GOOD INTENTIONS, QUESTIONABLE RESULTS: THE SHORTCOMINGS OF MANDATED REPORTING FOR CHILD MALTREATMENT

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INTRODUCTION

Child maltreatment is a worldwide health and social problem that negatively impacts the physical and psychological health of a significant number of children.¹ Each Canadian jurisdiction has a statute regulating child and family services that imposes a duty on all persons to report suspected child maltreatment.² These statutes include fines for professionals and officials working with children who fail to meet the duty to report.³ Health care professionals are one such group perceived to be in a position that allows them to sooner and better recognize signs of child maltreatment.⁴ Unfortunately, health care professionals experience a number of difficulties in addressing child maltreatment and meeting this duty to report. In practice, this has resulted in a troubling trend of under-reporting child maltreatment.

To be clear, child welfare legislation is not to blame for the trend of under-reporting. However, significant practical difficulties arise in the application of such legislation in the context of the Canadian health care system. To solve under-reporting problems in the health care context, changes need to be made in policy and practice. This paper will outline the shortcomings of mandatory reporting legislation, with a focus on the problem of under-reporting by health care professionals. Some potential legal and practical solutions to mitigate these shortcomings are then discussed.

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¹ Christine Wekerle, “Resilience in the Context of Child Maltreatment: Connections to the Practice of Mandatory Reporting” (2013) 37:2–3 *Child Abuse & Neglect* 93 at 94; see generally Canadian Child Welfare Research Portal, “Child Abuse and Neglect” (webpage), online: <cwrp.ca/child-abuse-neglect>.

² The provincial and territorial child and family service statutes across Canada have very similar language and goals when it comes to mandated reporting. To provide some focus, this paper will utilize the legislation in Ontario—the first province to adopt mandatory reporting legislation.

³ See e.g. Ontario’s *Child, Youth and Family Services Act*, SO 2017, c 14, Sched 1, ss 125(5)–(9) [CYFSA].

⁴ Under the CYFSA, the category of health care practitioners includes, but is not limited to, physicians, nurses, dentists, pharmacists, and psychologists.

I. AN OVERVIEW OF MANDATORY REPORTING UNDER ONTARIO'S *CHILD, YOUTH AND FAMILY SERVICES ACT*

In Ontario, the duty to report suspected child maltreatment is outlined in section 125 of the *Child, Youth and Family Services Act (CYFSA)* and applies to any person with reasonable grounds to suspect that a child is in need of protection.⁵ Suspicion that a child is in need of protection must be reported immediately and directly to a Children's Aid Society (CAS).⁶ The duty is ongoing, meaning that a suspecting person is required to make another report if additional reasonable grounds arise, even where they have already made a report, are aware of a previous report, or a CAS is already working with that child and family.⁷ Further, the obligation to report cannot be delayed or delegated by the suspecting person.

The duty to report prevails over any other statute, including the *Personal Health Information Protection Act, 2004*.⁸ Health care professionals are therefore legally required to report regardless of whether the information being disclosed would otherwise be protected by doctor-patient confidentiality.⁹ A person who complies with these reporting obligations is immune from liability, except where acting maliciously or without reasonable grounds to suspect maltreatment, even if the suspicions are later shown to be unfounded.¹⁰

Conversely, any person who performs professional or official duties with respect to children and *fails* to report a reasonable suspicion obtained in the course of his or her duties is guilty of an offence and liable to a fine of up to \$5,000.¹¹ Although the standard for reporting is the same for lay persons and professionals, this fine "recognizes that people working closely with children have a special awareness of the signs of child abuse and neglect" and places "special responsibilities" on professionals to identify and report suspicions of child maltreatment.¹² Additionally, this higher penalty "reflects the view that professionals are generally better informed about their

⁵ *CYFSA*, *supra* note 3, s 125(1). The meaning of these terms will be discussed in more depth below.

⁶ *Ibid*, ss 125(1), (3). Note that CAS refers to the Canadian organization for child protection services (CPS). However, the term CPS is also used in this paper when the applicable literature discusses CPS in the broader context. Moreover, CPS used hereto is not to be confused with the American organization, Child Protective Services.

⁷ *Ibid*, s 125(2).

⁸ *Ibid*, s 125(12); *Personal Health Information Protection Act, 2004*, SO 2004, c 3, Sched A, s 40(1).

⁹ *CYFSA*, *supra* note 3, s 125(1). However, s 125(11) states that the duty to report does not apply to information subject to solicitor-client privilege.

¹⁰ *Ibid*, s 125(10).

¹¹ *Ibid*, s 125(5), (6), (9).

¹² Ontario, Ministry of Children, Community and Social Services, *Reporting Child Abuse and Neglect: It's Your Duty: Your Responsibilities under the Child and Family Services Act* (Ottawa: Queen's Printer for Ontario, March 2018) at 4.

obligation to report and have special responsibilities to children.”¹³ Unfortunately, as explored below, professionals are not necessarily aware of the full extent of their obligations under the *CYFSA*. However, before turning to the shortcomings of mandatory reporting legislation, its advantages and the sound rationale for its enactment bear mentioning.

II. JUSTIFICATIONS AND BENEFITS OF MANDATORY REPORTING

There are many strong social policy reasons for mandatory reporting legislation.¹⁴ An estimated one-third of Canadians experience abuse before the age of 15 years.¹⁵ Moreover, many instances of family violence, and particularly abuse against young victims, often go unreported to police.¹⁶ More pertinent to mandatory reporting legislation, the majority of child maltreatment never comes to the attention of child protection services (CPS).¹⁷ Accordingly, it is unsurprising that great societal value is placed on facilitating the reporting of child maltreatment.

¹³ Health Canada, *Child Abuse: Reporting and Classification in Health Care Settings*, by Stanley K Loo et al, Catalogue No H49-123/1999E (Ottawa: Minister of Public Works and Government Services Canada, 1999) at 29.

¹⁴ See Statistics Canada, “Family Violence in Canada: A Statistical Profile, 2016,” by Marta Burczycka & Shana Conroy, *Juristat* 38:1 Catalogue No 85-002-X, (Ottawa: Statistics Canada, 17 January 2018) at 70–81; Statistics Canada, *Child Abuse and Physical Health in Adulthood*, by Tracie O Afifi et al, Catalogue No 82-003-X, 27:3 Health Reports 10 (Ottawa: Statistics Canada, 16 March 2016) (childhood abuse associated with physical conditions and self-perceived general health in adulthood); Statistics Canada, “Childhood Physical Abuse: Differences by Birth Cohort,” by Darcy Hango, Catalogue No 75-006-X, *Insights on Canadian Society* (Ottawa: Statistics Canada, 20 September 2017); Public Health Agency of Canada, “The Health and Social Impacts of Family Violence” (4 August 2014), online: <www.canada.ca/en/public-health/services/health-promotion/stop-family-violence/health-social-impacts-family-violence.html>; Tracie O Afifi et al, “Child Abuse and Mental Disorders in Canada” (2014) 186:9 CMAJ E324.

¹⁵ Public Health Agency of Canada, *The Chief Public Health Officer’s Report on the State of Public Health in Canada, 2016—A Focus on Family Violence in Canada*, by Gregory Taylor, Catalogue No HP2-1DE-PDF (Ottawa: Public Health Agency of Canada, October 2016) at 6; for global statistics, see Jill R McTavish et al, “Mandated Reporters’ Experiences with Reporting Child Maltreatment: A Meta-synthesis of Qualitative Studies” (2017) 7:10 BMJ Open 1.

¹⁶ Burczycka & Conroy, *supra* note 14 at 42, 70.

¹⁷ Wekerle, *supra* note 1 at 94, citing e.g. HL MacMillan, E Jamieson & CA Walsh, “Reported Contact with Child Protective Services Among Those Reporting Child Physical and Sexual Abuse: Results from a Community Survey (2003) 27 Child Abuse & Neglect 1397; see also Barbara Fallon et al, “Methodological Challenges in Measuring Child Maltreatment” (2010) 34 Child Abuse & Neglect 70 at 70-71 [Fallon et al, “Methodological Challenges”]; Carol McDonald & Marjorie McIntyre, *Realities of Canadian Nursing: Professional, Practice, and Power Issues*, 4th ed (Philadelphia, Wolters Kluwer Health, 2014) at 436, 442; Stanley K Loo et al, *supra* note 13 at 11, 17; Joan M Rankin & Amy E Ornstein, “A Commentary on Mandatory Reporting Legislation in the United States, Canada, and Australia: A Cross-Jurisdictional Review of Key Features, Differences, and Issues” (2009) 14:1 Child Maltreatment 12.

Since children and families affected by child maltreatment do not generally report it,¹⁸ mandatory reporting for all persons, and especially professionals, creates the opportunity for a “system of case-finding” to improve reporting rates.¹⁹ Early detection is critical because it often prevents serious injuries, relieves children of the burden to seek help for themselves, and “[enhances] coordination between legal, medical, and service responses.”²⁰ Considering the significant amount of child maltreatment that goes unreported and the high societal value placed on child protection, Canadian legislatures are certainly justified in mandating that communities work together to better identify and respond to child maltreatment.

In addition to the immediate protection of the child in danger, mandatory reporting has the following benefits: (1) preventing re-victimization and victimization of other children, such as the victim’s siblings; (2) official moral condemnation of child maltreatment; and (3) service provision, direct resource allocation, family support, and “linkages that may contribute to minimizing family stress, maltreatment-related impairment, and optimizing trajectories of healthy living.”²¹ As Christine Wekerle notes, “[r]esilience begins with that first experience of adversity. Maltreatment is impairing and preventable, but that first call to [CPS], reporting the suspicion of maltreatment, needs to happen.”²² Given low reporting rates, legally requiring all persons to report is intended to ensure children in need of protection can be recognized, assisted, and kept safe.²³

It also makes sense to place a higher responsibility on health care professionals. As Pietrantonio et al note, “[g]iven their role with children and families, health professionals are in a unique position to intervene on behalf of children and to advocate for their welfare and protection.”²⁴ Additionally, given their training and experience, health care professionals are often better able to identify the less apparent forms of

¹⁸ Ben Mathews & Donald C Bross, “Mandated Reporting is Still a Policy with Reason: Empirical Evidence and Philosophical Grounds” (2008) 32 *Child Abuse & Neglect* 511 at 512, citing Nico Trocmé et al, *Canadian Incidence Study of Reported Child Abuse and Neglect—2003: Major Findings* (Ottawa: Public Health Agency of Canada, 2005) at 86 (where it was found that, in Canada, child victims accounted for only a mere 2 per cent of substantiated reports and parents made up only 11 per cent).

¹⁹ Wekerle, *supra* note 1 at 95.

²⁰ Anna Marie Pietrantonio et al, “Mandatory Reporting of Child Abuse and Neglect: Crafting a Positive Process for Health Professionals and Caregivers” (2013) 37 *Child Abuse & Neglect* 102 at 103.

²¹ Wekerle, *supra* note 1 at 95.

²² *Ibid* at 98.

²³ See e.g. Diane Walters, “Mandatory Reporting of Child Abuse: Legal, Ethical and Clinical Implications Within a Canadian Context” (1995) 36:3 *Canadian Psychology* 163 at 166: “Having all persons mandated to report is helpful in those cases where there are preschool-age children who do not attend day care centres and who therefore are not typically in contact with professionals until their cases are severe enough to require medical attention.”

²⁴ Pietrantonio et al, *supra* note 20 at 102.

maltreatment.²⁵ Health care professionals—especially those delivering public health programs and those in community and primary health care settings—have opportunities to conduct in-depth physical and psychological assessments of children, to develop trusting relationships with patients, and to “observe child and family interactions over time.”²⁶

In light of the trend of under-reporting, it is clear that mandatory reporting regimes are generally beneficial. In theory, considering health care professionals’ ability to sooner and better recognize child maltreatment, it should also be beneficial to impose a higher responsibility on them. However, despite the implementation of mandatory reporting regimes across Canada, under-reporting is still a major problem among health care professionals because of a variety of practical difficulties in its implementation. These practical difficulties must be addressed before statutes like the *CYFSA* can effectively achieve their purpose.

III. PRACTICAL DIFFICULTIES: WHY HEALTH CARE PROFESSIONALS STILL FAIL TO REPORT

Despite the development of mandatory reporting legislation across Canada, most child maltreatment is never officially reported to CPS,²⁷ a significant part of which is due to the alarmingly low level of reporting among health care professionals.²⁸ This trend is surprising considering the liability for failing to report and the low thresholds created by Canadian legislation, which focuses on suspicion of risk of harm rather than knowledge thereof.²⁹ Contemporary reporting requirements began in the United States and in Canada for the specific purpose of rectifying “the problem of physicians failing to report child abuse.”³⁰ Despite health care professionals’ higher degree of responsibility to report child maltreatment, they account for only a small percentage of reports to CAS.³¹ In 2013, reports by professionals (including those of school and police forces) constituted 75 per cent of all investigations conducted in Canada, but

²⁵ Lil Tonmyr et al, “Patterns of Reporting by Health Care and Nonhealth Care Professionals to Child Protection Services in Canada” (2010) 15:8 J Paediatrics & Child Health e25 at e25.

²⁶ *Ibid* at e27–e28, e30.

²⁷ *Ibid* at e30, citing e.g. MacMillan, Jamieson & Walsh, *supra* note 17 at 1401–2 (only a small percentage of Canadian children exposed to either physical abuse [5 per cent] or sexual abuse [9 per cent] are ever officially reported to a child protection agency); see also Fallon et al, “Methodological Challenges,” *supra* note 17 at 70–71; McDonald & McIntyre, *supra* note 17 at 436, 442.

²⁸ Tonmyr et al, *supra* note 25 at e30; see also Pietrantonio et al, *supra* note 20 at 103–4; Anne Vulliamy & Richard Sullivan, “Reporting Child Abuse: Pediatricians’ Experiences With the Child Protection System” (2000) 24:11 Child Abuse & Neglect 1461 at 1462; Ruth Gilbert et al, “Recognizing and Responding to Child Maltreatment” (2009) 373:9658 Lancet 167 at 167; McDonald & McIntyre, *supra* note 17 at 436; Mathews & Bross, *supra* note 18 at 512.

²⁹ Wekerle, *supra* note 1 at 96.

³⁰ Vulliamy & Sullivan, *supra* note 28 at 1462.

³¹ Tonmyr et al, *supra* note 25 at e27; Wekerle, *supra* note 1 at 96.

community health and social services accounted for only 9 per cent of the reports made and hospital personnel accounted for only 5 per cent.³² Despite the good intentions underlying mandatory reporting, practical difficulties still generate a pattern of under-reporting, thereby preventing the success of mandatory reporting regimes. To solve the problem, reasons for under-reporting among health care professionals must be identified, understood, and addressed. The remainder of this section canvasses a growing amount of research that has focused on identifying why health care professionals may fail or refuse to report when required to do so.

Lack of Understanding of Reporting Legislation

Section 125(1) of the *CYFSA* provides a list of circumstances that will trigger the duty to report. To summarize, such circumstances can be organized into four groups: (1) physical harm; (2) sexual harm; (3) mental, emotional or developmental harm; and (4) parent is unavailable. Section 125 goes on to explain each group in detail.³³ Despite these detailed descriptions, individuals are uncertain about when to report. Despite the very inclusive language used throughout “duty to report” provisions, interpretive difficulties related to such provisions arise for mandated reporters. This section outlines some of these difficulties with reference to section 125(1) of Ontario’s *CYFSA*. Broadness in statutory definitions of “child in need of protection” is intentional and certainly desirable to the extent that it encourages a wider range of maltreatment reports. However, such broad definitions also complicate the decision-making process of potential reporters since much of the language used in reporting provisions is intentionally vague.³⁴

Anyone with “reasonable grounds to suspect” child maltreatment is required to report their suspicions to a CAS.³⁵ According to the Ontario Association of Children’s Aid Societies, “‘reasonable grounds’ refers to the information that an average person, using normal and honest judgment, would need in order to decide to report”³⁶ and it is a standard that Ontario courts have interpreted as a “low threshold for reporting.”³⁷ While

³² Barbara Fallon et al, *Ontario Incidence Study of Reported Child Abuse and Neglect—2013 (OIS-2013)* (Toronto: Child Welfare Research Portal, 2015) at 48 [Fallon et al, “Ontario Incidence Study”] (these percentages are similar to those in 2008, where professionals constituted 71 per cent of reports, community, health or social services constituted 12 per cent, and hospital personnel constituted 5 per cent); see also Pietrantonio et al, *supra* note 20 at 103.

³³ *CYFSA*, *supra* note 3, s 125(1)1–13.

³⁴ Walters, *supra* note 23 at 165.

³⁵ *CYFSA*, *supra* note 3, s 125(1).

³⁶ Ontario, Ministry of Children, Community and Social Services, *Reporting Child Abuse and Neglect: It’s Your Duty* (Queen’s Printer for Ontario, 2018) at 3: The Ontario Government also uses this definition of “reasonable grounds to suspect.”

³⁷ Ontario Association of Children’s Aid Societies, “Duty to Report” (2018), online: <oacas.org/childrens-aid-child-protection/duty-to-report> [OACAS]; see e.g. *BK2 v Chatham-Kent*

this information is helpful, communication of this low threshold to mandated reporters remains an issue, which is clear from the fact that many are still unsure of when there are “reasonable grounds” to report. Although health care professionals are largely responsible for properly educating themselves on their legal responsibilities, many are falling short. For this reason, further steps must be taken to ensure such an education is achieved.

Research shows that interpretation and application of the term “reasonable grounds to suspect” among various professionals is variable and inconsistent, and therefore “standardized training and evaluation” is required.³⁸ Studies show that this lack of communication may contribute to physicians’ hesitance to report child abuse.³⁹ Health care professionals with concerns about a child may fail to report entirely, or defer reporting until their reasonable suspicions become stronger.⁴⁰ Therefore, it is important for professionals to become better informed with regard to the degree of certainty in their minds that triggers their legal duty to report.⁴¹

Communication issues also arise when a child is suspected to be at risk of any of the types of harms listed in the *CYFSA*.⁴² While it is an admirable legislative goal to prevent future child maltreatment, this broad definition of “child in need of protection” requires reporters to engage in a difficult assessment of the likelihood of harm occurring in the future. This is even more problematic for laypersons and other types of professionals dealing with children, many of whom are usually less well placed than health care professionals to assess a child’s level of risk.

Unsurprisingly, children who have sustained injuries are reported more often than children only at risk of harm.⁴³ Since risk of harm is just as reportable as actual harm, efforts should be made to clarify what exactly constitutes reportable risk of harm. Mandatory reporting legislation across Canada requires reporting past, present, and future risk of or actual maltreatment. It is concerning that many potential reporters may feel the need to report only present or particularly imminent risk of maltreatment, when the legislation clearly mandates reports in a much wider range of circumstances. Efforts need to be made to make this clear to all reporters, especially professionals.

Children’s Services, 2016 ONSC 1921 at para 51 (where an Ontario court has firmly held the threshold to be “very low”).

³⁸ Wekerle, *supra* note 1 at 104, citing Kathryn Crowell & Benjamin H Levi, “Mandated Reporting Thresholds for Community Professionals” (2012) 91:1 *Child Welfare* 35 (although this was a US study, it examined how mandated reporters interpret “reasonable suspicion,” which is the same language used in the *CYFSA*).

³⁹ Pietrantonio et al, *supra* note 20 at 104.

⁴⁰ Walters, *supra* note 23 at 171, 173–74.

⁴¹ *Ibid* at 167.

⁴² *Supra* note 3, s 125(1).

⁴³ Tonmyr et al, *supra* note 25 at e30.

The statutory criteria for what constitutes “emotional maltreatment” is also incorrectly applied by many would-be reporters.⁴⁴ Unlike most provinces in Canada, Ontario’s legislation does not explicitly recognize a child exposed to intimate partner violence (IPV) as qualifying as a “child in need of protection.” However, the *CYFSA* provisions relating to emotional harm or even risk of physical harm may include situations involving a child exposed to IPV.⁴⁵ For instance, if “[t]he child has suffered emotional harm, demonstrated by serious (i) anxiety, (ii) depression,” and so on, “and there are reasonable grounds to believe that” such harm is the result of IPV, then the situation is reportable.⁴⁶

Despite the clear statutory criteria, determining whether IPV constitutes a reportable situation is inherently more difficult than with other types of harm. What if IPV is present in the home but the child has not actually been in the room when it occurred? What if IPV is heard but not seen by the child? What if IPV is emotional or psychological in nature rather than physical? Hearing about such situations and observing a child’s anxiety, depression, withdrawal, and so on, may lead a potential reporter to have to guess whether IPV is the cause.

Moreover, these are difficult situations for potential reporters who do not want to exacerbate family problems by reporting when the child has not and will not be harmed. For example, a study focused on public health nurses shows that despite the low threshold for reporting, deciding whether IPV exposure constitutes a risk or the presence of “emotional harm” leads to many competing considerations:

[If a nurse reports child maltreatment] where it is not legally justified, this may not only harm her relationship with the client, but also inappropriately breaks confidentiality. However, if a nurse does not contact [CPS] after an instance of child maltreatment that is reportable, she may face legal ramifications of failure to report. ... Focus groups with nurse home visitors in a large home visitation program revealed that nurses were aware of their reporting duties when it came to abuse and neglect perpetrated against children; however, they expressed uncertainty about the circumstances under which more indirect forms of maltreatment, such as children’s exposure to IPV should be reported.⁴⁷

⁴⁴ Lea Tufford, Faye Mishna & Tara Black, “Mandatory Reporting and Child Exposure to Domestic Violence: Issues Regarding the Therapeutic Alliance With Couples” (2010) 38 *Clinical Social Work J* 426 at 428.

⁴⁵ Danielle M Davidov et al, “Nurse Home Visitors’ Perspectives of Mandatory Reporting of Children’s Exposure to Intimate Partner Violence to Child Protection Agencies” (2012) 29:5 *Public Health Nursing* 412 at 413.

⁴⁶ *CYFSA*, *supra* note 3, s 125(1).

⁴⁷ Davidov et al, *supra* note 45 at 414.

Many nurses in the study did not know whether various levels of children's exposure to IPV constituted child maltreatment or if they would report the hypothetical cases described to them.⁴⁸ Exposure to IPV is merely one type of harm where reporting decisions are anything but simple, even for health care professionals.

Regardless of the language used in any given mandatory reporting regime, there will always be uncertainty in deciding when a child needs protection, because everyone, including professionals, has different sensitivities about what constitutes "reasonable grounds to suspect." For example, individuals may have varying beliefs about how far a caregiver can go in disciplining a child before the behaviour constitutes a risk of or the presence of physical harm. Variability in interpreting whether reporting is required is clearly an issue that must be addressed if mandatory reporting is to be practical and consistent, and ultimately successful.

Uncertainty as to the circumstances and degree of evidence that trigger a mandated report have been factors commonly associated with anxiety, confusion, and ultimate failure to report in the health care sector, both in Ontario and across Canada.⁴⁹ The public health nurse study mentioned above provides a typical example of the significant variability and uncertainty in participants' knowledge and attitudes as to what circumstances constitute "reasonable grounds to suspect."⁵⁰

Additionally, even when health care professionals decide to make a report, they are sometimes unsure of the basic practice and procedure for reporting. Pietrantonio et al identify that "lack of knowledge in understanding the process of initiating a report to [CPS] where mandated by law" is one of the main barriers to addressing suspected child maltreatment and contributes to health professionals' failure to report.⁵¹ Beyond these issues, there are many other factors that contribute to the pattern of health care professionals frequently ignoring their duty to report, including potential legal consequences.

Concerns Regarding the Legal Consequences of Reporting to Child Protection Services

As noted above, no legal action lies against a reporter who complies with the mandatory reporting provisions.⁵² The only way that liability might arise is if there is evidence of malice—intent to cause harm to the family—or no reasonable grounds for

⁴⁸ *Ibid* at 419.

⁴⁹ Walters, *supra* note 23 at 171; Vulliamy & Sullivan, *supra* note 28 at 1462; Ramona Alaggia et al, "In Whose Best Interest? A Canadian Case Study of the Impact of Child Welfare Policies in Cases of Domestic Violence" (2007) 7:4 Brief Treatment & Crisis Intervention 275 at 281.

⁵⁰ Davidov et al, *supra* note 45.

⁵¹ Pietrantonio et al, *supra* note 20 at 102.

⁵² *CYFSA*, *supra* note 3, ss 125(10), 126(2).

the suspicion.⁵³ There is very little case law that deals with reporter liability, and courts have tended to rule in favour of defendant reporters to protect their legal immunity in the few cases that do exist.⁵⁴ Despite legislative and judicial protections for good faith reporters, fear of legal consequences has been cited as a barrier to mandatory reporting by various health care professionals.⁵⁵

Experience with the court system has been found to reduce the likelihood of reporting to CPS in the future. As a study in the United States reveals, “particularly negative experiences in court are associated with reporting behavior among physicians.”⁵⁶ Physicians with any negative court experiences were more likely to have negative views of the entire process of caring for children experiencing maltreatment and were twice as likely not to report suspicions.⁵⁷ Additionally, personal costs to the potential reporter, including filing the report and attending court, are key reasons why physicians fail to report.⁵⁸

Lack of Faith in Child Protection Services

Another frequently identified reason for the reluctance of health care professionals to report is the fear of subsequent mishandling of the case by CPS, which might result in further harm to the child.⁵⁹ This is not necessarily an unfounded fear, and it sometimes has a basis in prior negative experiences in dealing with CPS.⁶⁰ One argument that has been made against mandatory reporting legislation is that it further strains an already overburdened child protection system.⁶¹ Therefore, some physicians feel they are “better equipped to address the concerns directly with the family” as an alternative.⁶² They fear reports to CPS will be inadequate and will merely disrupt family harmony. However, these concerns may be mere misconceptions attributable to a lack

⁵³ *Ibid.*, s 125(10).

⁵⁴ *Rolon v Bell*, 2015 ONSC 6042 (in which a nurse’s statements were found to be inaccurate and defamatory but a motion to strike was granted due to the liability immunity for good faith reports provided by the *CYFSA*); *BK2 v Chatham-Kent Children’s Services*, *supra* note 37 (in which a doctor reported a child patient’s untruthful allegations of physical and sexual abuse by the plaintiff father who was ultimately charged criminally and had child protection proceedings brought against him. Despite the plaintiff’s serious health consequences, emotional distress, and status on the Child Abuse Register that resulted from this, a negligence claim against the doctor was struck).

⁵⁵ Tonmyr et al, *supra* note 25 at e30.

⁵⁶ Adrea D Theodore & Desmond K Runyan, “A Survey of Pediatricians’ Attitudes and Experiences with Court in Cases of Child Maltreatment” (2006) 30 *Child Abuse & Neglect* 1353 at 1360.

⁵⁷ *Ibid.*

⁵⁸ Vulliamy & Sullivan, *supra* note 28 at 1462, 1468.

⁵⁹ Walters, *supra* note 23 at 171.

⁶⁰ Pietrantonio, *supra* note 20 at 104–5.

⁶¹ Tonmyr et al, *supra* note 25 at e30.

⁶² Pietrantonio, *supra* note 20 at 104–5.

of communication between health care professionals and CPS, and unrealistic expectations or general lack of awareness of the role of CPS.⁶³

Another major issue that health care professionals have with CPS is their lack of involvement in the CPS process.⁶⁴ Once a report is made, health care reporters are no longer active participants in the resolution process and CPS is not bound to consider their recommendations. This leaves health care professionals feeling as though they are “triggering a process over which they may not have any control or influence,”⁶⁵ which is a particularly discouraging factor for health care professionals who are very close or loyal to the child or their family. If a health care professional personally feels this way, they are less likely to make that report in the first place.⁶⁶

Finally, health care professionals are troubled by the fact that patients and clients are often terrified of CPS’s involvement. The *CYFSA* maintains that the autonomy and integrity of family units needs to be protected and that responses to families or children in need of protection should be as non-disruptive as possible.⁶⁷ Unfortunately, this does not change the fact that many families—and significantly, non-perpetrators in the home such as women who are also victims of maltreatment—still feel intruded upon, threatened, intimidated, and blamed when CPS perform investigations.⁶⁸ This is why health care professionals are receptive to such concerns when families express them. For example, public health nurses who provide home-visitation services have described reporting-related challenges when dealing with client fears and the misconception that mere involvement with CPS means their child will be removed from their care.⁶⁹ These are common concerns even though in 97 per cent of cases this does not happen.⁷⁰

Concerns Regarding the Maintenance and Effectiveness of the Professional–Patient Relationship

Despite the statutory exception to confidentiality for mandatory reporting,⁷¹ health care professionals still have valid concerns about breaching confidentiality that render them reluctant to report.⁷² In fact, one of the most frequently cited reasons for health care professionals’ reluctance to report is to avoid the nearly inevitable

⁶³ Vulliamy & Sullivan, *supra* note 28 at 1463.

⁶⁴ Walters, *supra* note 23 at 174–75.

⁶⁵ *Ibid* at 174.

⁶⁶ Vulliamy & Sullivan, *supra* note 28 at 1463.

⁶⁷ *CYFSA*, *supra* note 3, s 1(2).

⁶⁸ Alaggia et al, *supra* note 49 at 281.

⁶⁹ Danielle Davidov et al, “Mandatory Reporting in the Context of Home Visitation Programs: Intimate Partner Violence and Children’s Exposure to Intimate Partner Violence” (2012) 18:5 *Violence Against Women* 595 at 600–1.

⁷⁰ Fallon et al, “Ontario Incidence Study,” *supra* note 32 at 50.

⁷¹ *CYFSA*, *supra* note 3, ss 125(1), (12).

⁷² Walters, *supra* note 23 at 171; Vulliamy & Sullivan, *supra* note 28 at 1462.

deterioration of the clinical relationship with the child and family in question.⁷³ The relationship is at risk because of the inherent breach of trust involved in reporting to CPS. Even if the relationship remains intact, its effectiveness is at risk because patients are less willing to disclose important information to the professional, particularly that related to the maltreatment itself.⁷⁴ The potential for mandatory reports to damage or destroy these relationships has very significant health care implications. The “therapeutic alliance” between health care professionals and their patients is “integral across treatment modalities and is a powerful predictor of outcome despite clinician adherence to specific therapeutic approaches.”⁷⁵ Physicians are justifiably afraid that patients will seek another physician, or even fail to seek any health care at all.⁷⁶

Health care professionals’ fear of damaging patient relationships is no doubt aggravated by the high rate of unsubstantiated reports to CPS. For instance, in Ontario in 2013, 39 per cent of maltreatment investigations were unfounded, meaning that the balance of evidence indicated that abuse or neglect had not occurred, while only 34 per cent of investigations were substantiated.⁷⁷ One study noted that “[a] report which is substantiated in the eyes of a clinician but not by child welfare services can be confusing and frustrating for the clinician who determined it was necessary to report the situation and who worked to manage the client’s emotions during this process.”⁷⁸ Professionals are hesitant to risk harming the relationship with their patients when a report is unlikely to result in any assistance from CPS. As a result, reporting may result in no CPS assistance *and* the loss of effective medical treatment should the professional–patient relationship be destroyed.

Health care professionals who deliver intimate, continuing health care programs—for example, a program where public health nurses provide home visitation to first-time, low-income mothers—may grow very attached to the families they serve and want to protect them from this type of situation. Conversely, health care professionals may also want to protect families from “inappropriate intervention from child protection agencies.”⁷⁹ An eloquent summary of these concerns is provided by Diane Walters: “The challenge, then, becomes how to comply with the mandated child protective reporting laws while maintaining the proper balance between the child’s need for protection, confidentiality and other ethical principles, and preserving the therapeutic relationship.”⁸⁰ This balancing act is understandably complex—as

⁷³ Pietrantonio et al, *supra* note 20 at 105; Tonmyr et al, *supra* note 25 at e30.

⁷⁴ Walters, *supra* note 23 at 171.

⁷⁵ Tufford, Mishna & Black, *supra* note 44 at 426.

⁷⁶ Tonmyr et al, *supra* note 25 at e30.

⁷⁷ Fallon et al, “Ontario Incidence Study,” *supra* note 32 at 12.

⁷⁸ Tufford, Mishna & Black, *supra* note 44 at 428.

⁷⁹ Tonmyr et al, *supra* note 25 at e30.

⁸⁰ Walters, *supra* note 23 at 172.

competing ethical principles often are—and is only one of the many justifications health care professionals have for failing to report.

IV. POSSIBLE SOLUTIONS TO ADDRESS NON-REPORTING BY HEALTH CARE PROFESSIONALS

The under-reporting of child maltreatment is a very serious problem that must be addressed to preserve the goal of adequately protecting Canadian children. Even where it may seem that reporting is not in a child's best interest at a particular time, delayed or failed reporting may have drastic and even fatal consequences for that child or other children later on. Pietrantonio et al point out that "poor recognition and reporting of suspected maltreatment may leave children vulnerable to continued victimization and the potential resulting morbidity and mortality."⁸¹ The authors further argue that abuse is likely to reoccur in substantiated maltreatment cases, with 58 per cent of such cases in 2008 involving multiple incidents of maltreatment.⁸² Other children in the child's family are also more at risk than children who are in families where maltreatment does not exist.⁸³ All of this reinforces the need to encourage reporting among health care professionals. Accordingly, this section outlines a number of possible methods for addressing and mitigating the practical difficulties outlined above, thereby reducing under-reporting among health care professionals and enabling mandatory reporting legislation to finally achieve its purpose.

Increased Penalties in the Existing Framework

Although under-reporting is still an issue, mandatory reporting does increase detection of child maltreatment and generally protect harmed children.⁸⁴ Therefore, an argument can be made that part of the solution to under-reporting is simply encouraging compliance with the current regime by implementing harsher consequences for those who fail to report. In Ontario, this could mean increasing the \$5,000 fine and adding the potential for imprisonment. However, there is already significant variation in the maximum penalties for failing to report child maltreatment across Canada,⁸⁵ the highest of which fail to make a difference in rates of reporting. For instance, under British Columbia's *Child, Family and Community Service Act*, anyone who fails to report is subject to a fine of up to \$10,000 and/or jail for up to six months.⁸⁶ Likewise, under Alberta's *Child, Youth and Family Enhancement Act*, failure to report can result in a

⁸¹ Pietrantonio et al, *supra* note 20 at 104.

⁸² *Ibid.*

⁸³ *Ibid.*

⁸⁴ Tonmyr et al, *supra* note 25 at e30.

⁸⁵ Loo et al, *supra* note 13 at 29.

⁸⁶ *Child, Family and Community Service Act*, RSBC 1996, c 46, s 14(6).

fine of up to \$2,000 and a jail term of up to six months for default of payment.⁸⁷ Despite this penal provision, health care professionals in Alberta still have relatively low rates of reporting compared to other professionals.⁸⁸ As Loo et al assert, “[i]t is apparent that, for most individuals, the threat of prosecution is not a major factor in their decision to report.”⁸⁹ Accordingly, merely imposing higher penalties on non-reporting health care professionals would be an ineffective and ill-advised measure to reduce under-reporting. Instead, it would likely be more effective to address the practical problems experienced by mandated reporters that were outlined above. Potential legislative changes to increase penalties should not be considered until good faith attempts to solve under-reporting are made by way of changes to health care policy and practice. Accordingly, the following subsections outline some promising non-legislative solutions—namely, changes in health care practice that could be made to alleviate the trend of under-reporting.

Better Tools, Training, Education, and Support for Health Care Professionals

Evidence suggests that many health care professionals do not feel adequately trained to identify child maltreatment.⁹⁰ As a first and immediate response, hospitals and other health care facilities should ensure that they have the proper clinical tools available to help professionals recognize when child maltreatment is present. For example, the use of maltreatment checklists used in hospital emergency departments is promising. However, Wekerle points out that such checklists need to meet sensitivity and specificity requirements before becoming effective.⁹¹ An interesting strategy used in the Netherlands was to mandate screening for child abuse and neglect in emergency departments. As Wekerle describes, “[u]sing a screening checklist, along with staff training and physician follow-up, systematic screening increased the abuse detection rate 5-fold in a sample of over 100,000 cases from 7 hospitals over a 22-month period.”⁹² Therefore, the screening tools given to health care professionals can assist with identification, but tools alone are insufficient to alleviate the reporting concerns of health care professionals. Addressing under-reporting must begin with training, education, and support regarding child maltreatment generally and the intricacies of the duty to report.

⁸⁷ *Child, Youth and Family Enhancement Act*, RSA 2000, c C-12, s 4(6).

⁸⁸ Bruce MacLaurin et al, *Alberta Incidence Study of Reported Child Abuse and Neglect (AIS-2008): Major Findings* (Calgary: Faculty of Social Work, University of Calgary, 2013) at 20–21 (70 per cent of investigations in Alberta were referred by professionals, but community, health, and social services accounted for only 11 per cent of reports and hospital personnel accounted for only 6 per cent of reports).

⁸⁹ Loo et al, *supra* note 13 at 29.

⁹⁰ Theodore & Runyan, *supra* note 56 at 1361; Pietrantonio et al, *supra* note 20 at 104.

⁹¹ Wekerle, *supra* note 1 at 97.

⁹² *Ibid.*

Contributing to the practical problems outlined above is the startling lack of training for health care professionals with regard to child maltreatment and mandatory reporting. Unsurprisingly, the likelihood of reporting among practising physicians positively correlates with the amount of training they receive.⁹³ Therefore, mandatory training would likely reduce concerns cited by physicians that contribute to under-reporting. Training for professionals specific to reporting child maltreatment has been shown to result in improved knowledge of reporting legislation, improved relevant clinical skills, and ultimately a higher likelihood of reporting.⁹⁴ Nearly all studies related to mandatory reporting in the health care context conclude that ongoing, consistent, standardized, and evidence-based training and guidance is needed in the area of child maltreatment generally and the duty of health care professionals to report.⁹⁵

Multiple studies show that medical professionals—including medical students, residents, and even those with many years of experience—feel that they are inadequately trained with respect to identifying, responding to, and reporting child maltreatment.⁹⁶ For example, a study involving Canadian pediatric residents found that 92 per cent of residents want more extensive educational programs with regard to child protection.⁹⁷ At the time of this study in 2004, only 3 of 16 Canadian pediatric academic centres required clinical training in child protection for residents and none of the programs used a formal curriculum. Nine programs offered optional rotations devoted to child protection, but only 4.7 per cent of the residents surveyed had completed it, and seven of the programs did not offer either mandatory or elective clinical rotations.⁹⁸ Even senior residents reported having seen very few cases of suspected child maltreatment, which is significant considering exposure to these cases was found to be related to self-perceived competency in evaluating and managing cases of child maltreatment.⁹⁹

It is important for the training of health care professionals to incorporate a practical element that allows them to transfer their knowledge, develop their skills, and become more comfortable identifying, responding, and reporting child maltreatment.¹⁰⁰ Considering that 92 per cent of residents who had done a child protection rotation during their medical training reported feeling more competent in dealing with child maltreatment, it would be useful to implement mandatory child protection rotations into

⁹³ Michelle Ward et al, “Child Protection: A Neglected Area of Pediatric Residency Training” (2004) 28:10 Child Abuse & Neglect 1113 at 1117.

⁹⁴ Pietrantonio et al, *supra* note 20 at 105.

⁹⁵ Ward et al, *supra* note 93 at 1120; Davidov et al, *supra* note 45 at 419; Wekerle, *supra* note 1 at 98; Pietrantonio et al, *supra* note 20 at 107.

⁹⁶ Pietrantonio et al, *supra* note 20 at 104.

⁹⁷ Ward et al, *supra* note 93 at 1118.

⁹⁸ *Ibid* at 1117.

⁹⁹ *Ibid* at 1119.

¹⁰⁰ Pietrantonio et al, *supra* note 20 at 104.

the training of health care professionals. Mandating these rotations is arguably necessary because although nearly all the residents felt they needed more child protection training, only 40 per cent planned to pursue further training.¹⁰¹ If reporting child maltreatment to CPS is mandated, it is logical that training in the area of child protection be mandated as well. A majority of residents felt that training needed improvement and many went as far as to say that the training was inadequate.¹⁰² Interestingly, pediatric residents—one of the most likely types of health care professionals to encounter child maltreatment—identified deficiencies in training on the legal aspects of child protection.¹⁰³ However, other aspects of health care professionals' training also bear mentioning.

Effective training is certainly needed in the areas of interpreting child maltreatment legislation, local or job-specific reporting practices, and more practical legal components such as what is expected of professionals when they are testifying in court or preparing an abuse case summary.¹⁰⁴ Moreover, improvements are required in better understanding of more complicated maltreatment cases such as those involving emotional harm. For example, exposure to IPV and its impact on child health, behaviour, and development is not well understood by professionals.¹⁰⁵

Support for professionals is also recommended to help them manage the responsibilities of reporting and maintaining therapeutic, trusting relationships with patients.¹⁰⁶ Additionally, a growing body of research on preserving the relationship between families and mandated health professional reporters is instructive. It looks at factors that influence this type of relationship and outlines the most effective ways that health care professionals can fulfill their duty to report while avoiding some of the concerns outlined above.¹⁰⁷ Incorporating these patient-sensitive reporting frameworks into the training of mandated reporters could serve to preserve professional–patient relationships as well as significantly improve the confidence of professionals when they make reporting decisions. These are only a few suggestions, and there is still a great need for research into the development and evolution of “core maltreatment curricula for mandated professionals.”¹⁰⁸ Effective training in all areas will reduce confusion and

¹⁰¹ Ward et al, *supra* note 93 at 1118.

¹⁰² *Ibid* at 1116.

¹⁰³ *Ibid* at 1117.

¹⁰⁴ *Ibid* at 1118. For an example of what can be done to better prepare physicians for the court process, see Theodore & Runyan, *supra* note 56 at 1361: “Court attorneys and assistants could make it standard practice to contact physicians in advance of court cases and be more considerate of practicing physicians’ time constraints in scheduling court cases requiring physician testimony.” This study also recommended reducing the negative effects of the court process on children, which could potentially mitigate reporter concerns about subjecting them to court.

¹⁰⁵ Davidov et al, *supra* note 45 at 413.

¹⁰⁶ *Ibid* at 420.

¹⁰⁷ *Ibid* at 419. See also Tufford, Mishna & Black, *supra* note 44; Pietrantonio et al, *supra* note 20.

¹⁰⁸ Wekerle, *supra* note 1 at 94.

inconsistencies among reporters, address professionals' concerns about the potential negative consequences of reporting, and ultimately reduce under-reporting among health care professionals.

Collaboration with Child Protection Services and Other Professionals

Studies also recommend collaboration between health care professionals and CPS, especially to explain the legislation and address variability in reporting practices.¹⁰⁹ Collaboration can help establish “which circumstances are reportable” and which are “not appropriate for referrals.”¹¹⁰ Collaboration and consultation with CPS can also assist health professionals in evaluating “the options and needs of a given situation, as well as set the stage for in-service education as laws are refined over time,”¹¹¹ and would aid in alleviating health care professionals' concerns with regard to lack of post-reporting follow-up.¹¹²

Professionals need reassurance that a child will be safe after a report is made. Vulliamy and Sullivan discovered that physicians were less likely to report without feedback from CPS on the progress of the investigation.¹¹³ Such post-reporting involvement of health care professionals would also be beneficial for actual outcomes of the CPS process. For instance, Walters believes that more post-reporting involvement of referring psychologists would be helpful:

[T]he dilemmatic nature of these situations would be further ameliorated if psychologists had more impact on the process following reporting. Whereas courts are uniquely suited to adjudicate the issue of whether a child requires protection or is otherwise in need of compulsory measures of care, the same cannot be said with respect to the issue of appropriate disposition according to the child's best interests. Decisions of what is in the best interests of the child involve the “exercise of individualized discretion rather than the application of legal principle.” Psychologists' role in the decision-making process should therefore be expanded to allow decisions which are based on what is in the child's best interests.¹¹⁴

However, collaboration between health care professionals and CPS is complicated by the fact that social workers and medical staff who are expected to cooperate may be

¹⁰⁹ Pietrantonio et al, *supra* note 20 at 107; Tonmyr et al, *supra* note 25 at e25; Vulliamy & Sullivan, *supra* note 28 at 1462.

¹¹⁰ Davidov et al, *supra* note 45 at 413.

¹¹¹ Pietrantonio et al, *supra* note 20 at 103.

¹¹² Walters, *supra* note 23 at 179.

¹¹³ Vulliamy & Sullivan, *supra* note 28 at 1462.

¹¹⁴ Walters, *supra* note 23 at 179.

wary of each other's roles and have low motivation to collaborate.¹¹⁵ That said, there is also support for the idea of mandating such collaboration: "[Whether] social workers are routinely part of a hospital team or participants at case conferences, they can form a positive link between systems where expertise, ideas, and information can be shared."¹¹⁶ Vulliamy and Sullivan recommend that CPS begin providing feedback to health care professionals regularly.¹¹⁷ Such feedback would improve interagency communication, facilitate cooperation between health care professionals and CPS, and, ultimately, better protect maltreated children by "improving reporting relationships" and increasing the number of cases that come to the attention of CPS.¹¹⁸

The more health care professionals and CPS work together to help children, the more comfortable health care professionals will feel reporting and the better off children will be. The same is true of other professionals outside of CPS. For example, where health care professionals are unsure whether maltreatment is present or whether their reporting obligations are engaged, they can consult "child maltreatment experts such as child abuse pediatricians or child abuse specialty teams within their hospital or community."¹¹⁹ All mandatory reporting legislation in Canada has been updated to require that reports be made immediately when suspicions arise.¹²⁰ Health care professionals find this problematic because there is often no time to consult colleagues about reporting decisions.¹²¹ The decision to report should not be taken lightly and consultation with other professionals before doing so is highly recommended.¹²² Allowing for such consultation could be another possible solution to address the reporting concerns of health care professionals and to ensure that making a report is actually in a child's best interest.

Changing Perceptions

The perceptions of health care professionals with regard to the negative consequences of reporting need to be changed to encourage more reporting where appropriate. First, health care professionals need more assurance about their own legal—and even physical—protection after they make a report.¹²³ As suggested above, this could potentially be achieved through training. Second, while easier said than done, under-reporting may be significantly alleviated if health care professionals learn to put

¹¹⁵ Vulliamy & Sullivan, *supra* note 28 at 1463.

¹¹⁶ *Ibid* at 1464.

¹¹⁷ *Ibid* at 1469.

¹¹⁸ *Ibid*.

¹¹⁹ Pietrantonio et al, *supra* note 20 at 106–7.

¹²⁰ See e.g. *CYFSA*, *supra* note 3, s 125(1).

¹²¹ Walters, *supra* note 23 at 175.

¹²² Tonmyr et al, *supra* note 25 at e31.

¹²³ *Ibid* at e30.

more faith in CPS. This lack of faith appears to be unfounded as studies have shown that reporting generates “very few negative ramifications,” and is most often beneficial.¹²⁴ The bottom line is that society has “delegated the responsibility of child protection to [CPS’] social workers who are unable to meet that duty if they do not know the abuse is occurring.”¹²⁵

A professional who makes a report has the role of bringing concerns forward, and then it is up to CPS, using a professional and standardized investigation process, to determine whether further investigation is warranted.¹²⁶ Health care professionals should not assume that they are better able to determine whether protective intervention is warranted. This is particularly problematic when they have no remarkable experience with child maltreatment. While the concerns of health professionals for children are understandable, CPS are better able to determine whether intervention is warranted.¹²⁷

Investigations are initiated using a “traditional approach” in which facts are ascertained and evidence is collected, but where a case is less severe, a “customized approach” that is more flexible and individualized will be used.¹²⁸ The misconception of CPS as mere harmony-disrupting and child-removing entities must be eliminated. Again, this may be accomplished through training and more collaboration between professionals and CPS. Additionally, any efforts made to generate more effective CPS responses to mandated child maltreatment reports should be brought to the attention of health care professionals.

Potential Policy Solution in the Works: *Ontario Child Protection Standards (2016)*

In 2016, revisions were made to the *Ontario Child Protection Standards (2016)* [OCPS] that have great potential to mitigate the lack of confidence health care professionals have in CPS. The purpose of these guidelines is to promote the delivery quality, responsive services to children and families. The OCPS is to be applied in conjunction with the CYFSA, and particularly in the best interests of children.¹²⁹ The OCPS standardizes reporting intake under its Standard 1: “Intake: Receiving a Referral and Determining the Appropriate Response.”¹³⁰ This standard outlines the “expectations for [children’s aid societies] when they receive new referrals, reports or information that a child may be in need of protection,” including the information that is to be collected

¹²⁴ Vulliamy & Sullivan, *supra* note 28 at 1468.

¹²⁵ *Ibid* at 1462.

¹²⁶ OACAS, *supra* note 37.

¹²⁷ Ministry of Children, Community and Social Services, *Ontario Child Protection Standards (2016)*, (Ottawa: Queen’s Printer for Ontario, 2016) at 20 [OCPS].

¹²⁸ Jaime Wegner-Lohin et al, *Ontario’s Child Welfare System—CWRP Information Sheet #138E* (Montreal: Centre for Research on Children and Families, 2014) at 4.

¹²⁹ *Supra* note 127 at 4.

¹³⁰ *Ibid* at 19.

from and provided to the referral source, as well as how to determine the appropriate response to a referral. Standard 1 intends to: (1) ensure “that the actions taken in response to the referral are appropriate based on the unique needs of children (for safety) and their families (for support),” and (2) promote “engagement with the community so that community members understand their ongoing duty to report, and the role of [children’s aid societies] in responding to referrals received from the community.”¹³¹ Standard 1 seeks to address many of the problems and concerns of professionals, as described throughout this paper. Moreover, Standard 1 includes the subsection “Determining the Appropriate Response,” which outlines (1) various possible responses to a report, including child protection investigation, “community link,” or no direct client contact; (2) practices associated with each of the options, such as response times based on how imminent the threat is; and (3) other expectations regarding responding to reports effectively. This Standard also now contains case-specific factors to consider when determining the appropriate response to a referral. The practice notes lay out detailed explanations of various referral disposition options and extensively discuss expectations regarding investigation response times.¹³² All of this works to discourage a CAS from performing a full investigation unless it is in the best interest of the child, let alone removing the child from the home.

The *OCPS* may address some of the concerns that families and health care professionals have about CAS. These Standards might also address some other specific concerns professionals have about reporting. For example, the new “Permanency Planning” Standard tells CAS workers that they should be constantly looking for members of the child’s community and “persons who may commit to participation in planning for, and supporting the child” and attempt to “engage them in the service delivery process as appropriate.”¹³³ Such members include reporting professionals who are concerned about no longer being involved in the lives of the family or the child after making a report.

CONCLUSION

Mandatory reporting legislation is helpful and necessary for the protection of Canadian children. However, considering the high rate of under-reporting, statutes such as the *CYFSA* require much more from the health care community to defeat child maltreatment. Since mandatory reporting is desirable, reporting-related difficulties experienced by health care professionals across Canada need to be addressed through changes in health care practice. This paper outlined many factors that contribute to under-reporting among health care professionals. Despite the broad definition of “child

¹³¹ *Ibid* at 20.

¹³² *Ibid* at 23–24, 28–29.

¹³³ *Ibid* at 15–16.

in need of protection” and the low threshold of the duty to report, health care professionals still struggle to apply mandatory reporting legislation. Additionally, health care professionals have competing concerns with regard to the legal consequences of reporting, the effectiveness of CPS intervention, and the damage that reporting may cause to the professional–patient relationship. To address such practical difficulties, training with regard to child maltreatment and mandated reporting must be provided to health care professionals throughout their careers. Additionally, more collaboration and trust must occur between health care professionals and the CPS they report to. Until sufficient changes are implemented that will make professionals more consistent in their assessments and comfortable in reporting child maltreatment, under-reporting is very likely to remain a serious hindrance to the effectiveness of mandatory reporting legislation, and the ultimate protection of Canadian children.