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Children's and caregivers' perspectives about mandatory reporting of child maltreatment: a meta-synthesis of qualitative studies

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ABSTRACT

Objective To systematically synthesise qualitative research that explores children's and caregivers' perceptions of mandatory reporting.

Design We conducted a meta-synthesis of qualitative studies.

Data sources Searches were conducted in Medline, Embase, PsycINFO, Cumulative Index to Nursing and Allied Health Literature, Criminal Justice Abstracts, Education Resources Information Center, Sociological Abstracts and Cochrane Libraries.

Eligibility criteria English-language, primary, qualitative studies that investigated children's or caregivers' perceptions of reporting child maltreatment were included. All healthcare and social service settings implicated by mandatory reporting laws were included.

Data extraction and synthesis Critical appraisal of included studies involved a modified checklist from the Critical Appraisal Skills Programme (CASP). Two independent reviewers extracted data, including direct quotations from children and caregivers (first-order constructs) and interpretations by study authors (second-order constructs). Third-order constructs (the findings of this meta-synthesis) involved synthesising second-order constructs that addressed strategies to improve the mandatory reporting processes for children or caregivers—especially when these themes addressed concerns raised by children or caregivers in relation to the reporting process.

Results Over 7935 citations were retrieved and 35 articles were included in this meta-synthesis. The studies represent the views of 821 caregivers, 50 adults with histories of child maltreatment and 28 children. Findings suggest that children and caregivers fear being reported, as well as the responses to reports. Children and caregivers identified a need for improvement in communication from healthcare providers about mandatory reporting, offering preliminary insight into child-driven and caregiver-driven strategies to mitigate potential harms associated with reporting processes.

Conclusion Research on strategies to mitigate potential harms linked to mandatory reporting is urgently needed, as is research that explores children's experiences with this process.

Strengths and limitations of this study

- We employed clear and reproducible methods for this meta-synthesis, including the execution of a systematic search, the use of clear a priori study inclusion criteria and transparent and reproducible methods for analysis.
- An established study appraisal checklist, Critical Appraisal Skills Programme, was modified to better adhere to standard conceptions of rigour in qualitative research and applied to all included papers in this synthesis.
- This meta-synthesis balanced rigorous methods for finding studies (systematic search and article screening strategies) with in-depth interpretive syntheses methods.
- Due to little available data retrieved about children's perceptions of mandatory reporting and no data from low-income and middle-income countries, the generalisability of these findings is limited.
- Syntheses of the included studies relied on the availability of direct quotes from caregivers and children with experiences of mandatory reporting.

BACKGROUND

Although child maltreatment represents a significant global public health problem[1–5] that affects a large proportion of children,[6–8] many healthcare providers (HCPs) have not received adequate training about how to appropriately recognise and respond to children with this exposure.[9–11] It is well established that many HCPs do not report children they suspect have been maltreated.[12 13] Mandatory reporting of child maltreatment was proposed in the 1960s in the USA and subsequently in many other countries as a way to identify and respond to children experiencing maltreatment.[14]

Mandatory reporting laws may be broad or narrow depending on a number of factors, such as the types of reportable child maltreatment, the degree of harm deemed to be

reportable, the source of maltreatment and the persons who are required to file a report.[15] Narrower versions of the law could, for example, require only one profession (eg, physicians) to report one type of maltreatment (eg, sexual abuse), while broader versions of the law might require all adult citizens to report several types of maltreatment, such as physical, sexual and emotional abuse, neglect and children's exposure to intimate partner violence (with variations within these factors found across and within countries). Given the broad range of options for mandatory reporting laws, authors have argued that these laws can be drafted to suit the specific needs of different nations, including low-income and middle-income countries (LMICs).[14 16]

The nature of reporting laws may impact outcomes following a report. For example, some research has suggested that reporting from mandated professionals is more likely to lead to substantiated maltreatment than reporting from non-professionals (family, friends and neighbours).[17] Other research has suggested that universal mandatory reporting (reporting by all adult citizens) may not always improve the detection of children exposed to maltreatment; for example, universal mandatory reporting laws have not resulted in increased confirmation of physical abuse.[18–20] Additions of new forms of maltreatment to mandatory reporting legislation may not always benefit children who are experiencing harm, for example, when system burden may hinder the ability of child protective services (CPS) to identify those children most in need of an urgent response.[21] In short, it has yet to be shown that any specific mandatory reporting law can lead to a reduction in maltreatment recurrence or an improvement in child well-being.

A previous meta-synthesis of qualitative research[22] raised questions about the effectiveness of mandatory reporting after identifying: (1) no prospective research evaluating the link between mandatory reporting and child outcomes and (2) many accounts of harm to children, families and reporters following mandatory reporting and associated responses. This previous work summarised the views of mandated reporters across nine high-income countries and five middle-income countries.[22] The objective of the present paper is to systematically search for, critically appraise and synthesise qualitative research exploring children's and caregivers' self-reported perceptions and experiences of mandatory reporting. In doing so, we report the voices of caregivers and children who come into contact with CPS through mandatory reporting processes, in order to inform the development of child-driven and caregiver-driven strategies related to mitigating potential harms associated with reporting processes. Many of these strategies delineate how HCPs can improve their responses to children exposed to maltreatment and their caregivers.

Methods

The results of this meta-synthesis are reported according to Preferred Reporting Items for Systematic Reviews and Meta-Analyses and enhancing transparency in reporting the synthesis of qualitative research[23] checklist (see online supplementary file 1 for checklist). As there is no standard way to summarise qualitative literature,[23–25] for this meta-synthesis we follow the methods of Feder *et al*,[26] whose work builds on Noblit and Hare's[27] approach to meta-ethnography. Specifically, an information professional (JRM) conducted a systematic search in the following eight databases using broad terms for mandatory reporting and child maltreatment: Medline (1947-), Embase (1947-), PsycINFO (1806-), Cumulative Index to Nursing and Allied Health Literature (1981-), Criminal Justice Abstracts (1968-), Education Resources Information Center (1966-), Sociological Abstracts (1952-) and Cochrane Libraries. The search was originally conducted on 15 August 2016 and was updated to 14 December 2018 prior to publication (see online supplementary file 2, for example search strategy). Forward and backward citation chaining was conducted to complement the search. All articles were screened by two independent reviewers (JRM and MK) based on the following inclusion criteria: (1) primary, published article that used a qualitative design, (2) represented children's or caregivers' self-reported experiences with mandatory reporting of child maltreatment (broadly defined to include physical, emotional and sexual abuse, neglect, and children's exposure to intimate partner violence, as well as any indicator leading to CPS involvement, such as corporal punishment); (3) included direct quotes from the participants to facilitate the formulation of results and (4) conducted before 14 December 2018 (when the search was executed). Articles were excluded based on the following criteria: (1) non-qualitative research designs, including surveys with open response options; (2) did not examine mandatory reporting in the context of child maltreatment (eg, mandatory reporting of elder abuse or adult exposure to intimate partner violence only) and (3) reported the experiences of caregivers and children through the voice of professionals.

Critical appraisal was completed by one author (JRM) and checked by a second author (MK) using a modified version of the Critical Appraisal Skills Programme (CASP) checklist for qualitative research.[22] The questions listed in the CASP checklist were rearranged according to standard conceptions of rigour in qualitative research: credibility, transferability, consistency and neutrality. Other CASP questions that did not fit into these areas included questions about appropriateness of research (appropriateness of qualitative research and appropriateness of research design) and ethical considerations of research. Other strategies for establishing credibility, transferability and neutrality that are not discussed in the CASP tool but are found in other discussions of qualitative rigour[28 29] were included. Feder *et al*'s[26] approach to appraising qualitative literature prioritises studies that are ranked as of higher quality, which supports increasing recommendations to consider study quality, but also does not inappropriately exclude so-called lower quality studies that make

'surface mistakes' that would not otherwise invalidate their study findings.[24] Only the total CASP scores were considered, and studies were not excluded for poor study design, as we felt that the exclusion of any articles could exclude a valuable quote/perspective from a child/caregiver and that this exclusion could impact the meta-synthesis findings.

Data coding for this meta-synthesis was primarily inductive. Two reviewers (JRM and MK) independently placed the primary data from each study and its corresponding code into an Excel file, and these files were compared for consistency (JRM). Data analysis involved two independent reviewers (JRM and MK) coding (1) first-order constructs (views of caregivers and children), which were usually found in the Results section of the included articles; (2) second-order constructs (interpretations by study authors), which were usually found in the Discussion section of the included articles and (3) contradictory constructs, or first-order or second-order constructs that were contradictory across or within studies. For first-order constructs, quotes related to CPS responses were coded only if the paper also addressed perceptions of mandatory reporting. As per inclusion criteria listed above, papers were excluded if they only addressed CPS responses to reports. While the quantification of qualitative work has been criticised, in this study, individual concepts are 'counted' to let the reader decide about the relative importance of the themes. We suggest that themes that appear at a lower frequency are not necessarily less important (eg, child safety and well-being is discussed less often in included studies) but rather that other themes were priorities for caregivers and study authors due to the goals of the individual studies.

First and second-order constructs that appeared across studies were re-examined to develop the third-order constructs, or the conclusions of this meta-synthesis. This involved one author (JRM) identifying second-order constructs that addressed strategies to improve the mandatory reporting processes for children or caregivers—especially when these themes addressed concerns raised by children or caregivers in relation to the reporting process. These themes were, per Feder *et al*,[26] reworded as recommendations. For example, the following recommendation from this meta-synthesis addresses the second-order construct about research and legislative impacts of mandatory reporting and the first-order construct about caregivers' stated fear of being reported to CPS and corresponding avoidance of services: 'Research about mandatory reporting laws should attend to the unintended negative consequences of reporting, such as the creation of adversarial care environments'. The final third-order constructs were first discussed with the two authors (MK and HLM) involved in developing and evaluating the first-order and second-order constructs to ensure they reflected their understanding of the data, following which they were evaluated and approved by all authors.

Patient and public involvement

While this meta-synthesis sought to prioritise children's and caregivers' perceptions and experiences with mandatory reporting, as expressed in qualitative research, no patients were involved in developing or conducting the meta-synthesis.

RESULTS

A total of 7935 records were identified and, after deduplication, 4662 titles and abstracts were screened using the inclusion and exclusion criteria. After full-text screening of 144 articles, 35 articles (representing 34 studies) were included in this review (see figure 1).

Study characteristics and methodological quality

The methodological quality of the studies varied and the total score percentages for each article (total possible score was 20 'yeses') are reported in table 1. Fourteen articles (40%),[30–43] including two articles in the top quartile,[30 31] did not include details about strategies used to ensure ethical issues had been taken into consideration, such as seeking approval from an ethics committee for research. In addition, only 12 (34%) articles[31 32 34 35 44–51] discussed strategies to ensure neutrality (eg, the researcher critically examined how their own role introduced bias into the research question, study design or study execution).

All of the articles were published by authors in high-income countries, including the USA (22 studies), Australia (5 studies), Canada (5 studies), Israel (2 studies) and Finland (1 study) (see online supplementary file 3 for participant and study characteristics). The majority of included articles (n=33, 94%) described the experiences of caregivers, totalling 821 individuals. One additional article,[43] published almost two decades ago, described the experiences of 50 adults with a history of child maltreatment (physical, sexual and emotional abuse). Another article[35] described the effects of Israeli social policy on the experiences of 28 Palestinian children/adolescents with experiences of sexual abuse. Of the 33 included articles that addressed the perspective of caregivers, most were those of mothers or expectant mothers (n=28, 85%), with the remaining articles (n=5, 15%) including a majority of mothers in their sample. Furthermore, most of the caregivers represented in the sample were women with specific vulnerabilities, such as those using substances (n=18), or with experiences of intimate partner violence (n=10). Additional articles addressed caregivers who were new immigrants in New York City, USA (n=1), child welfare investigated caregivers in the USA (n=2) and mothers involved in a voluntary home visiting services in the Midwest, USA (n=1). One article, published over two decades ago, also investigated caregivers in Australia whose children had been exposed to sexual abuse (n=1). Most articles did not specify why caregivers had been reported to CPS. For those studies that included some information about referral reasons, types of exposures included sexual abuse,[35 42] failure to protect (neglect)[34 48]

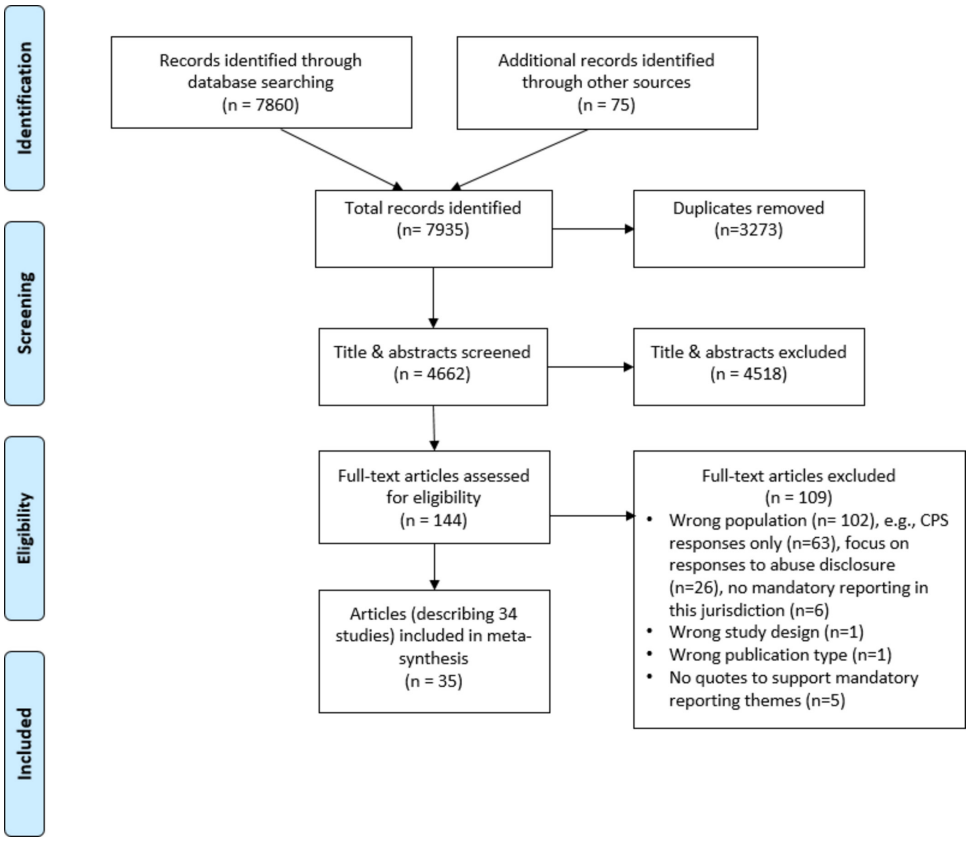

Figure 1 PRISMA flow diagram. CPS, Critical Appraisal Skills Programme; PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

or combination of maltreatment exposures, including physical abuse, sexual abuse, emotional abuse and physical or emotional neglect.[31 33 40 43] Beyond those articles citing single exposures (sexual abuse or neglect), we were unable to link experiences with mandatory reporting with specific types of maltreatment (in order to ascertain if experiences differed depending on maltreatment type). For example, while nine articles addressed children's exposure to intimate partner violence, this exposure is a specific form of reportable maltreatment in some

Table 1 Methodological quality of studies

Study ID	Total 'yeses' out of 20	% of total score
75% or above		
Paterno, 2018[51] Harvey, 2015[44]	18	90
Jarlenski, 2016[45] Stengel, 2014[106] Kelly, 2009[46]	17	85
Gueta, 2017[50] Jessup, 2003[30] Akin, 1997[31]	16	80
Campbell, 2017[57] Kearney, 1995[107] Meyer, 2011[108] DeVoe, 2003[48]	15	75
50%–74%		
Elms, 2018[49] Stone, 2015[32] Fleury-Steiner, 2011[33] Sullivan, 2005[34] Shalhoub-Kevorkian, 2005[35] Earner, 2007[109] Stevens, 2005[36]	14	70
Bergstrom-Lynch, 2018[110] Valentine, 2018[111] Roberts, 2011[112] Phillips, 2007[113] Howell, 1999[37] White, 2016[114] Davidov, 2012[56] Hathaway, 2002[38]	13	65
Leppo, 2012[115] Sword, 2004[39] Fong, 2017[40]	12	60
Kruk, 2011[41] Dowd, 2002[116] Roberts, 2010[58]	11	55
49% and under		
Scott, 1996[42]	9	45
Palmer, 1999[43]	7	35

jurisdictions and is reportable under emotional abuse or neglect in others.[14 52 53] It is also an experience that has a high co-occurrence with other forms of maltreatment (physical abuse, emotional abuse, sexual abuse),[54 55] and so it is unclear from this experience alone what would trigger a referral to CPS.

Across those articles (n=15) that described participants' race/ethnicity, an average of 48% of the participants included in this synthesis identified as white, 26% as Black/African American, 17% as Hispanic/Latina, 3% as mixed race and 2% as Asian/Pacific Islander, Indigenous/Native American or 'other' race. The 14 articles that mentioned the income level of participants described the majority of their participants as economically marginalised (ie, were 'low income', 'receiving social assistance', etc).

Fears, threats, perceptions of and responses to reports (first-order constructs)

Five first-order constructs (views of caregivers and children) are detailed in table 2, reflecting caregivers' and children's perceptions of mandatory reporting,

Table 2 Caregivers' and children's perceptions of mandatory reporting and associated responses

First-order construct	Found in article (n, %)	Description of construct	Illustrative quotes
Before a report			
Perceptions of mandatory reporting, mandated reporters and CPS responses	19, 54	This construct relates to children's and caregivers' perceptions of mandatory reporting, mandated reporters and CPS responses. Negative judgements involved both caregivers' perceptions about what CPS should be doing (the 'ideal') and their perceptions about what CPS was actually doing (the 'reality' of CPS).	'Because, um, all I know about [CPS agency] is that they take people's kids away from them. That's all I know.'[33] 'I think that the doctors should be a little bit more open to listenin' to somebody instead of more open to tryin' to write a CPS report right away, that maybe they should offer the woman help before they report them to CPS…'[58] 'Mandating is a key to get the women in here. Mandate them. If they're using during pregnancy, and [CPS is] threatening to take your kids, that's mandating!'[37]
Negative judgements	18, 51		
Positive judgements	1, 3		
Threats	9, 26	This construct relates to caregivers' experiences of being threatened with a report to authorities (CPS, criminal justice) by mandated reporters.	'[When] I was almost five months pregnant and they were already telling me, you know, you've been testing positive for meth and marijuana and so, if this happens in your next trimester, then you're gonna be CPS involved.'[58]
Fear	31, 89	This construct relates to children's, caregivers' and adults' (with histories of child maltreatment) fears about being reported and fear of CPS responses to reports or to threats of being reported.	'I was afraid that if I told, my children would be taken away."[34] '…you guys are bound by law [to report certain things]… You say it is confidential… but you are going to report me'[114]
Uses services less	12, 34		
Does not disclose information	7, 20		
Uses services more	6, 17		
Limits of confidentiality	4, 11		
Being reported			
Knowledge of being reported by a mandated reporter	6, 17	This construct relates to caregivers' recollections of being reported by a mandated reporter.	'They ran his name; he had a warrant. They didn't like the fact that I was in the car with a felon and had my child there, so they called. They called, CPS came—they called me and we talked, or whatever. I had to go through the whole drug test, home visit and everything like that.'[40]
Following a report			
CPS involvement	17, 49	This construct relates to caregivers' experiences with responses to reports and with managing relationships with CPS personnel.	'When I cleaned up toward the end of my pregnancy, my social worker promised me if I was clean when I gave birth to my baby he wouldn't be apprehended.… Yes, I was clean for 60 days, and he still apprehended my baby.'[41] 'I mean at first I thought their main goal was just to come here, snatch my kids away. You know, 'cause that's what everybody thinks about CPS. You know what I mean. And then she was like, 'This is what we're gonna do, this is how we're gonna handle this, do you have any questions.' So it really wasn't, you know, all that bad.'[33]
Negative experiences	14, 40		
Positive experiences	3, 9		

CPS, child protective services.

mandated reporters and CPS responses (construct 1), caregivers' experiences with being threatened with a report by mandated reporters (construct 2), caregivers' and children's fears about being reported, including fears of CPS responses to reports (construct 3), caregivers' recollections of being reported by a mandated reporter (construct 4), and caregivers' experiences with responses to reports and with managing relationships with CPS personnel (construct 5). All constructs are supported by articles from the top quartile (see table 1 above).

Only two of the included articles[34 56] explicitly sought to investigate caregivers' perspectives on mandatory reporting. Over half of the articles (54%) detailed caregivers' perceptions of mandatory reporting, mandated reporters and CPS responses to reports (construct 1). All of the articles supporting construct one included negative judgements about CPS responses, mandatory reporting and mandated reports; only one articles discussed positive judgements. Negative judgements about mandated reporters or the reporting process included discussions about betrayals of trust and confidentiality, unfairness of reporting or lack of understanding about why caregivers had been reported. Negative judgements of CPS included perceptions that they were 'child snatchers', unfair, coercive, threatening and that they did not understand the unique circumstances of the caregiver. Positive judgements of mandatory reporting included the perspective by one participant that mandatory reporting could force caregivers to get the addiction treatment they needed.[37]

Additional articles addressed threats of reports (construct 2) and fears of being reported (construct 3). Caregivers' fears of being reported impacted service use or disclosure of information that could make caregivers vulnerable to CPS involvement, such as experiences with intimate partner violence, substance use or mental health concerns. Fears of being reported or otherwise involved with CPS were described by caregivers as a reason to avoid services in 34% of included articles and as a reason to not disclose important information to mandated reporters in 20% of included articles. In 17% of the included articles, caregivers indicated that they made a special effort to never miss appointments or services due to fears of being reported. Some caregivers also discussed how their fears were linked to limits of confidentiality and discussed how betraying their trust or confidentiality was counterproductive to therapeutic relationships and, for example, drug treatment goals. Both the article that addressed children's perspectives[35] and the article that addressed the perspectives of adults' with histories of child maltreatment[43] contributed to the construct about fears of being reported or fears of responses associated with reports.

A few articles discussed caregivers' recollections of being reported by a mandated reporter (construct 4). Most articles contributing to this construct discussed caregivers' negative feelings associated with being reported: feeling angry, misunderstood, betrayed, confused and in the dark. One article[57] discussed both negative and positive feelings associated with knowledge of being reported. Positive feelings resulted when the non-offending caregiver (the mother) recognised child maltreatment in advance of the referral and felt relief in receiving support to provide safety to her children. Similar to mandated reporters,[22] caregivers in this study[57] had an easier time recognising maltreatment when they saw physical indicators of violence (eg, belt mark on child).

A significant number of articles (49%) also discussed positive or negative CPS responses associated with being reported (construct 5). Many of the negative experiences involved caregiver reflections on the impact of their children being taken away. Other negative CPS responses included discrepancies between what was promised to caregivers by CPS workers versus the actual actions by CPS workers, a general perception of unhelpfulness of CPS responses, and experiences with CPS that left caregivers feeling powerless and unheard. Positive experiences, reported in three studies,[33 37 57] addressed helpful referrals (eg, food stamp programmes, intimate partner violence advocate), support (eg, training, emotional and material support, including children's toys and clothes) and outcomes (eg, less yelling, shouting and spanking in the family, as well as more self-confidence reported by caregiver and increased caregiver ability to protect children).

Although not the focus of this paper, a few articles discussed caregivers' recollections of being reported by an informal relation (such as a neighbour, friend or family member).[32 40 43]

Coordinated responses (second-order constructs)

All second-order constructs (see table 3) were supported by articles from the top quartile of study quality (see table 1 above). While the included studies recruited participants from a variety of health and social service settings (hospitals, clinics, community drug treatment programmes, home visiting programmes, intimate partner violence shelters, etc), the study authors directed the majority of their recommendations to HCPs or CPS. This focus is reflected in the second-order and third-order constructs. Only one article suggested that an aspect of mandatory reporting (reporting of children's exposure to intimate partner violence) should be halted[34]; all other articles addressed ways through which the reporting process could be improved by HCPs, CPS, research or through changes to mandatory reporting legislation via policy-makers.

Over half of the articles (54%) addressed appropriate responses needed from HCPs (construct A), which included HCPs' responsibilities to communicate with clients about the limits of confidentiality. Appropriate CPS responses (construct B) were addressed by 29% of articles and included the desire for CPS personnel to understand and respond to the unique needs of clients. In 37% of included articles, it was noted that HCPs and CPS personnel require knowledge and training (construct C). It was recommended that both HCPs and CPS personnel receive training about the unique needs of vulnerable groups, including clients with addictions, those experiencing intimate partner violence, and immigrants. Study authors also recommended that HCPs

Table 3 Second-order constructs (views of study authors) and the number (n) and per cent (%) of articles that address each construct

Second-order construct	Found in article (n, %)	Description of construct	Illustrative quotes
Appropriate HCP responses	19, 54	▶ HCPs should respond to caregivers in a non-judgemental, empathetic, and warm manner, including offering support and referral to key services. ▶ HCPs should communicate with caregivers/children about the limits of confidentiality and the types of situations that can lead to a report.	'Finally, fear of the authorities and of losing a child to them was strong amongst the interviewees, indicating that clearer policies on child removal and more information about the protocol of child protection services should be provided to pregnant women with drug problems as early in the pregnancy as possible.'[115]
Appropriate CPS responses	10, 29	▶ CPS workers should seek out the voices and perspectives of clients they are serving. ▶ CPS responses should be based on principles of strengths, empowerment, honesty, partnership and cultural competence. ▶ CPS responses should focus on material supports for clients and referrals to community supports.	'Therefore, if it is deemed necessary to remove a child after a thorough strengths-based assessment that provides women with support, CPS workers need to address the trauma associated with apprehension.'[41]
Knowledge and training HCPs CPS	13, 37 7, 20 5, 14	▶ HCPs and CPS personnel should have nuanced knowledge/training about the unique circumstances of vulnerable groups. ▶ HCPs should know about their jurisdiction's reporting requirements and impacts of reporting and caregivers and children.	'Child welfare agencies also need continuing education regarding perinatal substance abuse and treatment options and can partner with courts, substance abuse treatment systems and child health agencies in therapeutic projects of child protection that promote recovery and family cohesion.'[30]
Collaboration and coordinated systems of care	12, 34	▶ HCPs and CPS personnel should collaborate and work to minimise structural barriers and maximise coordinated systems of care.	'Development of 'accessible, comprehensive and integrated services in centralised settings… underpinned by trauma-informed systems of care'… requires the collaborative effort of all service providers as well as consumer participation so services are acceptable to mothers'[44]
Impact of reporting—research and legislation	10, 29	▶ Future research should address the complexities and impact of mandatory reporting. ▶ Legislators and policy-makers should consider the impact of reporting legislation on children, caregivers, and reporters and on their therapeutic relationships.	'Further research should be conducted with the specific purpose of examining these mandatory reporting issues in the context of home visitation, as the present study indicates that health care professionals involved in home visitation are not unaffected by the issues related to mandated reporting in these two controversial instances'[56]
Child safety and well-being Focus on mother and child Focus on child	8, 23 7, 20 1, 3	▶ Children's safety and well-being must be prioritised. ▶ Ensuring the safety and well-being of adult victims of intimate partner violence (often the mother) helps to ensure children's safety and well-being.	'Programs must address the tension between child-focused and mother-focused providers and services. This tension is illustrated by the often adversarial relationships between child welfare agencies that seek to protect the children and substance abuse treatment providers who advocate for the mothers. As programs are developed, the mother–child dyad should be viewed from the beginning as the target unit to be served. This avoids later questions of 'Who is the client?'[37]

CPS, child protective services; HCP, healthcare provider.

have knowledge and training about their reporting duties. The need for collaboration between HCPs and CPS and coordinated systems of care (construct D) was mentioned by 34% of included articles.

Some study authors recommended that legislators and researchers should consider or evaluate the impact of mandatory reporting legislation on children, caregivers and reporters (construct E). Finally, 23% of included articles focused on the need for child well-being and safety (construct F), with the majority of these articles suggesting that child well-being and safety could best be achieved by ensuring the well-being and safety of the mother.

Apparent contradictions

Three contradictions were noted within and across articles: (1) whether or not fears of being reported increased or decreased service use by caregivers; (2) whether or not child safety is achieved through a focus on maternal

safety, child safety or both and (3) whether or not 'disclosures' of abuse experiences should be sought. The first contradiction was resolved within individual papers when authors noted that mothers attended all appointments to show that they were good mothers[32] or to prevent CPS taking their child away,[58] but negative experiences with services or CPS would make them less likely to attend services in the future. The second contradiction is well recognised across child-focused and mother-focused disciplines, where providers tend to prioritise the safety and well-being of their primary client, who is either the child or the mother. More nuanced attempts to resolve these tensions can be found in discussions about mothers with experiences of intimate partner violence, where authors note that ensuring the well-being and safety of the mother often helps to ensure the well-being and safety of the child (thus, advocating for child-focused professionals, such as CPS, to do better in responding to vulnerable mothers), but that when these interests are in conflict (eg, when the mother is abusing the child), that children's well-being and safety should be prioritised given their inherent vulnerability.[21] The final contradiction, also well-established in the field, is between those providers who believe disclosure/detection will necessarily lead to positive benefits for the child and those providers who recognise the severe limitations in current service responses to children experiencing maltreatment. More research on these contradictions is needed before firm conclusions can be made.

Recommendations for appropriate responses to reports (third-order constructs)

The third-order constructs represented in table 4 address study authors' interpretations, across the studies, of strategies to improve service when mandatory reporting processes are involved, as well as the need to acknowledge the limitations in what we know about the impacts of mandatory reporting processes. As stated in the Methods section, third-order constructs combine the insights of children (when available), caregivers and study authors seeking their perspective; these themes, per Feder *et al*,[26] are reworded as recommendations. Third-order constructs are arranged according to the socioecological model,[59] to draw attention to individual and social factors needed to address limitations in reporting processes. It should be noted, however, that most of the recommendations suggest improvement is needed at the interpersonal level (ie, improving communication and relationships between HCPs and CPS personnel and caregivers and children). Restriction of analysis to articles

Table 4 Third-order constructs—recommendations at each socioecological level

Socioecological level	Recommendation
Public policy (laws and policy)	Research about mandatory reporting laws should attend to the unintended negative consequences of reporting, such as the creation of adversarial care environments.
Community factors (relationships among organisations, institutions and informal networks)	All sectors involved in responding to reports of maltreatment should improve collaboration and the coordination of their responses, in order to minimise punitive, threatening and fear-inducing service responses.
Institutional factors (institutional characteristics and rules for operations)	Health and social service institutions should address tensions between their child-focused and mother-focused services, remembering that ensuring the safety and well-being of the mother is often essential in prioritising the safety and well-being of the child.
Interpersonal relationships (formal and informal relationships)	HCPs should listen to caregivers' and children's communicated concerns; respond to caregivers and children with empathy, warmth, understanding, support and appropriate referrals to the community; and, when appropriate, provide caregivers with information about the impact of exposures, such as intimate partner violence or addictions, on children in a manner that is non-judgemental. HCPs should communicate with caregivers/children about the limits of confidentiality and the types of situations that could or would not lead to a report. CPS responses should prioritise listening to caregivers' stories, opinions and aspirations; building relationships based on collaboration, partnership, honesty, trust and shared decision-making; enabling caregivers to gain access to material goods and other services (eg, housing, food, clothing, childcare, counselling, drug treatment); and caregivers' bond with their children. CPS responses should also strive to be hopeful instead of bureaucratic. In cases of intimate partner violence, CPS responses should focus on perpetrator accountability and support of adult victims, while monitoring the safety of children.
Individual factors (knowledge, attitudes, skills, etc)	HCPs and CPS personnel should understand the marginalised locations from which mothers seek care, which includes comprehensive knowledge about experiences with addictions and intimate partner violence and appropriate, non-judgemental responses to individuals with these experiences.

CPS, child protective services; HCP, healthcare provider.

in the top quartile did not change these third-order constructs.

DISCUSSION

For this meta-synthesis, we aimed to summarise caregivers' and children's perceptions of mandatory reporting; however, only one of the included studies addressed children's perceptions of mandatory reporting and associated responses (a challenge discussed below). As such, our findings relate more to caregivers' (especially mothers') perceptions. Furthermore, the majority of included articles addressed perspectives of mothers with specific vulnerabilities—especially mothers with experiences of substance use or intimate partner violence. This is likely because both mandatory reporting of children's exposure to intimate partner violence and reporting of pregnant women who use substances are contentious.[21 60 61] While the findings of this synthesis primarily focus on the needs and perceptions of mothers (due to the current evidence base), as has been noted by other authors, there needs to be continued efforts to engage fathers in services, when appropriate and safe to do so.[62 63]

Unlike mandated reporters who have a range of experiences with the reporting process (before, during and after the report), and who are primarily concerned with factors that impact the decision to report,[22] mothers primarily discussed fears or threats of reports and how this impacted their service use. Mothers' fears of being reported were described as most strongly tied to fears of losing their children. Qualitative research about mothers' experiences with child apprehension suggests that many mothers experience profound trauma when their children are taken away,[64 65] which can exacerbate the stress that may be contributing to the harmful behaviours or parenting practices that necessitated a report, CPS intervention and/or child apprehension.[66] Findings from this meta-synthesis suggest that fears of reports and associated responses led many mothers who are using substances to avoid all prenatal services; many mothers in abusive relationships also avoided disclosing abuse experiences to HCPs. As critics of mandatory reporting for these two groups have suggested,[60 61 67] mandatory reporting can impede mothers' access to good care; their lack of access to care, by extension, may jeopardise the safety and well-being of their children.

Several of the recommendations in this paper overlap with our previous meta-synthesis[22] about mandated reporters' experiences with reporting, while other recommendations are new. Both papers emphasised the importance for HCPs to disclose their reporting duties early in ongoing relationships with caregivers and the importance of non-judgemental and supportive responses from HCPs and CPS, as well as the need for coordinated communication and care responses for children and families. Both meta-syntheses also suggest that solutions to potential harms associated with mandatory reporting are needed at all ecological levels (ie, policies, communities, institutions and individuals). Unlike the themes reported in our previous meta-synthesis,[22] which focused on training specific to mandatory reporting legislation, themes in the present meta-synthesis spoke to the importance for HCPs and CPS to understand the marginalised locations from which mothers seek care. This involves comprehensive training/knowledge about how to appropriately respond to mothers experiencing intimate partner violence or addictions, training that is increasingly recognised as essential for providers.[68–70] For example, providers may not be aware of the potential consequences of perinatal marijuana use,[71] a substance that was recently legalised in Canada.[72] Unlike themes from the previous meta-synthesis which emphasised child safety, themes from the present meta-synthesis emphasised that to ensure child safety, it is often essential to prioritise the safety and well-being of the mother. Punitive responses towards mothers have been a long-standing concern in countries that take a child safety approach, as opposed to a child and family welfare approach.[73–75] In contrast, preventative interventions create an opportunity to support mothers and can lead to increased child safety and well-being.[76] These interventions require political will in order to ensure that the health sector, and other relevant sectors, are addressing violence against women and children.[68]

Finally, in comparing the themes across both meta-syntheses, it also becomes clear how little research is available that examines the perspectives of children. Sparse research about children's experiences of mandatory reporting may reflect the observation that children appear to focus on and be affected by the response to the report, including investigations,[77 78] medical examinations associated with investigations[79] and apprehension by CPS.[80 81] It may also reflect the ethical challenges that arise when doing qualitative research with children who may have experienced maltreatment,[82 83] although the need for child-focused research and practice, as well as research that attends to children's voices, is increasingly recognised as an essential right.[84 85] There is some Canadian research, for example, which suggests that children value control over both disclosures of abuse and reporting of maltreatment (which the children indicated was not possible when disclosing to mandated reporters).[86] In this study, children also discussed their perception that CPS responses were ineffective, which impacted their decisions to disclose maltreatment experiences.[86] While the present meta-synthesis did not identify studies from LMICs that met the inclusion criteria, findings from non-mandated LMICs also suggest that where child protection responses are less well developed, children may be especially prone to experiencing adverse outcomes from reporting.[87]

Safe, ethical research about children's experiences with mandatory reporting is urgently needed,[88] as are practical strategies/training for (1) relating to and interviewing children, taking into account their age and developmental considerations[89] and (2) case formulating[90] to determine 'the least detrimental alternative' for children and their families. While it is not ethical or feasible to

do a randomised trial of mandatory reporting in countries that already have this process in place, well-designed cohort studies with opportunities for child, caregiver and reporter feedback may provide insight into strategies for mitigating harms with this process. This research could uncover collaborative or more positive reporting strategies, some of which have been previously recommended,[91] but have not been empirically tested. With respect to training for relating to/interviewing children and case formulation, clear guidance is needed about developmentally appropriate strategies for these essential components of practice and how they relate to mandatory reporting duties. For example, HCPs need practical, developmentally appropriate strategies for communicating about the limits of confidentiality and inquiring about safety in the home.[92] Training is also needed with respect to strategies for inquiring safely about child maltreatment, such as—at minimum—ensuring that children and caregivers are interviewed separately by a clinician who is competent to inquire about maltreatment exposures.[89 92]

Mandatory reporting of child maltreatment remains a contentious process. While it likely increases the reporting rates of reluctant reporter groups[93 94] and increases the identification of children exposed to maltreatment,[95–98] to date there is no prospective research examining if mandatory reporting reduces recurrence of maltreatment or improves the well-being of children.[22] Given that mandatory reporting is so closely tied to CPS responses, there is also an urgent need to evaluate CPS responses (or lack of responses) following referrals. For example, a recent retrospective study investigated whether contact with CPS was associated with improved mental health outcomes among Canadian adult respondents who reported experiencing child abuse.[99] This study found no statistically significant differences for all outcomes, except those adults who had CPS contact were more likely to report lifetime suicide attempts.[99] A review of cohort studies that evaluated the impact of service use among children exposed to maltreatment found mixed results, with the majority of studies finding increased recurrence rates associated with the provision of services, including foster care.[100] A systematic review about out-of-home versus in-home-care suggested there was limited evidence for improved outcomes for children in out-of-home care and some worse outcomes for children in out-of-home care.[101] Systematic reviews about psychosocial interventions to address child well-being following maltreatment exposure also show limited evidence of effectiveness.[102 103] However, the findings of many of these studies, especially the cohort studies, are complicated by issues related to study design. Without clear assessments of baseline to postservice or post-treatment risk, it is unclear if certain populations (eg, those experiencing out-of-home care, those receiving service use following a report) are qualitatively different (eg, experiencing increased mental health problems at baseline assessment). If they are experiencing more severe maltreatment or more severe mental health symptoms at baseline, then no statistically significant differences between the groups postservice or post-treatment suggest that some of consequences of maltreatment have been ameliorated by the responses. The findings related to mandatory reporting and associated responses suggest an urgent need to prioritise research and funding for effective interventions that prevent maltreatment and recurrence, as well as service responses that reduce recurrence and improve child well-being following maltreatment.

Strengths, limitations and future research

We consider the strengths of this meta-synthesis to include the use of a systematic search, clear a priori study inclusion and exclusion criteria, use of an established study appraisal checklist, and transparent and reproducible methods for analysis. However, we appreciate that these methodological choices may also be considered limitations by some, or as a prioritisation of the 'technical skills' of searching, sorting and critical appraisal over the complexities of nuanced interpretation.[104 105] While we have endeavoured in this meta-synthesis to combine the benefits of transparent search and inclusion criteria with the demands of interpretive synthesis, future meta-syntheses would benefit from a close consideration of the benefits and limitations of critically appraising qualitative research, prioritising direct quotes in included studies over the study authors' summaries and interpretations of participant quotes, and quantifying themes (rather than drawing out the nuances in context across included studies). For example, as direct quotes often only support study findings, the prioritisation of direct quotes from articles (rather than the entirety of the study findings) could unintentionally skew the results of the studies to findings that are, for example, provocative. While we reviewed all aspects of the Results during data extraction and do not believe we have unintentionally skewed the findings of included studies, future meta-syntheses would benefit from not limiting analysis to direct quotes.

This synthesis aimed to address children's and caregivers' perceptions of mandatory reporting and as such does not reflect complete findings about (1) appropriate HCP or CPS responses to disclosures of maltreatment or (2) providers' experiences with reporting in a non-mandated context (such as the UK). While this synthesis set out to address children's and caregivers' perspectives about mandatory reporting, the paucity of research about children's experiences of reporting to date makes it unlikely that this synthesis captures children's unique experience with this process. Additional research about children's experiences is needed. Furthermore, as we were unable to link specific types of maltreatment referrals to participants' experiences with the reporting process, it is unclear if the reason for referral affects experiences of being reported. A prospective cohort study that linked reason for referral (eg, physical abuse, intrafamilial or extrafamilial sexual abuse, emotional abuse or neglect) to experiences of being reported could account for potential differences in perceptions of mandatory

reporting across maltreatment type. The lack of studies in this synthesis from LMICs suggests an increased need to invest in research in these settings.

CONCLUSION

Mandatory reporting of child maltreatment remains an influential and controversial process with a limited evidence base. It is concerning that due to fears about being reported, some mothers and children avoid disclosing essential information and other mothers avoid services altogether. Research on strategies to mitigate potential harms with reporting is urgently needed, as is research that explores children's experiences with this process.

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