

# Mandatory reporting: ‘A policy without reason’

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## ABSTRACT

This viewpoint explores the recommendation to introduce mandatory reporting from the recent report into the case of Malachi Subecz, a child who was killed by his caregiver. I argue that this policy would have unintended consequences. It is likely to flood the system with low risk cases, which could make identification of high risk cases more difficult. It reduces a focus on prevention; intensifies resources and power within Oranga Tamariki; and does not take into account either the complexity of issues causing abuse and harm, nor their widespread nature. This policy is also likely to exacerbate inequities for Māori, as bias is more likely to impact low risk reports. Currently, people may not report due to a lack of clarity around the type and severity of cases they should report, and limited or inadequate responses to previous reports made, not because they are unable to recognise the signs of abuse or are unwilling to act on them. Instead, we should keep a strong focus on prevention and devolution, while also urgently generating a clear consensus between Oranga Tamariki and key reporters about when, why, how and what the outcomes of reporting should be. Alternative recommendations are suggested.

**Keywords:** child protection; mandatory reporting; prevention; public health

Two recent reviews of practice in the wake of the tragic death of Malachi Subecz in Aotearoa New Zealand have made various recommendations to improve the system (Poutasi, 2022; Office of the Chief Social Worker, 2022). One of these is mandatory reporting: where professionals (and sometimes the public) are required by law to report to Oranga Tamariki (OT) about children they suspect are being abused. While on the face of it this might seem sensible, mandatory reporting does not necessarily lead to safer children. It leads to overwhelmed systems, inaccurate decision-making (the needle in a haystack effect), higher thresholds for action, increasing disparities for Māori, and damaged relationships with families who could have been provided with preventive support. Mandatory reporting pulls the

focus and resources of a child protection system away from prevention and towards reactivity. What’s more, the framing of this debate so far has been framed as ‘mandatory reporting or nothing’, ignoring the fact that we already have a legal requirement that every organisation working with children have a reporting policy in cases of suspected abuse. Sanctions for not reporting (which in the case of Malachi Subecz led to the early childhood centre closing down) are already in place, so the important questions are: will increasing personal legal liability for reporting improve the process compared to the current regulatory requirements? Will any improvement gained by this outweigh the negative consequences?

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To find the answers, we need a deeper understanding of why people don't report, what a focus on 'reporting' does to the system, and importantly, whether it makes children any safer. These questions can only be considered within an understanding that the child protection system both harms and helps. Previous reviews have laid bare the potential for negative effects of the statutory system, including unwarranted removals, overreaching investigations, racism and abuses of power (Waitangi Tribunal, 2021). At the same time, the statutory system undoubtedly also has positive effects in many cases, working through complex family situations to improve the lives of children and their whānau. The centralised system currently in place requires reports to the statutory arm of the system – Oranga Tamariki (OT) – which come from many other professionals, family members and members of the public. Over time, the influence of 'small state' thinking has progressively contracted out support, education, preventive and therapeutic services, steadily shrinking the functions of OT into its current statutory roles of investigation; coordinating services; managing family group conferences and plans; and sometimes applying for orders to bring children into care, then supporting those care arrangements. In part because of this division of services, the threshold for OT accepting reports is restricted to those children who need statutory intervention, with all others usually being sent back to community agencies for support-oriented services. In this kind of system, the decision to report becomes a question of: does this child and their family meet the threshold for what OT does? This question of 'threshold' then becomes fundamental, signalling another problem with the framing in the current media debate, as one based on an inability by reporters to 'recognise the signs of abuse'. This is not usually the problem. The decision for reporters is not really about a lack of recognition, more often it is something like: is the (constantly dynamic) level

of care provided to this child currently below a minimum acceptable standard of parenting, to the point that OT should act?

Onto this complex stage steps the issue of what mandatory reporting does. Harvey et al. set out the problems with this succinctly:

The US ... system often begins with well-intentioned professionals making child protection hotline calls, jeopardising their own ability to work with families and subjecting the families to surveillance.. By the system's own standards, most of this surveillance leads to no meaningful action... [Reporters]—whether motivated by genuine concern, which may nevertheless be informed by implicit biases towards low-income families and families of colour; fear of liability; or the desire to access services they believe families cannot acquire elsewhere—overwhelm our child welfare system with unnecessary allegations of maltreatment (Harvey et al., 2021, p1).

The US has had a mandated environment since the 1960s, following the discovery by Kempe and colleagues of the 'battered child' phenomenon (Melton, 2005). The expectation was that a few hundred people each year might be reported. Instead, they now have millions of reports, the majority of which are not substantiated. For example, Ho et al. (2017) compared states with and without universal mandatory reporting and found that the probability of reports being confirmed was significantly lower in mandated environments. In New South Wales (NSW), where mandatory reporting has been in place since 1977, (and named in the review as a mandatory reporting 'success') there are huge numbers of reports, a low percentage of which are substantiated compared to Western Australia, where there is no mandatory reporting (Ainsworth, 2002). In NSW the proportion of cases substantiated was just 21% of all reports, while in Western Australia it was 44% (Ainsworth, 2002, p.58). What these examples show is that mandatory reporting doesn't just flood

the system with cases that actually require statutory investigation – it floods the system with low-risk cases, due to professionals fearing liability and so reporting ‘just in case’. If a system flood resulted in more high-risk cases being reported, it would be much more persuasive (and worth the subsequent administrative burden) but it does not. Instead it can overwhelm the system with low-risk cases that reduce the ability to identify the high-risk ones.

As Gary Melton wrote in his famous article ‘Mandatory reporting: a policy without reason’, reporting was initially proposed as a fix for child abuse back when it was assumed by Kempe to be limited to those who had a kind of ‘syndrome’ or distinct psychological disorder that caused them to abuse their children. We now know that child abuse and harm are much more widespread, far beyond this imagined small group of ‘deviants’. We also know it exists on a continuum of parenting, along which people can move over time in either direction, as do the social definitions of what ‘counts’ as abuse. It is not just those who have some clearly identifiable ‘disorder’, but abusive behaviour can be perpetrated by anyone—there is really no ‘them and us’. So it’s not a matter of just being able to recognise ‘signs’ of abuse, what’s more relevant is understanding the causes of harmful behaviour towards children and how we can mitigate them, as well as at what level of severity to report.

On the question of causation, Melton (2005) explains the issue is more complex than first thought, with multiple types of abuse and complex causes, only a few of which are related to individuals per se. While there are individual factors that increase the chances of becoming abusive (own history of abuse, abuse-supportive beliefs about child discipline, impulsivity); social stressors, particularly poverty, increase the chances of child harm of all kinds. Exposure to poverty sets the scene for many social ills that can have a knock-on effect on parenting, for example: the chances of drug use and other mental health difficulties, other physical

health issues, poor housing, high care burdens, all of which put direct pressure on parenting. Just as hungry children can’t learn, hungry parents in cramped and inadequate housing with no money have an even harder time with the normal pressures of parenting. There are also community level causes, such as living in highly transient neighborhoods, low social cohesion, social isolation or low community resources. This is why reporting people to a central investigatory agency doesn’t automatically address or prevent the problem, because it doesn’t address those stressors or other social causes.

To report every possible case, however minor, creates a system big on monitoring and triaging, and small on prevention. It exacerbates the ambulance at the bottom of the cliff phenomenon and turns all professionals outside of OT into monitors rather than helpers. Of course, this doesn’t mean we should throw up our hands and do nothing—far from it. Serious cases should be reported as soon as possible. But it does mean that the resources we have to throw at the issue should be distributed in a way that is heavily weighted towards prevention, and that the reasons and thresholds at which reporting should happen are clearly agreed and communicated.

Currently the budget for prevention is already stretched, with some key services under strain. Strengthening families has been reduced in some parts of the country, and other services such as *Family Start* and *Social Workers in Schools* have had their budgets threatened. Within OT the number of social workers is falling. So the overall picture of a flood of reports, requiring a much higher number of social workers to process and triage them, combined with ongoing cuts to the budgets of preventive services, points to a much bigger issue than mandatory reporting. Making reporting mandatory in this environment could push the threshold even higher for action, because with less prevention and a lower reporting threshold, there will likely be many more reports. Unless

people and resources are available to assess each report, only the highest risk ones filter through the strained system, which will then be less able to identify the truly high risk ones. So there are some perverse consequences, and wider system factors to consider.

As mentioned above, a regulatory regime to encourage reporting is currently in place. The question of why organisations do not report when they clearly should is a legitimate one. Many of the situations people in the community deal with are rarely black and white. Most 'signs of abuse' are not deterministic, and are well known to community workers. It's not they can't recognise these signs, it's that many don't absolutely point to abuse. For many community workers the bigger question is 'how can I mitigate the potential for harm to the children in this family, and when does it reach a threshold for reporting?' Parenting behaviour occurs within a complex mix of family relationships, resources, and dynamics, some of which they can mitigate themselves more effectively than OT. Community professionals have a range of methods for addressing some types of family situations to stop them escalating into abuse, or working with families in educative and supportive ways to reduce harm without subjecting children and their parents to the harms and stresses caused by investigation. If we mandate reporting, reports will be forced through which won't meet the OT threshold for action, but will still damage the relationships between community workers and the family. The family may disengage, and then the children and their family could be left with no support that might actually reduce the harmful behaviour.

Some non-reports are a threshold issue—that is there may be a general concerning picture, but with protective factors as well that all change over time, but generally don't meet the threshold for OT to take action. There is a lack of clarity about where this threshold is, and it appears to be very high in many places, with unclear criteria, which community reporters must divine through trial and error. This is something

we should be examining more closely, because the other main reason professionals may not report is that they are affected by previous negative reporting experiences. They may have reported similar cases before and OT did not act on them; there was a long delay in contact or response from OT, (or none at all); OT didn't gather enough relevant information from the people closest to the case so arrived at an erroneous plan of action; or the reporter didn't know what the outcome was or the reasons for it. These experiences reduce trust in reporting. Clarification is definitely required about which cases can and should be reported, and a clear process that reporters and whānau can expect from OT once reports are made (there is some pleasing attention to this issue in recommendation 3 of the Oranga Tamariki practice review, and in the mention of better guidance around reporting and inter-agency work in the Poutasi report (Office of the Chief Social Worker, 2022; Poutasi, 2022)).

Just three years ago, in response to the Hawkes bay case, we were filing another case review, and another five reviews, all focussed on reducing the chances of children entering care, more acknowledgement of the potential for harm caused by the system itself, and on reducing disparities for Māori. Part of the ongoing action from that event (for example, the Waitangi Tribunal's urgent inquiry into OT, (2021) Te Kahu Aroha, the Ministerial Advisory Group) focusses on returning authority to Māori, on the devolution of resources to communities, and on preventing children entering care. But mandatory reporting will work in the opposite direction, increasing both total reports and Māori reports, intensifying the power of Oranga Tamariki, not iwi or community, and increasing disparities for Māori. This is because when people are encouraged to be risk averse, and act on suspicion for low level cases, that subtly entwines with racist assumptions about risk entering into decision-making. Racist biases that view Māori as inherently

'risky', are likely to increase the disparities for Māori in a mandatory environment (Keddell & Hyslop, 2019). Disparities will increase for another reason too. Structural disadvantages affect Māori more than non-Māori, so the effects of reducing risk levels for reporting also gathers up more whānau Māori suffering adverse social conditions.

Finally, careful thought is needed about what kinds of knowledge and education are required to navigate reporting decisions. Simply focusing on 'recognising the signs and symptoms of abuse' is answering the wrong kind of question if we want a system focussed on prevention. Instead of 'what are the signs?'—90% of which are fundamentally indeterminate anyway—we should be asking 'what are the causes of child abuse and harm and how can we mitigate them?'. This requires a much broader approach to child and family wellbeing, a contextual view of abuse and harm, and an understanding of effective responses. As Levi (2021, n.p.) pointed out:

Equally, if not more troubling, few ('signs of abuse') trainings take a broader view. Such a view would move us away from surveilling families with a "when in doubt make a report" approach, and toward supportive action and empathy. It is important to help people, especially mandated reporters, think more critically about what they see, and how they interpret it; when to be concerned, and when (and how) to take action to safeguard children and support families. There is a profound difference between poverty and neglect, and between abuse and parenting that is not what the observer thinks is ideal. Rarely are mandated reporters being trained to be on the lookout for children in a way that explores a broader concept of wellbeing, and understands the complex and compounding impact of economic inequities, cross-generational trauma and systemic racism.

On that note, it's worth asking: who will benefit from mandatory reporting? The

charities positioning themselves to offer 'training' on 'recognising the signs of abuse' will undoubtedly benefit, as requirements for that kind of ongoing education will make their services indispensable. There are huge conflicts of interest when we give them the microphone to promote their wares by supporting mandatory reporting. It would be good to hear from more professionals in the sector—from people who regularly make reports, people who are currently bound by reporting policies in their organisations, what it's like for the social workers who receive those reports, and from families who have been reported and what helped or did not help them. Children exist in a context, and unless we understand that context we are unlikely to make things any better for them.

#### **Alternative recommendations:**

- Create a consensus between community reporters and Oranga Tamariki on what kinds of cases should be reported, what the process will be following reports, who will be included in communication, why, and when. Communicate this consensus to all stakeholders, with clear guidance and an active education strategy. Ensure parents, whānau members, young people and Māori are included in the consensus-building process.
- Ensure that enough information is gathered at the initial assessment phase to make a sound decision. If the reporter is a community professional who knows the family well, speak to them. Tell reporters what to expect next and act on it.
- Focus education in the sector on what causes child abuse and harm, how to prevent it, and understanding families in context, rather than 'signs of abuse'. The former creates a workforce that can take action to prevent harm, the latter creates a workforce focussed on surveillance.
- Consider reporting within the wider context of Te Tiriti, prevention and community devolution paradigms.

## References

- Ainsworth, F. (2002). Mandatory reporting of child abuse and neglect: Does it really make a difference? *Child & Family Social Work*, 7(1), 57-63. <https://doi.org/https://doi.org/10.1046/j.1365-2206.2002.00228.x>
- Harvey, B., Gupta-Kagan, J., & Church, C. (2021). Reimagining schools' role outside the family regulation system. *Columbia Journal of Race and Law*, 11(3), 575-610. <https://doi.org/10.52214/cjrl.v11i3.8745>
- Ho, G. W. K., Gross, D. A., & Bettencourt, A. (2017). Universal mandatory reporting policies and the odds of identifying child physical abuse. *American Journal of Public Health*, 107(5), 709-716. <https://doi.org/10.2105/ajph.2017.303667>
- Keddell, E., & Hyslop, I. (2019). Ethnic inequalities in child welfare: The role of practitioner risk perceptions. *Child & Family Social Work*, 24(4), 209-420. <https://doi.org/10.1111/cfs.12620>
- Levi, B.J. (2021). Mandated reporters need training on context, critical thinking. *Imprint Magazine, Youth News*. <https://imprintnews.org/child-welfare-2/mandatory-reporters-training-context-critical-thinking/53308>
- Melton, G. (2005). Mandatory reporting: A policy without reason. *Child Abuse and Neglect*, 29, 9 - 18.
- Office of the Chief Social Worker. (2022). *Ko te huarahi pono. Oranga Tamariki*. <https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Performance-and-monitoring/Reviews-and-Inquiries/Practice-review-Malachi-Subecz-and-whanau/Ko-te-huarahi-pono-ka-watea-kia-whakamana-kia-whakatika.pdf>
- Poutasi, K. (2022). *Ensuring strong and protective safety nets: Joint review into the Children's Sector*. Oranga Tamariki. <https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Performance-and-monitoring/Reviews-and-Inquiries/System-review-Dame-Karen-Poutasi/Final-report-Joint-Review-into-the-Childrens-Sector.pdf>
- Waitangi Tribunal. (2021). *He pāharakeke, he rito whakakīkinga whāruarua oranga tamariki uregent inquiry WAI 2915. Waitangi tribunal*. [https://forms.Justice.Govt.Nz/search/documents/wt/wt\\_doc\\_171027305/he%20paharakeke%20w.Pdf](https://forms.Justice.Govt.Nz/search/documents/wt/wt_doc_171027305/he%20paharakeke%20w.Pdf)