuse and neglect indicated that they would consider the characteristics of the case in making their decision. Another respondent who had made a recent report noted that the authority to which the abuse is being reported needs to act with sensitivity and that this was "not a satisfying job but more a melancholy

2 Stepwise logistic regression analysis predicting non-reporting of suspected abuse for medical practitioners*

Step	Variable	B	Wald statistic	Odds ratio	95% confidence interval for odds ratio	
					Upper	Lower
1	Feeling that the abuse was a single incident	1.349	6.87**	3.85	1.41	10.56

Note. Models predict non-reporting of suspected abuse. * Model correctly predicts 74% (report 88%, non-report 35%); $n = 89$. ** $p < 0.01$.



duty". Another stated that the "authorities" did not offer much help. This theme was repeated in discussions with respondents.

We were particularly interested in the qualitative comments made by respondents who had indicated that they had suspected abuse and neglect but had made the decision to not report their suspicions. In one instance, the respondent suggested that it would "depend on the circumstances" of a child retracting his or her statement of abuse as to whether this would influence the respondent's decision to report suspicions. Another again referred to the sensitivity of the "authority" and expressed concerns in relation to the potential for "violent retribution". Another respondent stated that "it depends upon the perpetrator" as to whether they would disclose the abuse and affirmed their belief that many parents are capable of hurting their children under pressure.

Discussion and conclusions

Medical practitioners were largely aware of their legal and professional responsibilities to report suspected child abuse and neglect. This is consistent with Van Haeringen et al's study in which 93% of paediatricians and 72% of GPs had reported suspected abuse and neglect.⁶ However, the present study indicated that while some medical practitioners suspect abuse and neglect, 26% of respondent medical practitioners did not report their suspicions at least once. Although this percentage is considerably lower than that found in previous studies of this

population (eg, 43%⁶), it is of concern given medical practitioners' legal mandate to report and their professional position that is conducive to detecting possible cases of abuse and neglect. In contrast, only 10% of Queensland teachers, who are not mandated to report, indicated that they had made a decision to not report suspected abuse and neglect.²² It is therefore critical that we gain a better understanding of the reasons and reasoning processes for people's decisions not to report their suspicions.

A positive aspect of the current findings was an indication that the rate of non-reporting of abuse and neglect by medical practitioners has decreased from 47% in 1998 to 26% in 2003. This decrease in decisions not to report suspected child abuse and neglect has been accompanied by an increase in substantiated notifications of child abuse and neglect in Queensland from 6919 in the 1999–2000 period to 12 203 in 2002–03.⁹

Medical practitioners were found to have a reasonable level of confidence in identifying and reporting abuse. This is likely to positively affect their decision to report their observations.¹⁰ Further, analysis found that for this sample, the only factor predicting non-reporting of suspected abuse was the belief that the abuse was a single incident and, presumably, unlikely to occur again. This was confirmed by the qualitative data which emphasised the concerns that some practitioners felt in relation to the sensitivity of the reporting authority. Thus it appears that judgement that the abuse is a single incident takes precedence over legally

mandated obligations for many of those who failed to report suspicions. Again, the percentage of cases able to be predicted by the model was small, implying that perhaps there were many factors influencing the medical practitioners' decision not to report suspected abuse or neglect.

Given the belief that the abuse or neglect was a single incident and was a significant factor in predicting failure to report, our findings may best be understood from the "inflation of optimism" hypothesis.²⁵ This hypothesis suggests that in spite of logical or rational evidence, in this case past behaviour of abuse or neglect being the best predictors of future behaviour, human beings tend to make judgements based on an optimistic view rather than engaging in a rational decision-making process. In the case of medical practitioner's reporting of child abuse, this is reflected in the mistaken view that abuse or neglect is more often an isolated incident. It appears that doctors are overestimating their capacity to make predictions of the likelihood of future harm to the child. The implication is that medical practitioners are making decisions about whether to report based on their beliefs about specific cases in preference to making a referral to multidisciplinary specialised child protection teams who are credited with the expertise to undertake more complete assessments.

The current study relied on self-report data. Furthermore, the response rate of 30% was relatively low. These limitations might have resulted in some self-selection bias that might have influenced the findings. Future studies would benefit from adopting a methodology relying on alternative sources of data and higher response rates than that achieved in the current study.

The current study highlights the fact that while a significant proportion of medical practitioners, who have a mandated responsibility to report abuse, do in fact report their suspicions of child abuse and neglect, a proportion do not. Reasons for failure to report such abuse result not from their judgement about the presence of

child abuse and neglect but their judgement about the likelihood of recurrence. Rather than improving information on the signs and symptoms of abuse, any intervention aimed at increasing responsiveness of medical practitioners needs to address the beliefs underlying the behaviour of reporting. One exception may be in educating doctors on the complexities involved in estimating the future likelihood of harm. Medical practitioners need to consider in particular the personal beliefs and attitudes that influence their decision whether or not to report, addressing the reality that child abuse and neglect are rarely single incidents.

Further studies should examine other factors that may influence medical practitioners' thresholds for reporting as well as methods of attempting to change the beliefs that reduce the likelihood of reporting, with a view to gaining a greater understanding of the processes underlying decisions to report or to not report their suspicions.

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Competing interests

The authors declare that they have no competing interests.

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