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# An Evaluation of Child Abuse Reporting Policies in a Substance Abuse Treatment Hospital

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An Evaluation of Child Abuse Reporting Policies in a Substance Abuse Treatment  
Hospital: Mandated Reporter's Perceptions of Support

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December 14, 2014

FINAL APPROVAL OF MASTER'S PROJECT

HSA680 Continuing Issues in Health Service Delivery Systems

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Hospital: Mandated Reporter's Perceptions of Support

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**Abstract**

The purpose of the study was to evaluate organizational policies on child abuse reporting in a substance abuse treatment hospital to help identify factors that contribute to a perceived sense of support by mandated reporters employed there. A qualitative design was utilized to gain opinions and insight into what factors contribute to the perceived support. Employees from the hospital volunteered to participate; nine in-person interviews were conducted and one phone interview. From this, several themes emerged from this study: training, hesitations, support, confidence and purpose. Results from this study coincide with prior research of child abuse reporting hesitations and training components utilized for mandated reporters. For example, the use of consultation as a means of discussing the suspected child abuse provides support and can build confidence in the mandated reporter. Additional research is recommended to further explore an increased schedule of training that is specific to incidents more prevalent in a substance abuse treatment hospital. Additionally, it is recommended that management review and update policies in order to decrease confusion.

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## **Chapter 1 - Introduction**

### **Identification of the Problem**

There were approximately 3.3 million reports made to Child Protective Services (CPS) in the United States, consisting of 6 million children (DHHS, 2009). Of the nearly 1 million that were deemed substantiated, 64.1% were categorized as neglect and up to 80% included the existence of parental alcohol and drug addiction (DHHS, 2009). Substance abuse was reported as one of the two major problems for families where child abuse or maltreatment was suspected (DHHS, 2009). The responsibility and ability for mandated reporters to report suspected child abuse is critical to helping significant numbers of children and families.

Substance abuse counselors are included on a list of mandated reporting professionals in 14 states (Child Welfare Information Gateway, 2012); occupations include public positions, health care personnel, public protection positions and public contact positions (DPSS, 2014), yet some professionals do not report suspected child abuse consistently. There are several hesitations or barriers contributing to the problem.

Researchers found that mandated professionals do not feel confident in accurately detecting child abuse due to several training concerns, which could either stem from a personal self-confidence or from the level of training received (Alvarez, Kenny, Donahue & Carpin, 2004; Pietrantonio, Wright, Gibson, Allred, Jackson & Niec, 2013). Crowell and Levi (2012) show how additional training over the course of the professionals' career could result in a higher rate of reporting. It is argued, however, that no level of training in reporting procedures can raise the confidence of mandated professionals to report since inadequate descriptions of "reasonable suspicion", when a reporter is unsure of how to

read the “signs”, is stated to cause much of the current confusion (Levi & Portwood, 2011).

A few studies briefly mention the use of “experts” (Pollak, 1989) or a “community collaborative” (Flam, 2009) to provide guidance as the mandated professional struggles with reporting decisions. Some social learning theories illustrate the usefulness of mentors in an environment to guide the learning process (Callery, 1990). Although this limited mention of experts, mentors and community teams provides direction, no research was found to show if the use of internal team consultation could bolster the confidence and aid in the decision of whether or not to report suspected child abuse.

Additional barriers such as the countertransference that professionals experience due to their own personal background can also cause hesitations in reporting child abuse (SAMHSA, 2000, Ch. 4). Two groups of researchers noted that another reason professionals hesitate to report is concern for the post patient-client relationship (Alvarez et al., 2004; Pietrantonio et al., 2013).

### **Justification for Studying the Issue/Problem**

As noted above, one problem area is that mandated reporters need to have support while struggling with the moral, ethical and legal aspects of reporting child abuse. The stressors and concerns encountered during the process vary, as do the reporting results. A mandated reporter’s ability to confidently report suspected child abuse directly impacts many children and families every year.

**Purpose statement:**

The purpose of this study is to evaluate whether or not mandated reporters feel they have adequate support, resources and policies in place to confidently report child abuse.

**Implications of the Research Problem for Health Care Administrators**

Child abuse is a serious social issue that affects the welfare of millions of children and families throughout the United States and other countries. Substance abuse treatment hospitals are not immune to the social crisis; on the contrary, the instances of reporting are potentially substantial in view of the fact that there are correlations between child abuse and substance abuse. The position of this research would be to maintain training criteria in addition to utilizing abuse reporting teams formed within an organization.

How might the administrative process within a substance abuse treatment hospital for reporting child abuse look different when viewed from these perspectives?

Potentially, three facets of an organization will need to undergo change to facilitate an increase in employee confidence when identifying and reporting child abuse. Health care administrators can assist by recognizing subject champions and experts to form a multidisciplinary team. The diverse group should consist of individuals who are comfortable and well versed in the state child abuse law and of their own organizations' policies. It is plausible that the individuals on the team would need additional training periodically to increase their knowledge of any changes or updates to state laws. And in turn, this knowledge would be shared with others through consultation and training.

In addition, results of this research may find that a cultural change, one within an

organization to embrace team decisions, is needed if not already present. Policies and procedures, to include seeking consultation from a team, would need to be implemented as well. Finally, to be effective, the act of reporting must be valued as not only a means to help children but also to provide therapeutic guidance to patients who may be involved in the child abuse either as the perpetrator or as the victim from childhood experiences. Specific training to have therapists inform their patient of the report is advisable, as well as the implementation of treatment plans that incorporate support after such disclosure.

Guiding, coaching, and mentoring are the responsibility of any senior leadership team in an organization. Healthcare administrators can benefit from critically reflecting on the use of teams as a means to train, support and accompany staff in making tough decisions.

### **Conclusion**

Adults with substance use disorders are 4.2 times more likely to report neglectful behavior toward their children, who in turn are at greater risk of social and emotional problems, and at greater risk of having substance abuse issues as adults, (USDHHS, 2003). The urgency for health organizations to provide current training specific to situations most faced by their employees is critical to providing help and support to children and families. Exploring hesitations and adapting policies within the healthcare organization could be a vital part of providing support to mandated reporters.

## **Chapter II – Literature Review**

Substance abuse was reported to be one of the two major problems of families where child abuse or maltreatment was suspected (USDHHS, 2011). The question of how to help facilitate protection for children while maintaining support for mandated reporters is important to ask since improvements in both areas could lead to an increase in properly reporting child abuse. Particularly, in the substance abuse field, when mandated reporters are faced with client disclosures during the course of their treatment, reporters encounter several hesitations to reporting these findings.

The responsibility and ability for mandated reporters to report suspected child abuse is a major component of working with children that has been supported by training. Helping mandated reporters overcome their hesitations could prove to increase the likelihood of reporting, and in turn, save children from continued abuse. The purpose of this study will be to investigate ways that a substance abuse treatment hospital can support their staff in the process of reporting child abuse. The question this research will try to answer is: how do mandated reporters in a substance abuse treatment hospital perceive the support and guidance available by their organizations?

The following literature will review how abuse is defined by state legislature. A collective review of common hesitations demonstrates the confusion caused when determining whether or not to report. Training is one component already used to ensure mandated reporters are aware of definitions of abuse and reporting protocol. The apparent gap in research that exists involves workplace administrators and how they can consistently utilize consultation groups to support employees through the difficult task of

determining if their suspicions constitute making a report to the local social service agency.

### **Legislature**

Nearly 25% of the population is comprised of children (U.S. Department of Health and Human Services, Child Maltreatment (USDHHS), 2012), which means that a quarter of the population is potentially at risk of child abuse. Federal child abuse standards are defined in the Child Abuse Prevention and Treatment Act (CAPTA) of 1974 and as of 2010, was updated by the Reauthorization Act to include:

Any recent act or failure to act on the part of a parent or caregiver which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm (USDHHS, 2011, p. vii).

All fifty states have their own legislation to describe definitions of abuse, descriptions of mandated reporters, reporting protocol, and penalties or safeguards for designated reporters. California Penal Codes (11164-11173.4) are used for the purpose of this paper. Child abuse includes physical, sexual, unlawful corporal punishment or injury, emotional and neglect. The definition of “sexual abuse” includes touching or penetration of a child’s intimate parts with the perpetrator’s body parts; to include hands, mouth or genitals, or with other objects (CA Codes, pen: 11165.1(b)). Sexual abuse is also to include masturbation of the perpetrator’s genitals in the presence of the child, and exploitation; to include physical and images (CA Codes, pen: 11165.1(c)). Other abuse types noted in the California Penal Codes are “neglect”; including intentional failure to provide adequate food, clothing, shelter or medical care (pen: 11165.2), “the willful harming or injuring of a child or the endangering of the person or health of a child”;

where someone places a child in an unsafe situation (pen: 11165.3), “unlawful corporal punishment or injury”; a situation where someone inflicts cruel or inhuman punishment on a child (pen: 11165.4), and “abuse or neglect in out-of-home care” (pen: 11165.5).

Negligence is a form of child abuse that is prevalent in families dealing with substance abuse (DHHS, 2009). “Severe neglect includes situations where any person having the care or custody willfully cause or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered” (CA Codes, pen: 11165.2.). Cases disclosed by children, where one or both parents have an addiction to alcohol or drugs involve parents who were drinking and driving with their children in the car, being left alone and having to care for themselves or their younger siblings, or the use of uncontrolled substances in the presence of children; all reportable under California Penal Code 11165.2.

Since medical physicians were included as mandated reporters in 1968, state codes have changed to include several other professions. It was not until the 1970's that alcohol and drug addiction hospitals were included. An alcohol and drug counselor, as used in this article, is a person providing counseling, therapy, or other clinical services for a state licensed or certified drug and alcohol treatment program (CA Codes, pen: 11165.7(38)). Regardless of profession, most mandated reporters have encountered hesitations in reporting at one point in their career.

### **Organizational Support**

The hesitations and uncertainty mandated reporters have beckons the need for continued research to decrease underreporting and enhance confidence in the process of



detecting and reporting child abuse. Several studies have been done over the years that provide a glimpse into two areas in particular, training and consultation, which may help. The feeling of being supported in the workplace is vital to the growth of employees, especially in areas where employees may be new to the organization or a position. In areas concerning ethical or moral dilemmas, this task of support becomes even more vital to the well being of both the employee and the organization (Delaney, 2012; McCormick, Boyce & Cho 2009).

Research shows that employees supported by training and opportunities to consult with colleagues, benefit when it comes to child abuse reporting. Alderton (1999) studied 88 professionals working in business, engineering and healthcare fields to determine how learning takes place in work environments. Participants stated that most of the learning was done informally while performing daily tasks, however, they added that the degree of challenge and the support from peers solidified learning and increased individual confidence (Alderton, 1999), components that are consistent with Bandura's (1977) social learning theory. Appendix A, page 53, shows how challenges and support work as a system to build an individual's confidence in the workplace (Alderton, 1999).

**Training.** Understanding and acknowledging the hesitations mandated reporters have provide organizations an opportunity to support their employees. Adequate training is necessary for reporters to feel that they can make a knowledgeable, informed decision. Training guidelines are briefly mentioned in the California Penal Codes (11165.7 (c)), which encourages employers to educate staff in identification of abuse and in reporting

guidelines. The law further states though, that the absence of such training does not excuse the mandated reporter from the obligations to report (CA Code, p: 11165.7 (c)).

Workshops and continuing education programs can instill factual information, such as definitions of abuse, reporting protocol and legalities; however, vignettes and case review give a deeper understanding of how to detect suspected abuse (Alvarez, et al., 2004). Countertransference can cause a notable hesitation for therapist or counselors within the substance abuse field. It is suggested that education and training of employees should include arrangements for greater understanding of countertransference reactions through existing didactic programs and in the form of case studies pertaining to clinical skill building (Pollak, 1989). This hesitation is discussed in more detail below.

Training and continuing education requirements differ from state to state and variance is further seen between states for remedial training. For example, Iowa mandates at least two hours within one year of the initial licensing and every five years thereafter (ifapa, n.d.). Refresher courses are available for mandated reporters working in schools in Connecticut every three years (DCF, n.d.). California has a general training on-line, equaling four hours, plus professional-specific modules equaling two hours each (CDSS, n.d.).

There are several reports indicating that initial and subsequent training in recognizing and reporting child abuse benefit mandated reporters. Levi and Portwood (2011) discuss how mandated reporters need better guidance; however, despite good intentions of training, education may not improve the confusion regarding matters of “reasonable suspicion”. This was supported a year later when Crowell and Levi (2012) found that the more training a person received, although correlated with a lower threshold

to report, the lower the probability that they identified with reasonable suspicion. Participants were given a 12-item survey where both an ordinal and analog scale were used to determine how high on the list would suspected child abuse have to rank before they felt there was reasonable suspicion of child abuse. No significant association was found by the researchers with “prior education on reasonable suspicion”, suggesting that attention to developing standardization for interpreting and applying reasonable suspicion is necessary (Crowell & Levi, 2012). Crowell and Levi (2012) posit that training directed at understanding thresholds and the variability found in reasonable suspicion is needed based on their findings.

**Expert consultation.** Organizations can support their staff by placing expert teams or groups in charge of researching, training and supporting abuse reporting within their organization. California Penal Codes (11166.1(i)) state the reporting duties are individual and for that reason, no supervisor or administrators may impede or disturb the reporting responsibilities of a person making the report. The act of forming an internal team is to provide support only, not to establish whether or not the abuse occurred, and consequently, if a report should be made.

Professionals, inhibited by law and faced with conflicting ethical principles, grapple with reporting decisions. Consultation as a process in ethical decision-making is valuable (Henderson, 2013). Training appears to be helpful in some areas of reporting; yet research is unclear as to whether it helps the mandated reporter in all aspects of actually making a report. Regardless of training, research recommends the use of discussion and input from colleagues. There are some studies that suggest how the use of

a community collaborative (Flam, 2009), experts (Pollak, 1989), and the idea of mentors and social learning theory in the work place can positively affect the mandated reporter's perspective on reporting child abuse (Callery, 1990).

Many organizations form expert teams or groups for several reasons. So what is a team? Katzenbach and Smith (1993) describe it as "a small number of people with complimentary skills, who are committed to a common purpose, set of performance goals, and approach for which they hold themselves mutually accountable." Closely related is what Katzenbach and Smith (1993) define as a working group; where the group can come together to share viewpoints and insight, but where the individual, not the team, is accountable. The act of reporting child abuse is an autonomous one, therefore, the latter may be more suitable for organizations to form based on this definition.

Working as a team or group can reduce stress and facilitate support (SAMSHA, 2000), as well as decrease a sense of isolation. Flam (2009) points out that in order for a consultation team to work and benefit everyone, they should be non-intrusive. They should also be non-hierarchical (Alderton, 1999; Flam, 2009). Teams can allow the exchange of ideas in a way that gives a platform for each voice to be heard, without feeling that one person's opinion will matter more than the other (Katzenbach & Smith, 1993), solely because of their seniority (Flam, 2009). The team can provide a place to share knowledge (Flam, 2009) as well as discuss and debate best practice standards (Katzenbach & Smith, 1993).

Most mental health professionals utilize a process called Supervision. During Supervision, professionals can discuss feelings and issues raised, such as countertransference, while working with clients. Colleagues and the supervisor provide

feedback. This process utilizes the supervisor as the expert voice, and subsequently, can serve to persuade decisions. A process that would allow room for the individual to make final decisions would be beneficial for the mandated reporter, especially since the act of reporting is an autonomous one.

Research on how to support mandated reporters showed that many professionals use some sort of communication within their organization when handling suspected child abuse. Reporters were found to hesitate until they consulted with their supervisor, and found deferring to others as second opinions, and they deliberated with colleagues prior to reporting; all of which provided a sense of support (Francis et al., 2012). The same report also found that some professionals did not feel the support from their peers (Francis et al., 2012), resulting in decreased child abuse reporting for those individuals. Sensing support from peers can work as an igniter for making the report (Francis et al., 2012). Based on the research mentioned, it is reasonable to assume that same sort of internal consultation could benefit mandated reporters in substance abuse treatment centers.

### **Other Hesitations for Professionals**

Although this study will look at the direct support or hesitations that may exist in one particular organization, other hesitations to reporting can occur across all professions and will therefore be explored as well. Reporting barriers include lack of evidence, lack of knowledge, and misinterpretation of the law (Alvarez et al., 2004), lack of confidence in CPS (Henderson, 2013; Pietrantanio et al., 2013), fear of retaliation by perpetrator (Henderson, 2013; Pietrantanio et al., 2013) or fear of negative consequences, concern

that the child or family could ensue more damage, and the interpretation of reasonable suspicion (Alvarez et al., 2004).

Additional hesitations that are particularly difficult when substance abuse and treatment is involved are countertransference feelings (Feng et al., 2012; Pollak, 1989), fear of change to therapeutic relationship in the aftermath of reporting (Henderson, 2013), and fear of breaking confidentiality (Alvarez et al., 2004; Feng et al., 2012; AMHCA, 2013). The following is a description of reasonable suspicion as it pertains to a large portion of hesitations, followed by a review of countertransference, therapeutic relationships and confidentiality versus ethical codes.

**Reasonable suspicion.** The definition of when to report states that the reporter either “suspects” or has “reason to believe” that abuse or neglect has occurred, or that would “reasonably” result in a child getting hurt (Child Welfare Information Gateway, 2012). Child neglect is often overlooked due to the failure in recognizing the signs and symptoms (Alvarez, et al.). Lack of knowledge of the incident and misinterpretation of unclear definitions in legislature are among the many causes for hesitations by mandated reporters.

Although it is never easy to report child abuse, doubt in the actuality of the event does not exist when the victim or perpetrator discloses specific information to the mandated reporter and a report must be made. This process is obscured, however, when the victim or perpetrator does not disclose any details, rather, abuse is just suspected to have occurred. Just under half of the states mandate suspicion of abuse as having a “belief” that it occurred (Levi & Portwood, 2011), dictating that an individual holds the

idea to be true. The majority of states, including California, define the suspicion of abuse as a “reasonable suspicion”, allowing an individual to be concerned that abuse might have occurred. The legal definition for *Reasonable Suspicion*, is when...

it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. Reasonable suspicion does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any “reasonable suspicion” is sufficient (CA pen. code 11166.1).

While there is a fair amount of information guiding mandated reporters in identifying types of injuries and legal aspects of reporting, there is no lever or gauge that can be used to measure what degree reasonable suspicion of concern substantiates reporting.

The strength or probability that abuse took place is subsequent to the reporter’s knowledge of behaviors witnessed by the victim and their own gut instinct. Legal language needs to be translated into practical information and included in education for child abuse professionals (Feng, et al., 2012). To date, there is no procedure or model used to estimate the probability of suspected child abuse, and the inter-rater reliability among health care professionals is weak (Levi & Portwood, 2011). Appendix B, page 54, depicts how a mandated reporter might follow a model of “yes” and “no” questions to aid in deciding whether or not to report.

Research demonstrates that the degree of reasonable suspicion varies due to the lack of clear guidance in defining the term and due in part to the threshold level the individual reporter posits. Crowell and Levi (2012) find the that

respondents from their research who stated reporting on six or more children in the past five years, identified significantly lower thresholds for reasonable suspicion (38.2% vs. 52.3% for those reporting zero cases,  $p \leq 0.0001$ ; and 47.5% for one to five cases,  $p = 0.0006$ ). A more clear definition of reasonable suspicion could help in decreasing an individual's threshold to report, resulting in a better chance of reporting when necessary.

**Countertransference.** The relationship between clients and mental health professionals can be complicated. Countertransference refers to the range of reactions and responses that the counselor has toward clients including the client's transference reactions, based on the counselor's own background and personal issues (SAMSHA, 2000, Ch. 4). Countertransference reactions may include fear, guilt and shame, anger and sympathy (Pollak, 1989). These reactions can cloud the mandated reporter's view and disable their ability to assess the situation properly. Underreporting is a consequential probability.

There are many counselors working in the field of substance abuse treatment that either are recovering from their own addiction and or have been subjected to some sort of child abuse. Fear of verbal or physical assault by the client is a common response when working with highly volatile clients. The fear of ridicule by family or colleagues can occur when an individual has low self-esteem with respect to their competence level (Pollak, 1989).

Guilt and shame pertain to the betrayal of trust for breaking confidentiality. Acts of sympathy can occur when the individual feels they must rescue the client and



therefore, make excuses for their client's actions, and anger sets in when the individual posits an excessive need for control over the situation (Pollak, 1989). All of these situations delay or prevent the professional from reporting child abuse of their clients.

**Therapeutic relationship.** The very nature of the professional-client relationship can cause uncertainty in reporting. Since the relationship is based on trust, the lines between confidentiality and disclosure can become blurred. The American Psychological Association and Code of Ethics explains that mandated reporters working with clients who may disclose information in a therapeutic setting must inform their clients of the federal confidentiality rule in writing as well as informing clients of the exceptions, which include mandatory child abuse reporting (SAMHSA, 2000, Ch. 6). Although disclosure of personal information is important to the therapeutic process, a patient who has difficulty trusting the clinician or therapist may not disclose (Goold & Lipkin, 1999). In such a vulnerable state, the patient or client may jeopardize their treatment due to the inability to fully trust. The possibility for underreporting has the potential to arise due to this dual relationship.

A sense of fear felt by clinicians for what reporting will do to the therapeutic relationship is notable. Most counselors will be concerned that the family will be angry with them or betrayed by the break in confidentiality. Counselors may also fear that the relationship will cease and the patient will not seek further treatment from them or from other therapists (Alvarez et al., 2004; Pietrantanio et al., 2013), which may put the client's health at risk.

**Ethical obligations.** As counselors, it is essential that there is an understanding of and compliance with child abuse reporting laws and professional ethical codes. The practice is to hold all information regarding personal health information (PHI) confidential, however, counselors may disclose confidential information in extreme cases; “protection of life (suicidality or homicidality), child abuse, and/or abuse of incompetent persons and elder abuse” (American Mental Health Counselors Association, 2013). The foundation of the therapeutic relationship is to uphold confidentiality, which should be solidified by the use of an informed consent used at the beginning of any session with a client. The obligation of reporting child abuse is to protect and mandates that confidentiality be broken. Herein lies the conflict.

Above everything else, mental health counselors must be fully compliant and abide by all state and federal statutes regarding mandated reporting. California Penal Code (11172. (a)) provides information to insure that no mandated reporter shall be penalized for providing information in child abuse cases; they shall not be civilly or criminally liable, and that privileged communications are restricted for mandated reporters.

## **Conclusion**

Substance abuse treatment hospitals continue to serve patients who disclose either their personal child abuse, or reveal that they have maltreated their own child or children. The contradictory state of helping the client and contacting local authorities, as well as other issues, appears to cause hesitation in many mandated reporters. The field needs to look at ways, in addition to training, that serve to support mandated reporters; one that

provides respect and value to professionals dealing with a difficult task. Research shows that providing support through consultation could ease the process for reporters as they struggle with the decision. Further, some research shows that administrators can support the use of teams or consultation by ensuring that the people on them have proper skills and a necessary influence for developing recommendations that will carry weight throughout the organization (Francis et al., 2012).

### **Chapter III - Methods**

A formative evaluation using qualitative research methods was used to obtain mandated reporter's perceptions of support in a substance abuse treatment hospital as part of a review of current child abuse reporting procedures. Qualitative research is designed to answer complicated questions in order to describe and explain the phenomenon at hand (Cottrell & McKenzie, 2011). Rather than revealing "how much", qualitative research is concerned with a subjective "how". A qualitative method was chosen for this research in order to study participants in their natural setting and ascertain their unique insight through a collection of words (Cottrell & McKenzie, 2011).

#### **Research Design**

In order to collect subjective perceptions of mandated reporters, the process of interviewing and developing themes was useful through this qualitative approach. Interviews were conducted to obtain perceptions of support for reporting child abuse. All eligible staff was informed by means of their personal work e-mail of their opportunity to take part in the interview. The invitation to participate, Appendix C, and the Consent Form, Appendix D, can be found on pages 53 and 54.

Interviews consisted of open-ended questions to obtain an emic perception of support for mandated reporters currently employed by the hospital. In-depth interviews are preferable to focus groups due to the sensitivity of the subject matter. Child abuse reporting is an autonomous task that can cause uneasiness in the reporter. Individual interviews were chosen to avoid peer pressure to conform to expected answers.

The interviews consisted of 10 questions and were conducted in a private room, reserved at the hospital to provide comfort and confidentiality. The interview guide, Appendix E, can be found on page 55. Interviews took 15 to 30 minutes. One interviewer was utilized to conduct all interviews. Interviews were recorded for later transcription. Coding was performed with the help of the research advisor. Data gained from the interviews were kept anonymous and stored on a password-protected computer. Data was made available to policy stakeholders as part of the analysis.

An initial email was sent to all included staff (mandated reporters) to inform them of the interview opportunity. Interviews were conducted until data saturation occurred. Interviewees were notified individually to set an appointment time and place at the hospital that provided comfort and discretion. Pseudonyms were established so that names of the respondents could not be connected with any information gathered and shared.

### **Participants**

The substance abuse treatment hospital used in this evaluation employs over 300 staff. The level of training varies among staff based on past employment or experience and length of time with the hospital. All staff is introduced to the organizations policies for child abuse reporting during New Hire Orientation. They are introduced to their department's individual policies over the course of their probation period, which is usually 90 days. Additional child abuse training is provided by the organization every two to three years. The last training for mandated reporters at the hospital was held in

April of 2014. Reporting procedures, as outlined in the California Child Abuse Reporting Laws, as well as the hospital's two policies were discussed at this time.

All departments that staff mandated reporters were invited to participate and only those staff members considered to be mandated reporters were invited to participate in this study regardless of time employed by the hospital. Organizational positions included in the email were case managers, primary counselors, family counselors, children's counselors, nurses, chemical dependency technicians and managers or directors of these positions. All mandated reporters at the hospital are English speaking; therefore, the interviews were conducted in English only.

### **Method of Analysis**

The Regis University institutional review board approved the study. Interview participants provided consent by agreeing to schedule and participate in an interview. The Consent Form explained the goals, risks and benefits of their participation and asked to provide verbal consent at the start of the interview. Demographics for individuals were collected at the beginning of each interview. An explanation of the CART policy was provided to participants who could not recall when asked questions 7, 9 and or 10 of the Interview Questions; Appendix E, page 55. The interviews were structured and no additional questions were asked. All interviews took place over the course of six weeks.

Interviews were recorded and then transcribed by the interviewer. Following the interview, themes were generated from the transcripts then a second review was initiated from a second coder to establish inter and intra-coder reliability. A second member of the research team reviewed the data to verify the analysis process. A 9-step process for

content was conducted; define the units of analysis, pretest the coding on a sample of the documents, establish coding categories, assess the reliability of the coding, revise the coding categories if necessary, draw the sample of documents, code all units of analysis, assess the achieved reliability of coding and tabulate the categories. Reliability will be analyzed with inter- and intracoder reliability of coding and theme.

A thematic approach to analysis of the data was used to categorize the perceptions of the participants. The process of data analysis involved transcribing the audio taped data, reading and rereading the transcripts to become familiar with the data, and searching the data for commonalities and keywords. According to Cottrell and McKenzie (2011), qualitative research is based on personal opinion and interpretation done by the researcher of the research and aim of the study.

## **Chapter IV - Results**

### **Statement of Purpose**

The purpose of this study is to evaluate whether or not mandated reporters feel they have adequate support, resources and policies in place to confidently report suspected child abuse.

### **Description of Demographics**

The initial e-mail was sent to eligible staff from the Director of Staff Development's e-mail on behalf of the researcher, as can be seen in Appendix C. on page 55. Of the 127 e-mails sent, ten individuals responded positively by e-mail to participate. The researcher initiated phone calls in order to schedule a time and place for face-to-face interviews. All interviews, with the exception of one out-of-state interview that took place via phone, were conducted on the hospital campus either in the participant's personal office or in the researcher's office if the participant did not have one.

All of the sampled participants were staff currently working at the substance abuse treatment hospital, contacted between June and August 2014. There were four Chemical Dependency Counselors, two Chemical Dependency Technicians, one Children's Counselor, one Family Counselor, one Manager and one Registered Nurse. Eight of the ten participants were female. The number of years employed by the addiction hospital ranged from 1.5 to 28 years. Data indicating an individual's total number of years as a mandated reporter, to include experience while working at other organizations, to range from 1.5 – 41 years. See Table 1. The coding results are presented in Table 2.



**Table 1: Demographics of Participants of Interviews**

| <b>Interviews</b> | <b>Gender</b> | <b>Title</b>         | <b>Yrs. At Current Position</b> | <b>Yrs. As Mandated Reporter</b> |
|-------------------|---------------|----------------------|---------------------------------|----------------------------------|
| 1                 | F             | CD Counselor         | 1.5                             | 3.5                              |
| 2                 | F             | Registered Nurse     | 28                              | 41                               |
| 3                 | F             | CD Counselor         | 1.5                             | 16                               |
| 4                 | F             | Manager              | 11                              | 11                               |
| 5                 | F             | Family Counselor     | 5                               | 7                                |
| 6                 | F             | CD Technician        | 1                               | 1                                |
| 7                 | F             | Children's Counselor | 4                               | 5                                |
| 8                 | M             | CD Counselor         | 7                               | 12                               |
| 9                 | F             | CD Counselor         | 15                              | 23                               |
| 10                | M             | CD Technician        | 2                               | 2                                |

**Table 2: Staffing Research Qualitative Study on Support received by Staff: Photias 2014**

| Theme (record phrases here) | Key Words   | Definition: Code phrases into this category if they reflect...            | Inclusions  | Exclusions                                 |
|-----------------------------|---|---|---|--|
| <b>Training</b>             | Initial", "regular in-service", "policies", "CART meeting", "refreshed", twice a year", "links", "online", "law", "outside help", "other organization", "training department", "graduate school", another workplace, "reminded", "lecture", "confusing", "call", "e-mail", "not aware", "video" | Training as it relates to underutilization of current tools and frequency | Administration<br>Office of compliance<br>Clinical staff<br>Documentation<br>Reporting<br>Policies<br>Training Department<br>Child Protective Services<br>HOPE Collaborative Personnel<br>California Legal System | Patients<br>Families                       |
| <b>Hesitations</b>          | "draw the line", "make me pause", "not sure", "grey areas", "not as clear cut", "very confusing", "blurred", "recently", "currently", "necessary", "struggled", crazy day", transference", "retaliated", "threatening", "worry", "right thing", "be safe", "stop and think",                    | Hesitations related to typical situations in addiction treatment hospital | Clinical Staff<br>Supervisors<br>State<br>Patients<br>Families  |  |
| <b>Confidence</b>           | "definitely", "in the past", "newer", "perception", "more comfortable", "extremely", "not aware", "makes more sense"  | Confidence related to experience in field or the position held.           | Technicians,<br>counselors, case managers, managers, children counselors  |  |
| <b>Support</b>              | Policies, CART, "right decision", "group decision", felt supported", "differing opinions", "talk to someone", "freedom", guidance", "listen", "team", "don't know", brief discussion"   | Support derived from other staff and/or supervisor.                       | Organization<br>Clinical staff<br>Supervisors<br>Office of Compliance<br>Colleagues<br>Training Department  | Non-clinical staff<br>Administrative staff |
| <b>Purpose</b>              | "believe major problem", "families getting support", helps our patients", "mandated", "it's my job", "help the family"  | A sense that the work being done is purposeful to the family.             | Patients, children,<br>family members,<br>organization<br>State<br>Organization<br>Patients<br>Families   |  |

## Results of Analysis

### Training

While questioning participants about the form of training they had received from the organization regarding child abuse reporting, three sub-themes emerged, in-services, policies and procedures, and amount of training. There were mixed results related to training, specifically regarding policies and the amount of training provided.

**In-Services.** The treatment hospital provides the majority of training in the form of “in-services”. Recent training regarding child abuse reporting took place at the hospital three months prior to the interviews. An outside organization presented learning material for staff based on state law, followed by a review of the current organizational policies on the matter. All mandated employees are required to view the live in-service or video of the in-service if unable to attend. Overall effects of in-services were seen as positive, as evidenced by comments such as “enlightening” and “beneficial”.

Our online training which is very easy, because if you are not here for a training day, it's not like, oh, I missed it. Oh well. No, there is an opportunity for training no matter what time of the day, night you work. So, I feel that, I feel we do do a really good training.

**Policies & Procedures.** The organization provides updated written policies and procedures for staff. Regarding child abuse, the organization currently has two policies, Abuse Reporting and Child Abuse Reporting Team (CART). All of the participants could recall and refer back to the Abuse Reporting policy, stating that the Training Department

had them review the policies as an “initial” training. Others commented on how “current” the policies are and the importance of reading and “checking” them, as they are “updated very quickly.”

Several participants were not able to recall the CART policy as they could the Abuse Reporting policy. Of those that were aware and had utilized the CART policy, the overall sense was that the idea of a Child Abuse Reporting Team is good in theory. Others commented on being “confused” about who to call or how to do the paperwork, “unaware” of the policy in general and in need of a “refresher” by the interviewer. Additionally, another stated that the policy prevented the “freedom” to make the call to CPS immediately.

The first time was definitely confusing, cause I wasn't sure who exactly I call. I'm still not sure who exactly I call. You know, apparently there is an e-mail that isn't in the computer system anymore. I don't know if there use to be, but there's rumors of an e-mail list that I wasn't finding it. So, I don't know, so I think I went to ...(another counselor) or ...(director) and said, “Who do I contact?” and they just told me, kinda some people to contact.

I would like to have the freedom to call CPS right, cause that's where it falls anyway right? The policy is call them right away and see if it's reportable, that's the law, and it's almost just the freedom to do that.

**Quantity.** The request to receive subsequent and frequent training was a common point raised by several staff. Many wanted “regular” in-services in order to be “updated” and “reminded” of the issue. The need for “more”, one commented, was necessary to “fully understand”

We had a training here for an hour, what was that, 6 weeks ago, a couple of weeks ago. That was helpful. In social work I had some, you know, I had to study that, but you know, I needed to be refreshed all the time. I’ve had it once in six months in this position. I would hope that it’s more than just once a year. I would like it to be twice a year. It may be helpful to have links put up, occasionally to remind us to reread it.

### **Hesitations**

**Drinking and driving.** One of the most revealed scenarios of child abuse heard from patients is drinking and driving with their children prior to coming to treatment. This situation, in particular, causes mandated reporters at the hospital to question whether they should report it or not due to the time lapse between incident and treatment.

I don’t know where to draw the line, especially in cases and most particularly in cases where mothers have driven in the past with their children but may not be doing that currently because of circumstances before they came in and whether or not this institution supports reporting those cases because that would primarily involve almost every person that walks in my office

Ya, it's, I hesitate when I don't feel the child is been in danger recently or that currently in danger, or if the mother's been, especially in the cases where she has driven intoxicated where she maybe have been separated from the family for awhile and hasn't been driving recently with the children...So things like that can get, can make me pause I guess. It's not as clear-cut as I would like it to be. If I can say it that way, I would. Some times I am not sure if it is the necessary thing to do.

It makes you stop and think about if it is really reportable. Every one case is different and every situation is different. So, you may report one time, and the next time you wouldn't. It can be very confusing, so it's good to talk to someone first.

**Other common hesitations.** Some staff described other typical hesitations they encounter by interacting with patients at the hospital, including the need for “energy” to start the lengthy process, and feeling “uncomfortable” when the incident took place out of the country, due to a “lack of information”, and fear of not “doing the right thing”.

Some staff explained the line between reporting or not to be “blurred” that the decision has “grey areas” or that they are “not so sure if it is necessary or practical.” Hesitations caused by not knowing who to call can be “confusing” even after turning to their supervisor, where they have “struggled getting a clear answer from my superiors.”

Do I have any energy to make a phone call, it's been a crazy day, I mean, that's personal hesitation that sometimes they have. Um, you know, sometimes my

transference is that I like the patient too much that might cause me to hesitate a little bit. And then, the other hesitation that I had for a little bit was here was that I reported a drinking and driving case when I first started working here and the family kind of retaliated and like were threatening to sue and stuff like that. Um, there were like questions that if the case I reported was really reportable. And it made me feel like, um, is my job secure here cause I'm brand new and so then that made me hesitate a little bit in the future. It didn't stop me, but it had me hesitate cause I wondered about, um, my own welfare.

I guess I worry about a child's safety the most. If a child is going home with a parent that may relapse or get angry after they get a visit from CPS, it makes me stop and think about "is this the right thing to do?" My biggest concern is with the child and if they are going to be safe after we report.

### **Confidence**

Some staff displayed confidence and feeling "very comfortable" in reporting because of their experience in the field. Either because they had "worked with children a lot in the past" or because they had "been doing this type of work for several years" or just because, "it makes more sense after a while," and even though it may never get easier, you get "use to it after hearing so often."

When I was newer in the field, you think, what if it's blown up, what if I make it an issue and it's not. That whole fear which just comes with experience. The more experience you get, you know that it's not just your perception.

Although some had not had to report child abuse to date, they mentioned that they would be “comfortable doing it” and that they wouldn’t “have a problem with reporting”.

I guess I would be comfortable. I mean, I would have to do it if I heard something or if they told me they hurt their kid. I would need help though.

### **Support**

**Key staff.** Participants described specific people whom they would turn to for advice or to simply inform of the decision to report. Of those titles mentioned repeatedly were the lead worker, or the “team”. Direct supervisors or “boss”, managers and directors and the office of compliance were other sources of support. Some detailed qualities present in these sources of support, while one expressed their reason for consulting was because they would never report without consulting someone “superior” to them.

Definitely the clinical team here and the clinical directors. We have very skilled and experienced individuals that have worked in the field for years. So I think with them and the support, and their guidance and knowledge, it’s just, we are lucky to have them here. So like I said, many of them have been working with patients, whether here or other facilities, or even private practice. We have a lot of counselors that come from a history of private practice. I think their experience is so valuable. We are very lucky.



**Benefits.** Regardless of which individual they would turn to for support, staff expressed the reasons they needed support and how it helped them to make a decision to report or not. The idea of making a “group decision” or an “informative decision” in order to come up with the “right decision” was expressed. Seeking support for someone to “listen”, and talking to another staff member about a particular case provides what was described as a “sounding board” to talk through the processes. Some mentioned the benefit of receiving support from the team so that the responsibility does not fall “solely on my shoulders.”

So I think just that strong staff member that has the time and the knowledge and experience to just sit and listen first without jumping to a whole bunch of conclusions and, ya know, making it a real big issue. Just listen for a second. I think that is I think number one support. Let's make sure we make a rational, informative decision going forward. Help direct when needed to.

Participants provided insight regarding specifics of the CART meeting. From those who had attended a meeting, they described liking the “short” length of the gathering and that they were “given direction” without a lot of “fluff”.

Everyone here understands that we need to talk about it, and help one another. We get together, after calling to set a time, and the discussion is usually brief. I explain the situation and a few others will give me feedback or give me supportive material from the law.

**Obstacles.** Some staff encountered opposition after deciding to report. Differing opinions caused noticeable discomfort for staff.

I need the support of my team and my superiors because I did have a case where I got a lot of... and people didn't agree that I should have reported, that I reported. And I got a lot of backlash from that about that and that was difficult. To have differing opinions about whether or not to call on what I had called on.

Some participants discussed additional obstacles and options for those who felt it may be easier to seek support from someone not "directly involved in the case". Some participants reflected on additional obstacles that may get in the way of seeking support from other staff.

I think what I, the support, ya know, it's hard because all of our schedules are so packed in here so you know, it's a lot of different factors that need to be considered. Trying to get a hold of people and find time ourselves. Some times the "time factor" may get in the way.

And again, that it's not a fearful thing to be able to go to your supervisor. If someone, I don't think this happens often, but maybe someone has a problem with their direct supervisor, that the center always gives us an alternative to that as well.

**Reporting Purpose**

Several participants provided insight into their perception of purpose for their continued efforts to report child abuse. Staff expressed how they, believe child abuse, “is a major problem” and reporting, “is right”. They see reporting as a way to “advocate” and “help” the patient “when they feel safe enough to talk to us”. Several also saw reporting as a process of “getting support” for families, and a way to “break the family cycle” while “educating on how to be good parents”.

So now I am comfortable to make the call and know that what I am doing is right. That's why we are here, to help not only the parent get sober, but to help the family heal.

Others mentioned another layer of purpose to include the simple fact that it is, “my job to report anything they tell me that has to do with child abuse”. Some felt an “obligation” because they are “mandated by law”. One also knew that reporting was, “a step, a precaution.” And that they, “definitely don't want to jeopardize the corporation at all.”

**Conclusion**

The researcher conducted nine in-person qualitative interviews, and one phone interview in which five separate themes emerged from this research. The participants provided insight into their perception of support provided by the substance abuse treatment hospital and how the current child abuse reporting policies contribute to their understanding of organizational protocol.

## **Chapter V – Discussion, Conclusions and Recommendations**

### **Introduction**

The purpose of this study is to evaluate whether or not mandated reporters feel they have adequate support, resources and policies in place to confidently report child abuse.

### **Conclusion**

Child abuse is a critical social issue that affects the welfare of millions of children and families throughout the United States. Reporting child abuse is a fundamental responsibility of alcohol and drug addiction hospital staff that has direct contact with patients. As mandated reporters, counselors are in a unique position to assist children in obtaining the necessary intervention to stop abuse and face a future with hope.

The findings demonstrate that staff encounters some confusion and misunderstanding of the organizational process to reporting child abuse during the course of their work, suggesting that there may be a need for more extensive and explicit training. Findings also corroborate the idea for continued support in making decisions to report child abuse.

There appears to be openness to talking to a superior about such concerns, and that there is general acceptance to team decision-making at an institutional level. Participation in consultations for staff could be considered as a useful method to build their capacity to deal with the complexity of drinking and driving situations, which is the largest recognized situation their clients reveal. Consultation processes provide an opportunity

for structured exploration of issues and may therefore provide a means for staff to identify and then engage with the challenges that they encounter in clinical practice.

The five emerging themes included training, hesitations, confidence, support and purpose. Many hesitations common to research were discovered, however, two reoccurring issues have not been well documented, drinking and driving which involves a substantial time lapse between incident and treatment being sought, and time issues involved in gathering a consultation team, such as CART.

## **Discussion**

Participants appear to take the role of mandated reporter seriously as evidenced by their ability to speak to the law, the policy and the support they seek. The overall findings reveal the main issues for current staff involve several aspects of training and the underutilization of the CART tool. Additional hesitations were only mentioned briefly and should be reviewed by additional studies.

The request for increased training was not surprising given the mention of infrequent training provided by the hospital on the matter. Additionally, the participant's request for training to involve alcohol and drug related scenarios or vignettes was supported in research by Alvarez et al. (2004).

Mandatory reporting carries a significant professional responsibility, with a focus on wanting to "get it right". This study revealed that decision-making is influenced by professional experience, prior experience of reporting and support. The data indicate that participants in the study are not immune to consulting with others prior to reporting child abuse; indeed, the majority agrees that the support received by fellow colleagues and by

their superiors in particular is vital to their rate of confidence, which was supported in the findings and recommendations of other researchers (Henderson, 2013; Flam, 2009; Francis et al., 2013).

Arranging to come together for case consultation with a multidisciplinary team can provide each department an opportunity to both present and to listen freely to each collaborative viewpoint and concerns and to listen to clear possible contrasting opinions. Thus, the consultation format can give an example of modeling non-intrusive and non-hierarchical collaboration.

The data, however, do not allow drawing conclusions about differences between consultation with one's immediate team and from other department staff involved in the CART team, as is the current policy at the hospital. This suggests that the use of CART is founded, however, clarification and expectations for the use of the policy need further development. The consultation format constitutes an invitation to share and to listen to experienced professionals from different areas and at the same time equally important departments represented.

It is suggested that the gap in utilization of CART may be due in part to the unnoticeable support and buy-in of the tool from all levels of leadership, as perceived by the lack of dialogue pertaining to the encouragement from team leaders or supervisors to call a CART meeting. The suggestion was also derived by the lack of knowledge for the CART policy in general from several participants. It is the responsibility of leadership to provide all resource material on the matter and to expect compliance.

There was no mention from participants concerning "reasonable suspicion", or the inability to determine if an incident was indeed reportable, as indicated by their

confidence supported by their years of fieldwork. The problem area for staff is not in distinguishing if an incident is reportable as child abuse or not, rather, the repeated problem came from the staffs' inability to determine if the organization would be in agreement, as evidenced in comments regarding "grey area" and receiving backlash from those who disagreed with their decision to report. Additionally, a problem area for staff appeared to regard the amount of time it takes to call a CART meeting and gather the members.

There was no significant existence of countertransference. Although one staff mentioned the hesitation, as it may be applicable to other counselors, it is suggested that the correlation between a counselor's personal experience (SAMSHA, 2000) and the requirements of their profession could clash and lead to underreporting. Research involving a counselor's personal experience with either DUIs or Child Abuse may give more insight.

Finally, hesitations involving interference in the therapeutic relationship between the client and the counselor were not raised. The dual relationship between mandated reporter and therapists did not seem to be a concern of the staff interviewed. The line of questioning may have contributed to the lack of data in this area, as no questions pertained to the aftermath of reporting patients and their subsequent therapeutic visits.

An unexpected finding was the reoccurring theme of purpose. Based on the data, the staff identifies with their responsibility as mandated reporters as defined by law. In addition, their purpose within the organization speaks to the mission and vision of the organization. Treatment of alcohol and drug addictions must involve recovery and support for the entire family.

**Limitations**

Respondents comprised only a small segment of the mandated reporter population of the hospital, however, the findings are consistent with a survey of clinical and research experts in child abuse (Levi & Crowell, 2010). Furthermore, the results may not accurately reflect the actual behavior of mandated reporters. Participant's behaviors may have been directly affected by the researchers role as the interviewer and also as a permanent member of the CART team. Consequently, it is noted that responses could have been altered due to the researchers role in current policies and procedures; therefore, future research should exclude any member of the policy or CART team as acting members of direct interviews. Furthermore, after review of the evaluation by stakeholders, it may be beneficial to share the results of the staff's perceptions and needs with middle management.

The sample included those from one particular alcohol and drug treatment hospital. Populations to include other addiction treatment hospitals should be considered. It is recommended that this study should be replicated with larger samples before the preliminary recommendations can be fully accepted.

The line of questioning should be extended to develop greater insight into the relationship subordinates have with their superiors that will help to establish cause for seeking support. In addition, this study did not explore the aftermath of reporting, and the effects that reporting will have on the therapeutic relationship between therapist and client. Further studies should explore this aspect to determine if training should involve matters of how to combat this particular hesitation.



This study shows that mandated reporters at the addiction hospital feel they have adequate support needed to fulfill their mandated responsibilities. However, it was determined that additional training and resources are needed. Additionally, policies need further development to potentially increase the participant's confidence in reporting child abuse.

### **Recommendations**

Mandated reporters are more likely to report if they feel they are professionally competent and confident in their ability to decide whether or not child abuse or neglect has occurred. Mandatory reporting policies have been presented in an in-service educational format by the addiction treatment hospital with the help of outside agencies. Employing bodies are encouraged to provide a suitable support mechanism to decrease confusion and increase perceived support by the entire organization. Organizations should be working with these agencies to establish vignettes related to the field the mandated reporters work in to decrease confusion in detecting child abuse. Such specificity in reporting practices is currently limited, therefore, training programs specific to the alcohol and drug addiction field need to be developed and formally evaluated in controlled outcome studies prior to implementation.

Participants reported feeling prepared for the process of reporting suspected child abuse or neglect and indicated that mandatory reporting was covered in their new hire orientation by means of reviewing the organizational policies. Some participants suggested education should be ongoing and presented more often. In addition to field-related vignettes, it is recommended that increased training intervals to refresh

established staff as well as to engage newer and less experienced staff be researched further.

For some, following the channels seem accepted practice; namely, reporting to their team leader. Drug and alcohol counselors tend to instigate a joint or collaborative inquiry within the healthcare team. There is evidence, however, that deterrents to the process exist. The main deterrents mentioned were scheduling time to gather the team, lack of clarity in CART participants and the sense that CPS should be called immediately if the information revealed is straightforward. The Abuse Reporting policy and CART policy should be reviewed and updated for staff to expedite the process. The CART process should be presented in such a way that provides staff the benefits and training opportunity to make informed decisions.

Because of the unfamiliarity with the concept of CART and consequent benefits, it is possible that building trust in the CART process and staff involved will be important to the success of the service. It is recommended that middle management gain a firmer understanding for the tool. Additional research on the matter may give insight into the breakdown. The existing risk that children exposed to abuse and violence do “fall through the cracks”, points to the importance of further studies of team practices. These outcomes, if further investigated, and supported by different health care institutions, have the potential to develop a more robust notion of team collaborative and specified training. Consideration of these recommendations could help to provide necessary support for mandated reporters while improving outcomes for children at risk.

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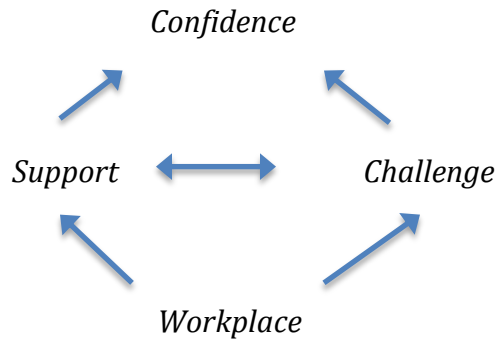
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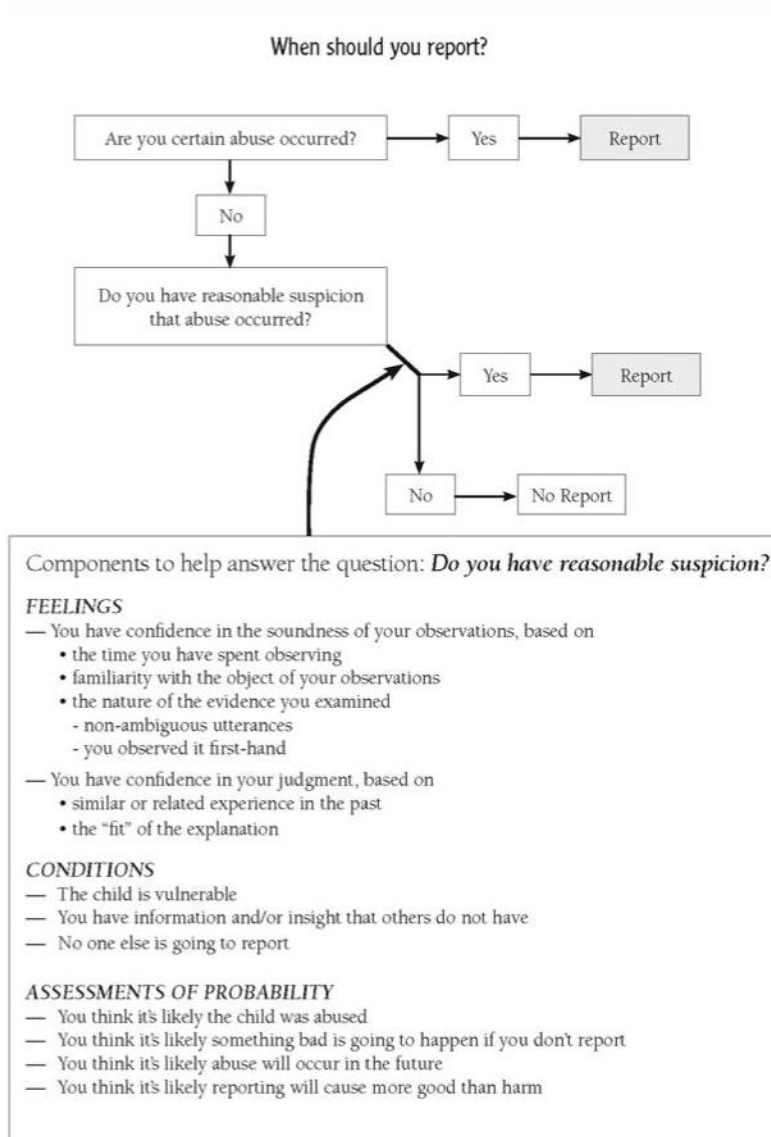
**Appendix A: Workplace Learning Factors**



*Resource: Factors Which Facilitate Workplace Learning: Confidence, Challenge and Support (Alderton, 1999).*

## Appendix B: Proposed Framework for Whether to Report Possible Abuse

(Note that at present there is no legal threshold that defines *reasonable suspicion* in terms of numerical probability.)



Resource: *Reasonable suspicion of child abuse: Finding a common language* (Levi & Portwood, 2011).



**Appendix C: Invitation to Participate**

Helene is conducting a research project for her Masters in Health Administration Program. She is in need of participation to answer questions about child abuse reporting in substance abuse hospitals. Please read the attached letter for more details (the Informed Consent).

Your participation is voluntary and would be appreciated. Your responses and participation will be completely confidential between you and Helene.

Let's help a fellow staff member achieve academic success.

Thank you in advance for your participation.

Director of Staff Development

**Appendix D: Consent Form**

I am a student working on my Master's in Health Administration at Regis University. My contact information is: hphotias@regis.edu and 760-837-8643. I am conducting a study entitled "An Evaluation of Child Abuse Reporting Policies in a Substance Abuse Treatment Hospital: Mandated Reporter's Perceptions of Support".

I am asking you to participate in this study because you are a mandated reporter at the hospital. Your participation is voluntary. Choosing not to participate will not affect your access to any goods or services. Any risks associated with this study are minimal. There are no direct benefits to participating in the study other than an opportunity to express your perception of support provided.

I will not be collecting any data that can link you to the answers you provide. Your anonymity and the confidentiality of your responses will be protected as much as possible. If you are uncomfortable answering any question, you may choose to not answer that question or to stop your participation and have any notes or recordings destroyed. To further protect the confidentiality of your responses, I will not be collecting a signed consent form but will instead consider your participation in the study as consent permitting me to collect the data you provide.

Should you have any questions or concerns about participation in this study, you may contact me using the contact information in the first paragraph. My faculty advisor is Dr. Tristen Amador. You may contact her by e-mail or phone with any questions or concerns at: tamador@regis.edu or 303-458-4146. You may also contact the Institutional Review Board (IRB) with any questions. The email address for the IRB is: irb@regis.edu. or you can contact the IRB by mail at: Regis University, Office of Academic Grants, 447 Main, Mail Code H-4, 3333 Regis Blvd. Denver, CO, 80221.

Sincerely,

Helene Photias

**Appendix E: Interview Questions**

1. Tell me about the child abuse cases you encounter the most with your clients.
2. Tell me about your comfort level with reporting child abuse.
3. What type of hesitations to reporting have you experienced?
4. What resources do you use when faced with suspicion of child abuse?
5. To whom might you go to for advice or support? Why?
6. Tell me about the training you received from your organization.
7. Have you called a CART meeting before?
  - a. Yes - Tell be about your experience.
  - b. No - Why not?
8. What kind of support do you need when reporting child abuse?
9. Describe your impression of the organization's policies for reporting child abuse.
10. Describe your impression of the organizations' CART policy.