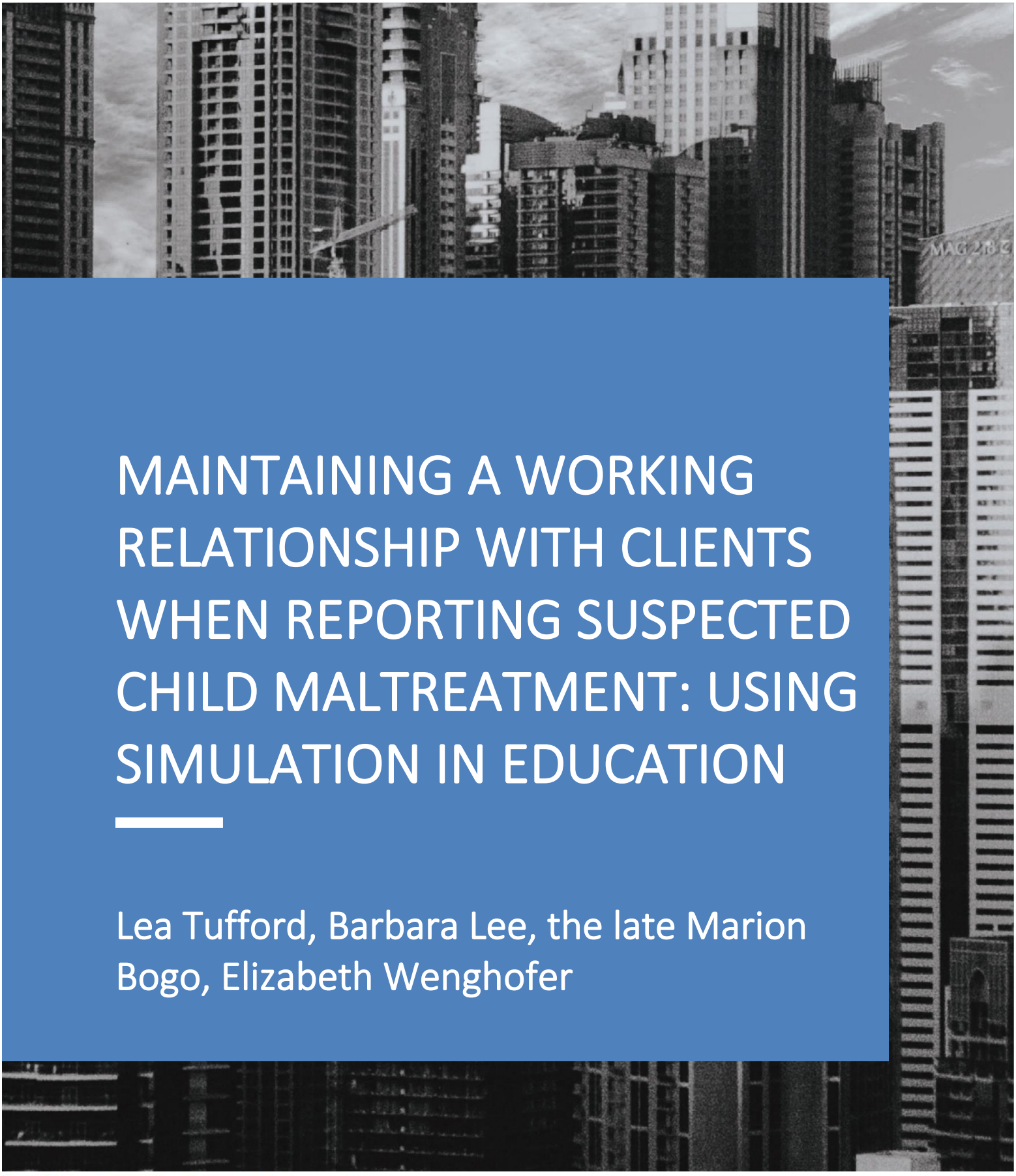

MAINTAINING A WORKING RELATIONSHIP WITH CLIENTS WHEN REPORTING SUSPECTED CHILD MALTREATMENT: USING SIMULATION IN EDUCATION

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Land Acknowledgement

We respectfully acknowledge that Laurentian University is located on the Robinson-Huron Treaty of 1850 territory and on the traditional lands of the Atikameksheng Anishinawbek and Wahnapitae First Nation.

We respectfully acknowledge that the University of Toronto sits on the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit.

We respectfully acknowledge that the University of British Columbia is located on the unceded traditional territories of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and səlilwətaɬ (Tsleil-Waututh) Nations.

We respectfully acknowledge that the University of Calgary is on the traditional territories of the peoples of Treaty 7, which include the Blackfoot Confederacy (comprised of the Siksika, the Piikani, and the Kainai First Nations), the Tsuut'ina First Nation, and the Stoney Nakoda (including Chiniki, Bearspaw, and Goodstoney First Nations).

Introduction

The purpose of this manual is to help prepare social work practitioners and students in their decision-making to report suspected child maltreatment and maintain the therapeutic relationship with the client. Our purpose is to help students and practitioners feel empowered and knowledgeable when working with children and their families. The manual focuses on empirically supported decision-making factors and strategies currently used by social workers in the field to repair and restore the therapeutic relationship before and after a report to Child Protection Services.

To complement the participant manual, the educational toolkit features a presentation, PowerPoints of the core material, case vignettes depicting the typology of maltreatment at minimal, moderate, and extreme levels of severity. Discussion questions of these vignettes are provided to assist students and practitioners to reflect on their decision-making processes. For training environments wishing to implement an Objective Structured Clinical Examination (OSCE), the module contains a performance rating scale, reflection rating scale, reflection questions and instructions on implementing an OSCE.

Section One: Information on Mandatory Reporting

This section begins with a brief description of how child welfare legislation in Canada has evolved and outlines how legislation is differentiated amongst the provinces and territories. The definitions of child maltreatment are expanded upon as well as the circumstances in which these various forms of maltreatment are often found. In addition, this section will provide a brief list of the occupations that are required to report to Child Protection Services.

History of Child Maltreatment Legislation in Canada

Canadian child welfare legislation grew from the concept of *parens patriae*, a Latin term for "protector" or "father of the country" whereby the court may substitute as a benevolent parent on behalf of the state (Bala & Clark, 1981). Although interventions originally focused on enforcing standards of care as opposed to the caring aspects of parenting, the *parens patriae* framework served to inform Ontario's 1893 Act for the Prevention of Cruelty to and Better Protection of Children and the 1908 federal Juvenile Delinquents Act (MacIntyre, 1993). The latter legislation was designed to protect children from their or others' "evil tendencies" through providing state representatives to offer guidance and assistance.

Juvenile and family court judges were charged with the responsibility of acting in the role of the benevolent parent on behalf of the state and render their decisions for the child's best interests accordingly. Amendments to provincial child welfare and federal juvenile delinquent acts throughout most of the 20th century were based on the concept of *parens patriae*, which provided the state with the right to remove some authority from the family, define good and bad parents' behaviour, articulate safe living conditions for children, propose possible outcomes for young persons involved, and establish services for children believed to be in need of state intervention (MacIntyre, 1993).

In Canada, child welfare falls under provincial and territorial matters. With the enactment of child welfare legislation, arose the establishment and growth of Child Protection Services (CPS) and provincial departments of child welfare. Early legislation did not concern itself with societal issues of poverty, exploitation of children, or other social issues which resulted in neglected, abandoned, or maltreated children, but did enforce that parents no longer had the right to absolute power over their children (MacIntyre, 1993). Child welfare legislation continued to

expand and refine in scope throughout the 21st century. In the 1960s, provinces began introducing mandatory reporting legislation (Mathews & Kenny, 2008) and since 1980, every province and territory has enacted some form of this legislation (Walters, 1995).

Definitions of Child Maltreatment

Legislation differs across provinces, territories, and states in the definition of maltreatment. At the federal level, the Public Health Agency of Canada (2006) stipulates that "child maltreatment refers to the harm, or risk of harm, that a child or youth may experience while in the care of a person they trust or depend on, including a parent, sibling, other relative, teacher, parent or guardian. Harm may occur through direct actions by the person (acts of commission) or through the person's neglect to provide a component of care necessary for healthy child growth and development (acts of omission)" or "psychological harm, or serious risk of harm to the child."

Physical maltreatment involves actions such as: shaking, pushing, grabbing, throwing, hitting with a hand, punching, kicking, biting, hitting with an object, or other forms such as choking, strangling, stabbing, burning, shooting, poisoning, and the abusive use of restraints (Trocmé et al., 2010). Emotional maltreatment has vague definitions due to a lack of a specific incident or visible injury and tends to become apparent over time. This type of maltreatment includes threatening, belittling or defamation, inadequate nurturance / affection, invasion of privacy, negligence, and exposure to non-intimate violence such as between adults other than parents (Trocmé et al., 2010).

Neglect includes omissions in care by parents or legal guardians resulting in significant or, the risk of significant, harm and involves failing to provide for a child's basic needs (i.e., food, clothing, shelter, supervision, medical care, emotional care, education, psychological /

psychiatric treatment, a hazard free home, affection) (Dubowitz, 1997; Trocmé et al., 2010). Neglect is often found in families living at or below the poverty level who are struggling with economic issues to provide for necessities such as food (Trocmé et al., 2010).

Sexual maltreatment encompasses acts involving physical contact including penetration, attempted penetration, oral sex, fondling, sex talk, voyeurism, exhibitionism, exploitation, inappropriate touching of genitalia as well as those of non-contact including exposure to pornography or sexual acts (Trocmé et al., 2010).

Exposure to intimate partner violence is an addition to mandatory reporting legislation in the Canadian context and involves a child either directly witnessing violence between parents or indirectly witnessing the violence, such as through seeing the physical injuries on the parent or overhearing the violence. Within the previous decade, seven jurisdictions have included exposure to intimate partner violence as a circumstance where a child is in need of protection (Newfoundland and Labrador, Alberta, Manitoba, the Northwest Territories, Nova Scotia, Prince Edward Island, and Saskatchewan) (Mathews & Kenny, 2008). Ontario does not currently have this legislation; however, these cases are processed as child protection services based on the Ontario Child Welfare Eligibility Spectrum (2021) and some municipal police protocols.

These categories should be analyzed within the context of their varied circumstances, for example, neglect may have different meanings and manifestations for a child aged four as opposed to an adolescent aged 14. Neglect may also have a different meaning for an upper middle-class family as opposed to a family living below the poverty level.

Mandatory Reporters

In addition to social workers, there are many professional groups who are considered mandatory reporters. Some of the professional groups include medical personnel (physicians,

surgeons, osteopaths, resident interns, nurses, dentists, dental hygienists, medical examiners, pharmacists), mental health professionals (psychologists, social workers, marriage and family clinicians, family counsellors), educational personnel (teachers, teacher's assistants, administrative officers, school principals), members of the clergy, employees of the justice system (probation officers, parole officers), and occupations specific to children / youth (operators or employees of a day-care facility, youth or recreation workers, employees of public or private day camps, foster parents, group home personnel). This list is not exhaustive, and those occupations with mandatory reporting obligations vary per provincial and territorial legislation.

Canadian Association of Social Workers

Despite the fact that mandatory reporting legislation is provincially and territorially directed, all registered social workers practicing in Canada are governed by The Canadian Association of Social Workers Code of Ethics, Values and Guiding Principles (2024). The Code of Ethics is not silent on the mandatory reporting of child maltreatment but speaks to this issue at various points:

- Guiding Principle 1.7: Social workers uphold the rights of every person, group, and community to be free from violence or threat of violence;
- 1.7.3 being knowledgeable about the signs of physical, emotional, and sexual abuse and the sexual exploitation of children and youth and taking the necessary measures to protect their safety and well-being and, where circumstances require, fulfil their professional duty to report specified under child protection legislation in their jurisdiction

The code also speaks about confidentiality:

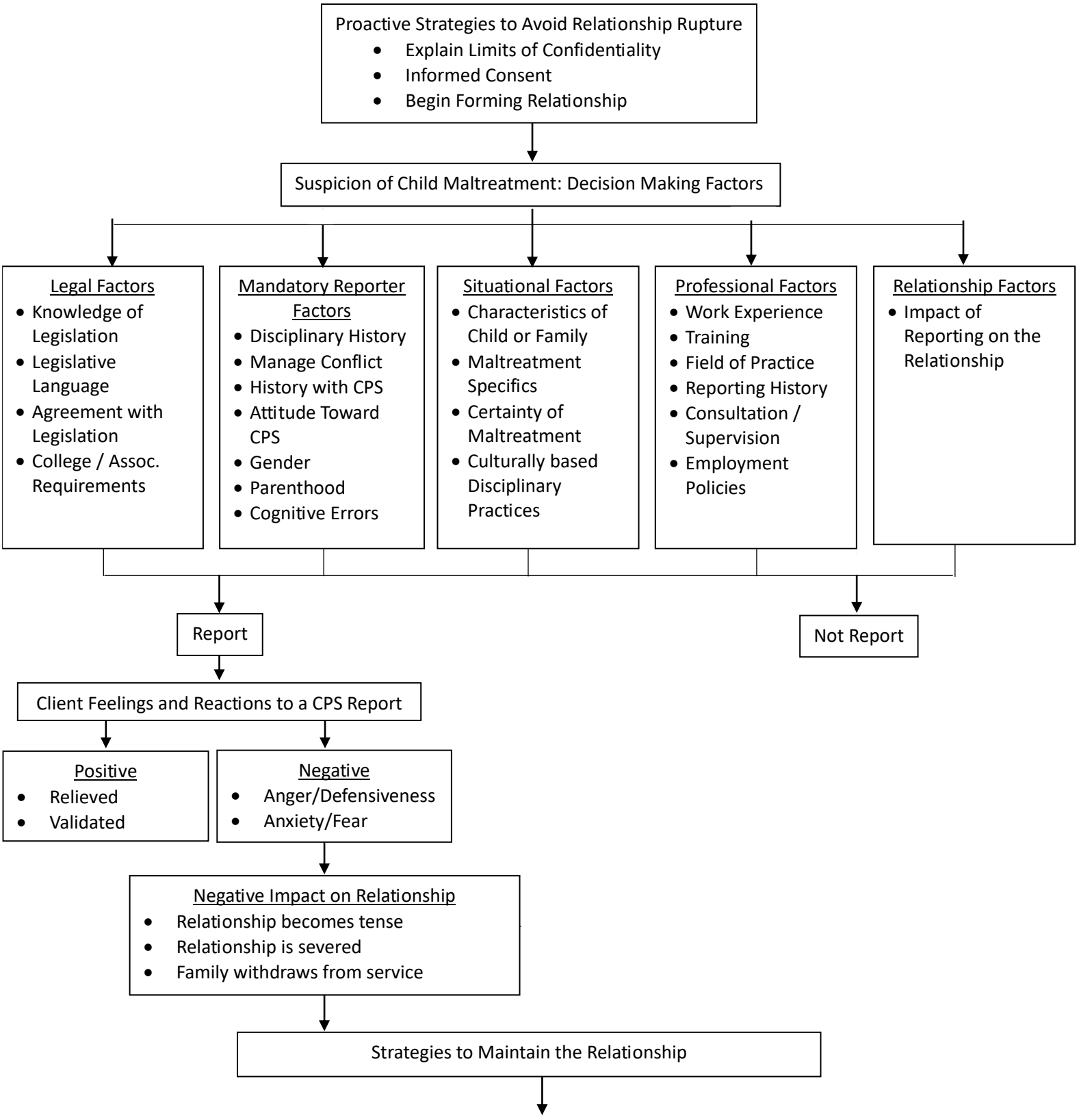
- Guiding Principle 6.3: Social workers are transparent about the limits of confidentiality in their professional practice;

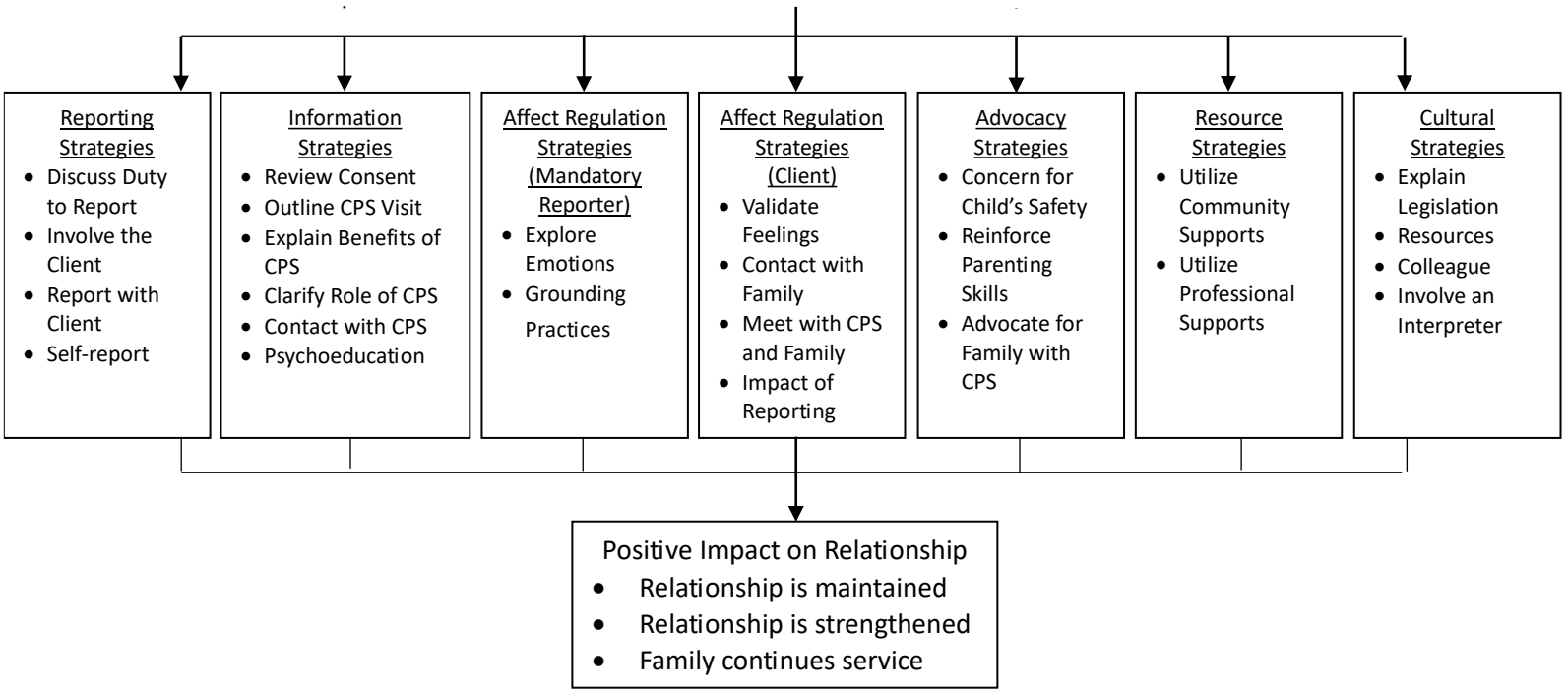
Guidelines: Social workers inform service users of the limits to privacy and confidentiality related to:

- 6.3.1: the individual rights of children and adolescents, couples, families, or groups sharing information in service provision, which may or may not be respected by all

Figure 1

Framework for Mandatory Reporter Decision Making and Relationship Repair




Reporting Strategies
Discuss Duty to Report
Involve the Client
Report with Client
Self-report
Information Strategies
Review Consent
Outline CPS Visit
Explain Benefits of CPS
Clarify Role of CPS
Contact with CPS
Psychoeducation
Affect Regulation Strategies (Mandatory Reporter)
Explore Emotions
Grounding Practices
Affect Regulation Strategies (Client)
Validate Feelings
Contact with Family
Meet with CPS and Family
Impact of Reporting
Advocacy Strategies
Concern for Child's Safety
Reinforce Parenting Skills
Advocate for Family with CPS
Resource Strategies
Utilize Community Supports
Utilize Professional Supports
Cultural Strategies
Explain Legislation
Resources
Colleague
Involve an Interpreter
Positive Impact on Relationship
Relationship is maintained
Relationship is strengthened
Family continues service

The framework of Figure 1 is based on Brosig and Kalichman's (1992) model of practicing psychologists' child maltreatment reporting decisions. This framework begins with the strategies respondents outlined qualitatively to avoid relationship ruptures prior to the disclosure of reportable material. Specifically, respondents noted explaining the limits of confidentiality at the start of counselling, asking clients to sign an informed consent statement, and building a therapeutic relationship early within counselling.

From these initial strategies, the framework proceeds to outline the decision-making factors to consider when faced with suspected child maltreatment. These include legal, mandatory reporter, situational, professional, and relationship factors. Based on these discrete but interrelated factors, the mandatory reporter decides to report or not report to CPS. In the event of reporting, the family may have a positive or negative reaction to the report or somewhere in between. A positive reaction could include that the family feels heard and understood and is appreciative of the report. A negative reaction could include that the family feels afraid, angered, and betrayed by the mandatory reporter. This could then lead to the relationship becoming strained and tense and possibly resulting in the family withdrawing from treatment. In the event that the family's reaction is negative, the mandatory reporter can draw from a number of relationship repair strategies, specifically reporting, information, affect regulation, advocacy, resource, and cultural strategies. Emerging from these strategies is the impact on the relationship which can be maintained or strengthened leading to continued treatment.

In presenting this framework, some mandatory reporters may have been trained to not tell the client they are reporting, or their workplace policy is not to tell clients while other readers may have been trained to discuss reporting with the client prior to doing so. The framework is

predicated on discussing the report with the client, but this may not be the case for all mandatory reporters. However, the relationship repair strategies can still be useful for mandatory reporters who do not discuss reporting with clients prior to filing a report.

Proactive Strategies to Avoid Potential Relationship Rupture

At the top of the framework are the proactive strategies to avoid potential relationship rupture. The first strategy involves explaining the limits of confidentiality, which will look different depending on the geographic region. When explaining the limits of confidentiality, it is recommended to discuss the different types of abuse and neglect, namely physical, sexual, emotional, intimate partner violence, and neglect. This lets the client know that there are different types of abuse as often clients may think of only physical abuse.

It is also important to discuss any legal reasons why confidentiality cannot be maintained, for example, there may be situations where client notes must be submitted for court proceedings. There may be other situations, for example, in Ontario, if a client discloses they are being treated in an unethical manner by a regulated health care provider such as an occupational therapist, physiotherapist, teacher, or doctor, the mandatory reporter is obligated to contact that professional's college. Should the client have any questions about any aspect of confidentiality, their questions and the social worker's responses should be documented and remain in the client file.

The second strategy is informed consent. This involves asking a client to sign an informed consent statement that would explain the limits to confidentiality as well as other information such as fees, cancelation procedures etc. Some clients may not feel comfortable signing an informed consent statement and may wish to give oral consent. In this situation it is important to document that the informed consent statement was explained in detail and the client

chose not to sign but gave oral consent. The final strategy involves beginning to form the therapeutic relationship with the client. This will be demonstrated in the simulation videos which are part of the educational toolkit. Building the relationship can take place by asking how the client is doing, expressing concern for their wellbeing, offering condolences when a loss has occurred, and treating them not just as a parent but as an individual. It is important to remember that most clients are trying to parent the best they can often under challenging circumstances such as inadequate housing, poverty, disability, illness, and bereavement.

Summary

Section One provided critical information on the legal and ethical aspects of mandatory reporting in Canada as well as information on CPS. Social workers new to the practice are advised to familiarize themselves with this information and to stay current with legislative and ethical revisions which may impact their practice. Section Two outlines the empirical literature on decision making concerning the mandatory reporting of child maltreatment.

Section Two: Decision-Making and Mandatory Reporting

There are various factors social workers consider when rendering accurate reporting decisions concerning child maltreatment which include legal, mandatory reporter, situational, professional, and relationship. Social workers must balance these factors to render decisions that are ultimately in the best interests of the client. This section will provide further explanations on these factors.

Legal Factors

Knowledge of Legislation

Mandatory reporting legislation varies from province to province and territory to territory. There does not exist a single, unified system of child welfare. Previous research has shown that clarity of a professional's legal requirement was most strongly related to the likelihood of reporting child abuse and neglect. When social workers understood when a report of child maltreatment was legally required, they were more likely to report (Goodyear-Smith, 2012; Tufford & Lee, 2019).

Legislative Language

Definitions of maltreatment range from broad and general to narrow and specific. Statutory wording of mandatory reporting laws has been found to be a cause for concern, with vaguely worded statements potentially leading to underreporting (Finkelhor, 2005) or overreporting of maltreatment (Besharov, 2005). Vague language such as "reasonable suspicion," "cause to believe," and "reasonable cause to know and suspect" are listed as potential reporting requirements and terms such as "maltreatment" and "neglect," that lack precision in their definitions, can confuse mandatory reporters as to what constitutes reportable behaviour and leave discretion to the reporter (Levi et al., 2006; Levi & Loeben, 2004). Wording of this nature may lead mental health professionals to make decisions guided by factors of a personal or subjective nature that may have no relevance to the situation in question (Ashton, 1999).

Agreement with Legislation

Social workers may agree or disagree with mandatory reporting legislation. Research has shown that social workers who do not agree with their legal obligation as a mandatory reporter were less likely to report child maltreatment (Tufford, 2014; Tufford & Lee, 2019).

College / Association Requirements

Due to the regulated nature of the social work profession, social workers must be part of a provincial or territorial college or association. Colleges or associations may have a Code of Ethics to guide professional behaviour with regard to issues of confidentiality, informed consent, and mandatory reporting of child maltreatment.

Mandatory Reporter Factors

Disciplinary History

Disciplinary history concerns the personal discipline the social worker received during their formative years. The experience of hearing a child or adult recount a disciplinary experience within a professional context is likely to generate reflection and possible emotional response regarding one's own disciplinary history (Baginsky, 2003; Buckley, 2000). The relationship between how adults were disciplined during their formative years and their beliefs about discipline and maltreatment is complex; for example, a social worker who experienced a type of punishment as a child is more likely to feel that this type of punishment is appropriate and approve of its use unless his or her appraisal of the experience is negative (Ashton, 2001, 2004). Negative appraisals generally include feelings of rejection, unfairness, harshness, or abuse and thus, lead to a decreased likelihood of endorsing this form of punishment as normative (Schenck et al., 2000). This is very much an individual value judgment in which parental behaviour considered to be serious by one social worker may not be viewed as serious by another social worker. Social workers who assessed their childhood experiences of discipline as abusive were more likely to suspect potential or questionable abuse (Hansen et al., 1997; Nuttall & Jackson, 1994). Conversely, punishment not appraised to be abusive or harsh was more likely to

be evaluated as appropriate, which may be problematic as mandatory reporters may be required to report behaviours they experienced and labeled as appropriate forms of discipline.

Manage Conflict

A social worker who experiences difficulty managing conflict and who perceives that a parent will become angry or upset may be more hesitant to report despite having the best of intentions to maintain the relationship following the report (Tufford, 2012).

History with CPS

Social workers who were involved with CPS during their formative years may be impacted either positively or negatively by this involvement now that they are acting in the role of a professional. A previous positive experience with the CPS may lead to a willingness report whereas social workers with an unfavourable experience may be reluctant (Tufford, 2012).

Attitude Towards CPS

A social worker's attitude towards the functioning of CPS may affect their decision-making processes. Tilden et al. (1994) found that the primary reason why clinicians choose to not report suspected child abuse and neglect is that doing so unleashes a series of events which unfold outside their control. Research has shown that social workers' have many concerns around CPS including a perceived inadequacy to conduct thorough investigations, failure by intake and investigation workers to take reports seriously, failure to protect other children residing in the home, lack of funding for CPS, and negative responses by child protection workers toward the reporter (Strozier et al., 2005; Tufford & Lee, 2019, 2020; Tufford & Morton, 2018). If a social worker believes that a situation will not be investigated due to lack of resources or not taken seriously, this may affect his or her decision to report. However, social

workers are legally obligated to report suspected child abuse and neglect. Therefore, social workers who are biased against CPS may not report, which may result in harm to the child.

Gender

Gender may also factor into the decision-making process; however, the evidence is contradictory. Some studies have found gender (female) is a factor (Al-Moosa et al., 2003; Attias & Goodwin, 1985; Broussard et al., 1991; Dukes & Kean, 1989; Gunn et al., 2005) while other studies have found gender is not a factor (Ashton, 2004; Tufford, 2012).

Parenthood

This factor examines the social worker's status as a parent. This could have implications in that social workers are not simply hearing about parental discipline from the client but may be currently in the role of disciplinarian themselves to their child. Parenting one's own child may surface discipline issues previously unconsidered and may foster opinions about what constitutes acceptable or unacceptable parenting practices. Some studies show parenthood being a significant predictor (Snyder & Newberger, 1986) while other studies do not support this (Ashton, 2004; Tufford, 2012).

Cognitive Errors

Mandatory reporters' decision-making can be impacted by cognitive errors, also known as mental shortcuts. One mental shortcut is called the "affect heuristic" which involves an increased tendency to remember images and experiences which are disturbing, vivid, and negative. These are given more weight than images or experiences which are positive. Negative experiences of calling CPS will stand out in the minds of mandatory reporters more readily than positive experiences and may impact decision-making.

Situational Factors

Child or Family Characteristics

Some of the more common characteristics are age and socio-economic status. For example, mandatory reporters are more likely to report in situations with younger children as opposed to older children (Kalichman & Craig, 1991). Mandatory reporters are also less likely to report situations where clients are white and affluent (Newberger, 1983). In terms of socio-economic status, it is well documented that children from poor families are overrepresented in the child welfare system. Low socio-economic status is often related to living below the poverty level, having inadequate housing, and/or receiving assistance from social services. This may increase the likelihood of contact with mandatory reporters.

Maltreatment Specifics

In determining the necessity of a report, social workers seek pertinent information or specifics around a disclosure such as what type of maltreatment, who was involved, what occurred, how did the child and parents react, what happened afterwards, were objects used, and what harm occurred. In seeking these details social workers gain a fuller understanding of the maltreatment scenario and then utilize their professional judgment to render the best decision. Research has shown that sexual maltreatment is more likely to be reported (Fraser et al., 2010; Kim & Lee, 2013). Severe injuries are also more likely to be reported (Kenny, 2004; Mathews & Kenny, 2008; Nouman et al., 2020; Xu, 2021). Maltreatment presently occurring is more likely to be reported than past maltreatment (Mathews & Kenny, 2008). Finally, an injury not consistent with the history or the child's developmental level is more likely to be reported (Flaherty et al., 2008).

Certainty of Maltreatment

This factor concerns the mandatory reporters' level of certainty that maltreatment has, in fact, occurred. This may depend on the amount of evidence that is presented (Watson & Levine, 1989). Kalichman and Craig (1991) and Kalichman et al. (1989) found that child abuse and neglect where the child provided a verbal account of being maltreated were more likely to be reported. This is a significant finding for many maltreated children remain silent due to the fear of aversive consequences of disclosing maltreatment (Pierce & Pierce, 1985).

Reporting increases when a child has physical signs of maltreatment, a parent admits to being abusive (Kalichman et al., 1989) or when a child provides a verbal account of being maltreated (Kalichman & Craig, 1991). Increased evidence may imply more serious maltreatment whereas the perception of a lack of evidence may lead to non-reporting (Francis et al., 2012; Price & Kehn, 2022; Talsma et al., 2015). Some mandatory reporters wait for additional evidence to confirm if the situation warrants reporting (Strozier et al., 2005).

In addition, given that a disclosure of child maltreatment can take place without the child present, the dilemma for social workers is to make a decision concerning the welfare of the child in the absence of actually seeing or interacting with the child (Agatstein, 1989). Thus, social workers are basing the reports on the accounting of the clients before them. Some social workers do not report and instead wait for additional evidence to appear to confirm if the situation warrants reporting (Strozier et al., 2005). However, waiting for additional evidence is problematic, as the majority of legislation requires the reporting of a suspicion of child maltreatment and not evidence that it has occurred.

Culturally-based Disciplinary Practices

Parents immigrating to Canada may engage in culturally sanctioned child rearing practices considered non-normative or harsh compared to those practices in Western society and may be viewed as maltreatment (Chang et al., 2006; Dubowitz, 1997; Fontes, 2002; Maiter, 2004). How social workers differentiate cultural parenting practices from child maltreatment while factoring in legal reporting obligations is unclear (Terao et al., 2001). Although acculturation should always be taken into account (Azar & Benjet, 1994), the obligation of social workers is to keep children from any culture free from present or future harm (Terao et al., 2001).

Professional Factors

Work Experience

The first factor is mandatory reporters' work experience. Research has shown that mandatory reporters with more work experience were more likely to report to CPS and were less concerned with the potentially negative consequences. Essentially, more work experience can lead to more accurate assessment of the physical and emotional state of children (Kenny, 2001). Mandatory reporters with less work experience were more concerned with potentially negative attitudes by parents and parents and were less likely to report. However, other research has shown that professionals with longer practice histories tend not to report (Gunn et al., 2005). These latter professionals may be more cynical about their ability to intervene successfully in a case of suspected child maltreatment (Rollins et al., 2016; Tufford & Morton, 2018).

Training

A second professional factor that may impact reporting decisions is training in the recognition of child maltreatment. Many mandatory reporters receive training during in-service

opportunities, staff meetings, and webinars. Training can lead to improved recognition and reporting of child abuse, how to identify types of abuse, how to work with families affected by abuse, and a better understanding of CPS processes. Research has consistently shown that mandatory reporters with prior training in child abuse and neglect identification are more likely to report suspected maltreatment (Alvarez et al., 2010; Flaherty et al., 2000; Fraser et al., 2010; Gunn et al., 2005; Rolim et al., 2014; Shechter et al., 2000). Moreover, lack of training can be a barrier to accurate reporting (Al-Ani et al., 2021).

Field of Practice

There is a paucity of research on how a social worker's field of practice impacts one's decision to report suspected child maltreatment. The majority of existing studies focus on the distinctions between mental health professionals such as social workers, psychiatrists, and psychologists; however, they fail to delineate fields of practice within each profession. An early study by Delaronde et al. (2000) did examine social workers, physicians, and physician assistants employed within four primary work settings: individual practice, group practice, hospital-based, and social service / school to determine their preference for an existing child maltreatment reporting policy or an alternative reporting policy. This latter category refers to reporting only certain types of suspected maltreatment while reserving less severe child abuse and neglect cases for consultation with a specialist functioning independently from CPS. The study found that mandatory reporters who worked in individual practice were significantly ($p < 0.05$) more likely to favour the alternative policy than those in group practice or in a hospital setting.

More recent research (Tufford, 2012) examined the decision to report based on a social worker's field of practice including medical related practice, community related practice, child

related practice and private practice. This research did not find that field of practice was a significant predictor in the decision to report suspected child maltreatment.

Reporting History

Reporting history may also affect mandatory reporters' current reporting tendencies. If reporting results in stopping maltreatment, this may increase the likelihood of future reporting. However, when reporting leads to negative results such as disruptions in therapy or litigation against the mandatory reporter, this will most likely decrease future reporting (Chatziioannidis et al., 2018). The effects of reporting on subsequent reporting decisions relate to the consequences of the decisions rather than the decisions themselves (Flaherty et al., 2013; Tufford et al., 2015).

Consultation / Supervision

Consultation with peers, a supervisor, or discussion with the members of an interdisciplinary team may also impact the decision to report suspected child maltreatment as social workers value the opinions and perspectives of colleagues in their decision-making. Research conducted with members of the Ontario Association of Social Workers revealed that the opinion of colleagues was the top factor influencing decision-making to report suspected child maltreatment (Tufford, 2012). Consultation offers another perspective on the family's struggles, provides guidance in ambiguous cases of child maltreatment, validates conflicting feelings around the inclusion of the CPS, and reduces feelings of isolation in the reporting process. Peers can play a meaningful role in assisting and guiding their colleagues to appropriate and professional decision-making.

This finding is consistent with that of other researchers who found clinicians in community settings (McLaughlin et al., 2010) and in a mental health and addiction centre (Bogo et al., 2011a, 2011b) sought and valued the advice of peers and co-workers when faced with

clinical decision-making and challenging clinical issues. Specifically, clinicians appreciated the shared experience, practice wisdom, values, and perspectives of colleagues and even ranked talking with a colleague as the most important source of high-quality information. Clinicians learn from reflective discussions with colleagues, receive feedback, and are assisted in managing difficulties. Thus, findings from these two studies clearly demonstrate that social workers, even those not directly involved in a case of potential child maltreatment, play a meaningful role in assisting and guiding their colleagues to appropriate and professional decision-making.

Employment Policies

In many social work settings, employment policy dictates that suspicions of child maltreatment must be discussed first with the social work supervisor prior to filing a report. The following paragraphs highlight the protocol social workers are expected to follow in a sample of three social work settings: a children's mental health organization, a pediatric hospital, and a mental health research and counselling center.

A social work supervisor at a children's mental health centre outlined that when faced with a suspicion of child maltreatment, the social worker and his or her supervisor must complete and sign a form. In addition, there is often an informal process of discussion before a report is filed, particularly if the situation is ambiguous in nature.

A social work supervisor at a pediatric hospital where social work functions within an interdisciplinary team explained the process in their setting. When a situation meets the legal reporting criteria a verbal report must be submitted directly to the CPS. The duty to report must not be delegated to another team member, in order to limit any possibility of inaccuracy and to allow for clarification questions by the CPS. If a health care team mutually decides that a case meets the legal reporting criteria, a designated member of the health care team, preferably the

most knowledgeable about the client circumstance, should complete the report. The staff member who is reporting to the CPS is required by law to complete the report whether or not the responsible physician and / or other health care team members are in agreement. The hospital recommends that discussion occur with the CPS regarding informing the family of the report as well as with the responsible physician.

At a large mental health centre where social work also functions within an interdisciplinary team environment, the social worker who holds the suspicion that child maltreatment may be occurring must report verbally to CPS and note the report in the patient's file. The hospital advises social workers to discuss any potential report to CPS with the interdisciplinary team while outlining the rationale for the report and any supporting information.

As can be seen in the above examples, employment policies may differ from context to context. When starting a new place of employment, social workers are advised to familiarize themselves with mandatory reporting requirements. In addition, should a place of employment offer training in mandatory reporting, social workers are advised to avail themselves of this training.

Relationship Factors

Impact of Reporting on the Relationship

Mandatory reporters such as doctors, teachers, or school principals often have lengthy relationships with patients or students that can span years. Moreover, in rural or remote parts of Canada there may not be another doctor or social worker clients can see or another school to attend. Mandatory reporters are often concerned about the impact on the relationship, clients having decreased trust of their social worker or terminating the relationship altogether which

leaves mandatory reporters in the position of not being able to intervene to prevent future maltreatment.

Some mandatory reporters fail to report because they are afraid of affecting the therapeutic relationship. Research has shown that clients had been in treatment for roughly three months prior to the disclosure of child abuse or neglect. Thus, mandatory reporters may have formed powerful, therapeutic relationships with their clients. Therapeutic relationship outcome studies in cases of mandatory reporting have consistently shown that roughly 25% of cases were classified as having a negative outcome. Negative outcomes may include termination, missed appointments, lateness, client expressed anger, or threatened violence during session (Bean et al., 2011; Pietrantonio et al., 2013; Steinberg et al., 1997; Tufford et al., 2019; Weinstein et al., 2000).

Summary

This section examined the relevant decision-making factors social workers take into account when rendering decisions concerning child maltreatment. Some factors exist at a structural (legislation), professional (ethics), or personal (gender, parenthood, personal disciplinary history) level while other factors concern the occupational context (institutional policies) in which the social worker practices or the situational factors around the maltreatment. Social workers will vary in the degree of awareness given to factors described in this section. Finally, concerns over the loss or rupture of the relationship will impact the decision to report.

Section Three: The Therapeutic Relationship

This section will begin with a brief overview of the history and development of the therapeutic relationship between the social worker and the client. The importance of client engagement is examined, followed by a short case example. Relationship ruptures, how these might serve to strengthen the therapeutic relationship, and what social workers need to be aware of when working with their clients are discussed. Lastly, awareness in regard to how clients may feel or react towards a CPS report is considered, as well as how these reports may impact the clinical relationship and the work that is being done.

History of the Therapeutic Relationship

Historically, social work authors have characterized the relationship as the "soul" (Biestek, 1957), the "heart" (Perlman, 1957), and the "major determinant" (Hollis, 1970) of social work intervention. Roger's seminal book, *Client-Centered Therapy* (1951), bestowed the relationship with healing and restorative functions, which are predicated on the qualities of congruence, acceptance, empathy, warmth, and unconditional positive regard. Within Cognitive Behavioural Therapy, the relationship is posited as one of teamwork (Raue & Goldfried, 1994), which involves clients and clinicians working together to identify problems and solve client concerns. A postmodern approach to alliance formation emphasizes a relationship based on collaboration and mutual respect (Richert, 2010) whereby the client is both invited to co-construct new meanings and behaviours (Sexton & Whiston, 1994) and is viewed as the expert on their life and concerns.

Edward Bordin (1979) is credited with the term "therapeutic alliance" and put forth the existence of three, inter-related components of the alliance: bond, goals, and tasks. Empirical studies show that the therapeutic alliance plays an integral role in the interactions between social worker and client and is one of the most consistent and strongest predictors of treatment success (Horvath, 2001; Horvath & Symonds, 1991; Lambert & Barley, 2001; Martin et al., 2000) independent of social worker adherence to specific therapeutic approaches (Bickman et al., 2004; Chatoor & Krupnick, 2001; Horvath & Bedi, 2002; Karver et al., 2006; Luborsky, 2000; Martin et al., 2000; Sexton et al., 2005). For the purposes of clarity, the term "relationship" will be used to refer to qualities which encompass both the concepts of "relationship" and "therapeutic alliance."

Engagement

Engagement begins from the first point of contact, whether this occurs in the traditional waiting room or with the rise of electronic technologies, via email or text message (Mishna et al., 2012). This will include introductions and brief social talk and should be predicated on Rogers' (1951) time honoured principles of warmth, genuineness, and non-judgmental regard. In this way, the social worker creates an inviting space for clients to tell their story (Bogo, 2018). The adage of "starting where the client is" in the engagement stage enables social workers to understand the situation from the perspective of the client and allows the client to feel heard in their distress. Although engagement is most pressing in the initial stage of therapy, engagement is an on-going process which must be re-established with succeeding sessions or contact. Early relationship formation can lessen the negative impact of a report to CPS.

Within the engagement stage, it is essential that mandatory reporters are transparent regarding the limits of confidentiality and their legal obligation to report suspected child maltreatment. By being honest as to their reporting obligations, an atmosphere of trust is created (Smith, 2001). This discussion, undertaken in the early stages of the therapeutic relationship, also empowers the family by allowing them a measure of control over what information they wish to share in session (Bean et al., 2011; Davidov et al., 2012; Tufford, 2012, 2014).

Jasmine, a social worker at a children's mental health centre, is meeting parents Juan and Yolanda for the first time, who immigrated to Canada three months ago. Their five-year-old son Jorge is reportedly socially withdrawn at school. After inquiring if they found the centre easily and engaging in some initial pleasantries regarding the weather, Jasmine produced the centre's informed consent document. She outlined the limits to confidentiality to ensure Juan and Yolanda understood this information clearly prior to beginning the session.

Therapeutic Relationship Ruptures

Despite the importance and centrality of the therapeutic relationship, every social worker experiences from time to time "relationship ruptures," also known as "deteriorations in the relationship between clinician and client" (Safran & Muran, 1996, p. 447). Safran and Muran (1996) note that relationship ruptures emerge from both social worker and client contributions. Clients may demonstrate behaviours or communications requiring exploration in session while social workers may become caught in maladaptive, interpersonal cycles similar to clients' other interpersonal interactions that serves to confirm clients' beliefs about how they relate to others (Safran, 1990).

Relationship ruptures may waver in intensity, duration, and frequency and may go undetected by either social worker or client (Safran & Muran, 2000). Intense relationship ruptures can lead to a weakened relationship, thus resulting in dropout or treatment failure (Samstag et al., 1998). However, when a mandatory reporter manages a relationship rupture well, it can serve as the basis for therapeutic change and provide clients with a "new constructive interpersonal experience" (Safran, 1993). Given that clients may be neither willing nor able to voice their concern regarding a lack of comfort or disagreement with their social worker, it thus becomes critical for the social worker to recognize when the relationship is in jeopardy and address the rupture in a sensitive fashion to allow exploration and a minimum of client anxiety (Safran et al., 2001). The relationship may improve if social workers can respond to clients in a non-defensive fashion, adjust their behaviour accordingly, and address ruptures as they arise (Rhodes et al., 1994).

Client Feelings and Reactions to a CPS Report

Returning to the framework earlier in the manual, when a client is told that a report will be made to CPS, clients can have many feelings and reactions. Some clients feel relief and appreciate the support they will receive from the CPS because they do not have access to resources. Some clients also understand the reason for the report and the duty and obligation on the part of the social worker to report. Some parents are able to understand that the report is made in the best interests of the child.

Some clients may also experience negative feelings such as anger and defensiveness that they are not receiving the assistance they expected to receive from the social worker (Tufford, 2012, 2014). Some clients may feel anxious that a report will be made. The child may also feel anxious that they are to blame for the family's involvement with CPS. Fear is another negative feeling and may centre on the child being removed from the home (Asnes & Leventhal, 2010; Tufford, 2012, 2014), fear of the unknown, or fear that the perpetrator now knows a report has been made. Some clients may feel shame that a secret has now been revealed while others feel suspicious of the social worker's motives upon hearing of the report and that the social worker has taken the side of the CPS. Feeling violated and judged are other negative feelings in addition to families feeling alienated and betrayed. Finally, some clients will deny the occurrence of maltreatment and blame the social worker for the involvement of CPS.

Social workers are advised to prepare themselves for a range of feelings and reactions on the part of the client. From a clinical perspective, social workers should understand the distinction between primary and secondary emotions (Fosha, 2000; Greenberg, 2002). Clients facing a report to the CPS may experience primary emotions such as shame or embarrassment which can be quickly covered by anger used as a defense against these more primary and

vulnerable internal feelings. Secondary emotions, such as anger should be first validated and then explored to uncover the primary emotions (Greenberg, 2002).

Impact on the Clinical Relationship and Clinical Work

A report to CPS can impact the clinical relationship and clinical work. The relationship may be maintained or strengthened through the social worker's honest explanation of the reason for the report and for stating that the first priority is safety for the child. If social workers can demonstrate their desire to improve family functioning this often maintains the relationship.

However, the opposite may also be true. The relationship can become strained and tense and there can be a loss or diminishment of trust in the relationship. The loss of trust often centers on the breaking of confidentiality. Negative impacts on the clinical work include the family withdrawing from treatment altogether or families continuing in treatment but sharing decreasing amounts of information. This may depend on the presence and strength of the therapeutic relationship with the family, how long the social worker has known them and been working with them. These impacts can vary from family to family.

Section Three: Strategies to Maintain the Relationship

This section will focus on the different strategies that social workers can take to maintain the relationship between worker and client when a CPS report is involved. These strategies are separated into reporting strategies, information strategies, affect regulation strategies (mandatory reporter), affect regulation strategies (family), advocacy strategies, resource strategies, and cultural strategies. Each of these will be expanded upon with specific examples of ways in which social workers can implement these strategies.

Strategies to Maintain the Relationship

Reporting Strategies

Reporting strategies involve how the report is made to CPS. It is important to note that Canadian law does not require mandatory reporters to inform the client prior to making a report. Some mandatory reporters may choose to discuss the duty to report with the client before reporting or tell them afterwards to remove a sense of betrayal (Tufford, 2012, 2014). Mandatory reporters may also try to involve the client in the reporting process and there are several ways to do this. One option is to have the client present when the mandatory reporter calls CPS. Another option is to encourage clients to self-report with the mandatory reporter present or having stepped out of the room. A third option is for the mandatory reporter and the client to call together. These options promote transparency, allow the client some control over the reporting process and reduce the sense of isolation felt by the client (Pietrantonio et al., 2013; Steinberg et al., 1997).

Chris, a social worker at a children's hospital, listened to Jennifer's account of how her three-year-old daughter was sexually molested last week by a daycare worker. After briefly consulting with his interprofessional team, Chris relayed to Jennifer that the CPS needed to be called. Jennifer was frightened at this turn of events so Chris suggested they contact CPS together where both could be on the phone. This helped Jennifer feel more supported.

Information Strategies

There are many information strategies. Revisiting the signed consent form from the start of treatment can remind clients of the original agreement and the obligation to report suspected child maltreatment. Mandatory reporters can also provide important information to clients about CPS such as the process of reporting and the process of a CPS investigation in that the protection

worker may come to the residence. However, this last point is not akin to coaching clients on what to say to CPS should an investigation occur. Mandatory reporters can also explain the role of CPS as a protector of children as well as the benefits of involvement with CPS such as in-home assistance with parenting struggles. It is important to note that not all CPS across Canada offer these services to families, but for those that which do, this may help parents see CPS in a supportive rather than punitive light.

Mandatory reporters can maintain contact with CPS throughout the process of an investigation and support clients. Finally, mandatory reporters who work in the mental health field may offer psychoeducation to clients to assist them in deepening their familial connections, decreasing shame, and exploring how family of origin disciplinary practices impact present disciplinary decisions.

Affect Regulation Strategies (Mandatory Reporter)

Mandatory reporters may feel intense, negative feelings after reporting to CPS as well as when facing families' anger. In order to stay focused and calm, it may be helpful to explore these negative feelings with a colleague or supervisor. By remaining composed and attuned to one's feelings in the face of a client's emotional reaction, mandatory reporters may help the client to "down regulate," thus promoting dialogue and the management of negative emotions (Tufford, 2012, 2014).

Sajedeh, a social worker at a family counseling center, found herself on the receiving end of the Gonzales family's anger at a report she made to the CPS. She took deep breaths and planted both feet on the floor to remain calm while validating Ramone Gonzales' anger and shock. After the family left, Sajedeh spoke to her colleague Daphne about the situation who reassured her that she took the appropriate action and validated her stressful feelings.

Affect Regulation Strategies (Family)

In addition to practicing sound affect regulation strategies of a personal nature, allowing the family time to process their emotions regarding the report and validating negative emotions, are respectful behaviours and send the message that negative emotions are normal at this time. Mandatory reporters can explore and validate family's feelings of shame, fear, blame, and anger, with the family. Validating parenting struggles is also a means by which parents can feel heard and understood by the mandatory reporter. Mandatory reporters can also openly and directly acknowledge the impact of reporting on the relationship in terms of trust.

During the investigation process, mandatory reporters can try to maintain contact with the family by reaching out to them via telephone or asking the family to attend further sessions. This shows interest in their well-being and reduces feelings of abandonment and judgment in the investigation process. If possible, mandatory reporters can meet with CPS worker and the family together to demonstrate transparency and so the family can hear them communicate openly with the investigation worker. which helps the family.

Advocacy Strategies

In terms of advocacy strategies when children are maltreated, they often need a mandatory reporter to advocate on their behalf. One advocacy strategy is to express concern for the child's safety and well-being as often the child does not have a "voice" per se and needs the social worker to speak on their behalf. Mandatory reporters need to be transparent with the reality of how the child is being treated or what is lacking in the child's care. A second advocacy strategy is to reinforce parenting skills and strengths. Mandatory reporters can remind parents of times when they have shown strength in handling difficult situations with their child. They can also communicate to parents their belief that the family desires and has the ability to do better.

Finally, a third advocacy strategy involves advocating on behalf of the family with CPS. Mandatory reporters can reassure parents that the fact they are seeking help speaks volumes about their strength as a family and that this message would be shared with CPS.

Ivy, a social worker on a family health team, reported a situation of emotional abuse as the parents belittled, name called, and used profanity towards their eight-year-old son around his fear of medical appointments. Ivy noted to the CPS intake worker that although the parents' approach to their son's fears was maladaptive, the parents were clearly concerned about their son's health and sought medical attention for their son when the need arose.

Resource Strategies

Mandatory reporters may find that parents lack the necessary resources to look after their children appropriately and safely. It is important to ask if extended family, friends, or neighbours could assist in helping parents to care for their children. Community supports such as food banks, clothing depots, walk-in medical services, or interim housing may also be a means of providing concrete necessities the family may not currently possess. Mandatory reporters may also have a network of professional supports that could assist families. In a situation where the parents are too upset about the report to continue working with the mandatory reporter, offering families the option of working with another professional may keep the family engaged in treatment. However, this may be more challenging in rural or remote communities where there are fewer social workers available to service clients.

Cultural Strategies

Some families, particularly those who are new to Canada, may not be aware of mandatory reporting legislation and that the laws governing the treatment of children may be entirely different from those in their home country. Explaining mandatory reporting legislation

and acknowledging possible cultural differences in the views of discipline may help clients to understand accepted disciplinary practices in Canada. Other strategies that are mindful of culture include referring families to culturally specific resources whereby the family could begin to develop a social support system. Another strategy involves consulting with a colleague or supervisor knowledgeable of the client's culture, particularly as it relates to disciplinary strategies specific to that culture or to cultural norms or expectations. Reporters may utilize the services of a translator when faced with significant language challenges. Mandatory reporters are encouraged to practice "cultural humility" and receive training in anti-oppressive/anti-racist strategies. Finally, it is important for mandatory reporters to build relationships with cultural organizations.

Linking Strategies to Client Need

Although the above strategies are presented as separate and discrete, in reality, social workers practice a multiplicity of strategies in tandem. For example, social workers provide information about the CPS while concurrently validating family feelings regarding the report. It is also imperative that strategies be used in a purposeful fashion according to client need.

Tamika, a social worker in a family counseling centre, reported a case of child maltreatment. The father, mother, and seven-year-old son are recent immigrants to Canada with few economic or social resources. In addition to explaining mandatory reporting legislation in Ontario and discussing alternative disciplinary strategies, the social worker in this situation provided the family with the name and location of a nearby food bank as well as a local cultural centre where the family could meet people from their home country.

Positive Impact on Relationship

Through using the various relationship repair strategies described above, this will hopefully have a positive impact on the therapeutic relationship. It will become stronger, and the family continues in treatment.

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Suggested Timeline

1. **Introduction**
2. **Framework**
3. **PowerPoint Presentation**
    - **I. Information on Mandatory Reporting**
    - **II. Decision making on Mandatory Reporting**
    - **III. Therapeutic Relationship**
4. **LUNCH BREAK**
5. **Case Vignettes (Group Work)**
6. **Discussion Questions**
7. **Framework Review**
8. **Simulation Videos of Good Practice**

Teaching Resources

Incident and Risk of Future Harm Questions

The following incident and risk of future harm questions are meant for self-reflection and ask students and social workers to position themselves regarding reporting suspected child abuse and neglect.

Knowledge of Legislation

1. Is the situation reportable according to my provincial and territorial legislation?
2. Do I know where to report?

Agreement with Legislation

1. Do I agree with mandatory reporting laws?

Disciplinary History

1. Is the way I was disciplined while growing up impacting my decision making in this current situation? If so, how?

Manage Conflict

1. How will the family react when I tell them a report needs to be filed?
2. Am I confident in my ability to manage this family's negative emotions and reactions?

History with Child Protection Services

1. Was Child Protection Services involved in my life while growing up?
2. What was the impact of this experience on me?
3. Is this experience impacting my current reporting decision? If so, how?

Attitude towards Child Protection Services

1. Do I have confidence that Child Protection Services will be receptive to this information?
2. Do I have confidence that Child Protection Services will keep me informed?

3. Do I have confidence that Child Protection Services will intervene appropriately?
4. Do I have confidence that Child Protection Services has the necessary resources to meet the needs of this family?

Parenthood

1. Is how I discipline / disciplined my own child(ren) impacting my reporting decision? If so, how?

Characteristics of Child or Family

1. Is the child's gender, age or race impacting my reporting decision? If so, how?
2. Is the family's socioeconomic status impacting my reporting decision? If so, how?

Maltreatment Specifics (All Maltreatment)

1. What prompted the maltreatment?
2. Who was involved in the maltreatment?
3. Who was present when the maltreatment occurred?
4. What is the impact on the child?
5. How did the child react?
6. What was the reaction of the parents?
7. How long has the maltreatment been occurring?
8. How frequent is the maltreatment?
9. Has maltreatment occurred previously?
10. Are other children in the household experiencing maltreatment or have experienced maltreatment?
11. What is the risk that this child may be maltreated?
12. Is the type of maltreatment impacting my reporting decision?

13. How severe do I consider the maltreatment to be?
14. Is the maltreatment presently occurring or did it occur in the past?
15. How are these factors impacting my reporting decision?

Maltreatment Specifics (Physical Maltreatment)

1. What was used to harm the child?
2. Has the child ever been injured?
3. Have the parents ever sought medical treatment for the child as a result?
4. What is the likelihood of future harm?

Maltreatment Specifics (Neglect)

1. What is lacking in the child's care?
2. Why is this not being provided for the child?
3. What is the likelihood that parents will withdraw X (i.e., food, clothing, shelter, medical care, supervision) from the child?
4. Have parents threatened in the past to withdraw X (i.e. food, clothing, shelter, medical care, supervision) from the child?
5. Will the child be harmed by not having X (i.e. food, clothing, shelter, medical care, supervision)?

Maltreatment Specifics (Sexual Maltreatment)

1. What is the relationship, if any, between the child and the alleged perpetrator?
2. Where was the child touched?
3. What was the child asked to do?
4. Who possesses and has access to child pornography and in what form (hard copy or electronic)?

Maltreatment Specifics (Emotional Maltreatment)

1. What was said to the child?
2. Has the child's behaviour changed in any way as a result of being spoken to in this manner?

Maltreatment Specifics (Intimate Partner Violence)

1. What did the child witness?
2. What did the child hear?
3. What was the child told about the other parent?

Maltreatment Specifics (Harmful or Extreme Discipline)

1. How was the child's discipline harmful?
2. Has the child ever been physically injured or emotionally harmed as a result of discipline?
3. What is the likelihood that parents will continue using this method of discipline?

Certainty of Maltreatment

1. How certain am I that maltreatment has occurred?
2. Does the child display signs of maltreatment?
3. Is a parent admitting to maltreating a child?
4. Is this a first-hand account or a second / third hand account?

Culturally based Disciplinary Practices

1. Is the discipline described as culturally appropriate by the parents?

Training in Recognizing Child Abuse and Neglect

1. What did I learn in my training on recognizing child abuse and neglect that could assist me in this reporting decision?

Reporting History

1. What has been my experience with reporting suspected child maltreatment in the past?
2. Is this experience impacting my decision-making on this case? If so, how?

Consultation / Supervision

1. How comfortable do I feel consulting about this situation?
2. In my practice context with whom I should consult?
3. What do I need from this consultation (assistance with decision making, sounding board for my thoughts, emotional support)?
4. What is the guidance of my peers, colleagues, supervisor, or interdisciplinary team to this situation?
5. Do I agree with the assessment of my peers, colleagues, supervisor, or interdisciplinary team?

Employment Policies

1. What are the policies around mandatory reporting in my place of employment?
2. Do I agree with these policies?
3. Is my agreement or disagreement impacting my reporting decision?

Impact of Reporting on the Relationship

1. How confident am I that I can maintain the relationship with the client should I report?
2. How concerned am I that the client will terminate the relationship?
3. How do I cope with the potential repercussions of reporting suspected child abuse and neglect?

These questions are not exhaustive, and their relative importance will vary between social workers, practice contexts, individual cases, and Child Protection Services.

While it is important to consider the impact of these factors, it is imperative that if child abuse or neglect has occurred, these factors are not used as a justification to not report and place a child in harm's way.

Case Vignettes

Physical Abuse – Minimally Severe

Family Members:

- Subject of Referral - Samuel (age 4)
- Subject of Referral - Grace (age 36)
- Father - Joseph (age 43)

You are a social worker in a family service counselling department. Grace was receiving support from a settlement agency for immigration sponsorship of her parents and other family members and was referred to counselling to help with stress. The family emigrated from the Philippines two years ago in hopes of starting a new life in Canada. There are no other supports for the family in Canada. Grace is concerned about her four-year-old son Samuel's aggressive behaviours with other children at his preschool including screaming, hitting, and grabbing toys from the other children. This is the third session. Soon into the interview, Grace reports that four days ago while playing in their family room, her son threw a ball which knocked over a lamp and broke it. She was in another room at the time and came running to see what happened. When she realized that her son was the cause of the broken lamp, she grabbed his arm and struck him on the buttocks with her hand. She does not remember how many times specifically she struck her son and is uncertain if a mark has been left. She feels very bad for overreacting but has been under a lot of stress lately. She feels overwhelmed with Samuel and is willing to attend parenting classes.

Physical Abuse – Moderately Severe

Family Members:

- Subject of Referral - Samuel (age 4)
- Subject of Referral - Grace (age 36)
- Father - Joseph (age 43)

You are a social worker in a family service counselling department. Grace was receiving support from a settlement agency for immigration sponsorship of her parents and other family members and was referred to counselling to help with stress. The family emigrated from the Philippines two years ago in hopes of starting a new life in Canada. There are no other supports for the family in Canada. Grace is concerned about her four-year-old son Samuel's aggressive behaviours with other children at his preschool including screaming, hitting, and grabbing toys from the other children. This is the third session. Soon into the interview, Grace reports that four days ago while playing in their family room, her son threw a ball which knocked over a lamp and broke it. She was in another room at the time and came running to see what happened. When she realized that her son was the cause of the broken lamp, she grabbed his arm and struck him on the buttocks with her hand. She does not remember how many times specifically she struck her son. That evening, Samuel said it still hurt. When helping him into his pajamas, she noticed that there was redness on his buttocks.

Physical Abuse – Extremely Severe

Family Members:

- Subject of Referral - Samuel (age 4)
- Subject of Referral - Grace (age 36)
- Father - Joseph (age 43)

You are a social worker in a family service counselling department. Grace was receiving support from a settlement agency for immigration sponsorship of her parents and other family members and was referred to counselling to help with stress. The family emigrated from the Philippines two years ago in hopes of starting a new life in Canada. There are no other supports for the family in Canada. Grace is concerned about her four-year-old son Samuel's aggressive behaviours with other children at his preschool including screaming, hitting, and grabbing toys from the other children. This is the third session. Soon into the interview, Grace reports that four days ago while playing in their family room, her son threw a ball which knocked over a lamp and broke it. Grace was in another room at the time and came running to see what happened. When Grace realized that her son was the cause of the broken lamp, she grabbed his arm and struck him on the buttocks with a wooden ruler. Grace does not remember how many times specifically she struck her son. That evening, Samuel said it still hurt. When helping him into his pajamas, Grace noticed that there was redness on his buttocks.

Sexual Abuse – Minimally Severe

Family Members:

- Subject of Referral – James (age 40)
- Girlfriend – Michelle (age 40)
- Girlfriend's daughter - Melissa (age 13)

You are a social worker on a family health team. James was referred to counselling services by his family doctor. He is an IT consultant who is having difficulty keeping up with the pace of technological change. James worries about losing his job to a younger worker and his ability to secure another position in this economy. A recent visit to his doctor revealed high blood pressure, which James attributes to work stress. He has been referred to you for stress management. This is your third session with James. James has not attended counselling before but disclosed feeling comfortable talking with you. James indicates that he enjoys spending time alone and occasionally attends the local community centre by himself to watch people swim, which helps him to not think about work. He further explains that he enjoys watching a girls' competitive swim team practice every two weeks. When you ask what he finds enjoyable about watching the competitive swim, he admits being "turned on" by seeing adolescent girls in their bathing suits. He reports that the physical changes for 13-year-old girls during puberty are beautiful and what he is doing is harmless. Later in the session you discover that his girlfriend, Michelle, and her daughter Melissa moved into his apartment a few weeks ago. James reports falling asleep beside Melissa while watching TV on a few occasions and recently bought her a bikini to wear when they go swimming together.

Sexual Abuse – Moderately Severe

Family Members:

- Subject of Referral – James (age 40)
- Girlfriend – Michelle (age 40)
- Girlfriend's daughter - Melissa (age 13)

You are a social worker on a family health team. James was referred to counselling services by his family doctor. He is an IT consultant who is having difficulty keeping up with the pace of technological change. James worries about losing his job to a younger worker and his ability to secure another position in this economy. A recent visit to his doctor revealed high blood pressure, which James attributes to work stress. He has been referred to you for stress management. This is your third session with James. James has not attended counselling before but disclosed feeling comfortable talking with you. James indicates that he enjoys spending time alone and occasionally attends the local community centre by himself to watch people swim, which helps him to not think about work. He further explains that he enjoys watching a girls' competitive swim team practice every two weeks. When you ask what he finds enjoyable about watching the competitive swim, he admits being "turned on" by seeing adolescent girls in their bathing suits. He reports that the physical changes for 13-year-old girls during puberty are beautiful and what he is doing is harmless. Later in the session you discover that James's girlfriend, Michelle, and her daughter Melissa moved into his apartment a few weeks ago. James reports falling asleep beside Melissa while watching TV on a few occasions. He reveals that he has gone swimming alone with Melissa a couple of times and was happy that she wore the bikini he bought for her. The first time he went swimming with her, Melissa's bikini top unraveled, and he reported feeling "turned on" by this. The second time he went swimming with her, he reported "rinsing off" with her in the family bathroom. When he accidentally exposed himself to her while showering, she looked away.

Sexual Abuse – Extremely Severe

Family Members:

- Subject of Referral – James (age 40)
- Girlfriend – Michelle (age 40)
- Girlfriend's daughter - Melissa (age 13)

You are a social worker on a family health team. James was referred to counselling services by his family doctor. He is an IT consultant who is having difficulty keeping up with the pace of technological change. James worries about losing his job to a younger worker and his ability to secure another position in this economy. A recent visit to his doctor revealed high blood pressure, which James attributes to work stress. He has been referred to you for stress management. This is your third session with James. James has not attended counselling before but disclosed feeling comfortable talking with you. James indicates that he enjoys spending time alone and occasionally attends the local community centre by himself to watch people swim, which helps him to not think about work. He further explains that he enjoys watching a girls' competitive swim team practice every two weeks. When you ask what he finds enjoyable about watching the competitive swim, he admits being "turned on" seeing adolescent girls in their bathing suits. He reports that the physical changes for 13-year-old girls during puberty are beautiful and that what he is doing is harmless. Later in the session you discover that James's girlfriend, Michelle, and her daughter Melissa moved into his apartment a few weeks ago. James reports falling asleep beside Melissa while watching TV on a few occasions. He reveals that he has gone swimming alone with Melissa a couple of times and was happy that she wore the bikini he bought for her. The first time they went swimming together, Melissa's bikini top unraveled, and he reports feeling "turned on" by this. He admits to holding Melissa very close to him while swimming. He likes "rinsing off" with her in the family bathroom because he can touch her. He likes to dry her off, brush her hair, and watch her get dressed. He describes feeling close to her in these moments. The second time they went swimming together, he reported "rinsing off" with her in the family bathroom. When he accidentally exposed himself to her while showering, she smiled, and they began fondling one another.

Exposure to Intimate Partner Violence – Minimally Severe

Family Members:

- Subject of Referral – Anton (age 12)
- Subject of Referral – Tania (age 10)
- Mother – Elena (age 33)
- Father - Andrei (age 33)

You are a social worker at a local domestic violence shelter. Elena, and her two children, Anton and Tania, recently entered the shelter. Elena immigrated to Canada from Romania after getting married. Elena speaks English well, obtained a high school diploma in Romania and is a full-time, stay-at-home mother. This is your third session with Elena. Anton and Tania describe their father as “angry” and “mean” because he yells and throws objects at their mother. Anton, who appears anxious and mildly aggressive, reports feeling the need to protect his mother and Tania. During the last incident, the father broke the kitchen table, and this scared Elena and the children, which led them to seek refuge in the shelter. Recently, Elena has been on the phone with Andrei in the shelter for long periods. She wants her children to be involved with their father. She informs the social worker that she has resolved her challenges with Andrei and will be leaving the shelter tomorrow with her children. She explains that things will be different this time. She has asked her children to pack their bags and plans to reunite with Andrei tomorrow morning.

Exposure to Intimate Partner Violence – Moderately Severe

Family Members:

- Subject of Referral – Anton (age 12)
- Subject of Referral – Tania (age 10)
- Mother – Elena (age 33)
- Father - Andrei (age 33)

You are a social worker at a local domestic violence shelter. Elena, and her two children, Anton and Tania, recently entered the shelter. Elena immigrated to Canada from Romania after getting married. Elena speaks English well, obtained a high school diploma in Romania and is a full-time, stay-at-home mother. This is your third session with Elena. Anton and Tania describe their father as “angry” and “mean” because he yells and throws objects at their mother. Both children report seeing their father hit, kick, and punch Elena. Anton, who appears anxious and aggressive, feels the need to protect his mother and Tania. He would often get involved in his parents’ arguments and jump in front of Elena to defend her. His father would then direct his anger towards Anton by yelling at him, telling him to stay out of the fight and pushing him into the bedroom. During the last incident, the father broke the kitchen table, and this scared Elena and the children, which led them to seek refuge in the shelter. Recently, she has been on the phone with Andrei in the shelter for long periods. She wants her children to be involved with their father. She informs the social worker that she has resolved her challenges with Andrei and will be leaving the shelter with her children. She explains that things will be different this time. She has asked her children to pack their bags and plans to reunite with Andrei tomorrow morning.

Exposure to Intimate Partner Violence – Extremely Severe

Family Members:

- Subject of Referral – Anton (age 12)
- Subject of Referral – Tania (age 10)
- Mother – Elena (age 33)
- Father - Andrei (age 33)

You are a social worker at a local domestic violence shelter. Elena, and her two children, Anton and Tania, recently entered the shelter. Elena immigrated to Canada from Romania after getting married. Elena speaks English well, obtained a high school diploma in Romania and is a full-time, stay-at-home mother. This is your third session with Elena. Anton and Tania describe their father as "angry" and "mean" because he yells and throws objects at their mother. Both children report seeing their father hit, kick, and punch Elena. Anton, who appears anxious and aggressive, feels the need to protect his mother and Tania. He would often get involved in his parents' arguments and jump in front of Elena to defend her. During the last altercation, the father threw a telephone at Elena; however, Anton tried to block his mother and sustained a black eye. This incident led Elena and the children to seek refuge in the shelter. Recently, Elena has been on the phone with Andrei in the shelter for long periods. She wants her children to be involved with their father. She informs you that she has resolved her challenges with Andrei and will be leaving the shelter with her children. She explains that things will be different this time. She stated that her husband did not mean to hit Anton and that she will try harder to protect her children in the future. She has asked her children to pack their bags and plans to reunite with Andrei tomorrow morning.

Emotional Abuse – Minimally Severe

Family Members:

- Subject of Referral – Jaspreet (age 6)
- Mother – Sonia (age 24)

You are an elementary school social worker. Jaspreet is a six-year-old boy in grade 1. His mother, Sonia, recently finished a 30-day detoxification program for alcohol and drug abuse. Sonia is a single parent to Jaspreet and his teachers have expressed concerns about his withdrawn behaviours. This is your third session with Sonia and Jaspreet. Jaspreet's teachers have contacted you out of concern for him. Jaspreet appears socially withdrawn. He does not greet the teachers or make eye contact with other children. When you meet with Jaspreet and Sonia, Jaspreet sits in the corner away from his mother. When you ask Jaspreet what he likes to do for fun he replies, "Nothing, everything's stupid. I'm stupid." Sonia reports feeling disconnected to Jaspreet as he reminds her of her ex-husband. She feels ashamed but discloses that she sometimes feels anger and resentment for giving birth to Jaspreet. However, she wants to "make things right" and treat Jaspreet better. You recommend a parent drop-in program for Sonia and Jaspreet. She is very grateful and follows through by setting up an appointment.

Emotional Abuse – Moderately Severe

Family Members:

- Subject of Referral – Jaspreet (age 6)
- Mother – Sonia (age 24)

You are an elementary school social worker. Jaspreet is a six-year-old boy in grade 1. His mother, Sonia, recently finished a 30-day detoxification program for alcohol and drug abuse. Sonia is a single parent to Jaspreet and his teachers have expressed concerns about his withdrawn behaviours. This is your third session with Sonia and Jaspreet. Jaspreet's teachers have contacted you out of concern for him. Jaspreet appears socially withdrawn. He does not greet the teachers or make eye contact with other children. When you meet with Jaspreet and Sonia, Jaspreet sat in the corner away from his mother. When you ask Jaspreet what he likes to do for fun he replied, "Nothing, everything's stupid. I'm stupid." Jaspreet reported that he just wants to sleep all day, and that his mother yells at him to get out of bed. He indicates that Sonia yells at him all the time. Sonia admits to sometimes calling Jaspreet "stupid" while she was intoxicated. Sonia feels disconnected to Jaspreet as he reminds her of her ex-husband. She feels resentful for giving birth to Jaspreet. She believes that being divorced with a child is undesirable and that she will never remarry. However, she wants to "make things right" and wants to treat Jaspreet better. You recommend a parent drop-in program for Sonia and Jaspreet. Sonia is very grateful; however, she has yet to follow-up.

Emotional Abuse – Extremely Severe

Family Members:

- Subject of Referral – Jaspreet (age 6)
- Mother – Sonia (age 24)

You are an elementary school social worker. Jaspreet is a six-year-old boy in grade 1. His mother, Sonia, recently finished a 30-day detoxification program for alcohol and drug abuse. Sonia is a single parent to Jaspreet and his teachers have expressed concerns about his withdrawn behaviours. This is your third session with Sonia and Jaspreet. Jaspreet's teachers have contacted you out of concern for him. Jaspreet appears socially withdrawn. He does not greet the teachers or make eye contact with other children. When you meet with Jaspreet and Sonia, Jaspreet sits in the corner away from his mother. When you ask Jaspreet what he likes to do for fun he replies, "Nothing, everything's stupid. I'm stupid. My mom said she wishes she never had me." Jaspreet reports that he just wants to sleep all day and that his mother yells at him to get out of bed. He reports that she yells at him all the time. He indicates he would rather live with his father because he is "nice" and does not yell at him. There was an incident report in which Sonia admitted to calling Jaspreet "stupid" while she was intoxicated. She feels disconnected to Jaspreet as he reminds her of her ex-husband. She feels resentful for giving birth to Jaspreet. She believes that being divorced with a child is undesirable and that she will never remarry. She wants to make friends in the community with the other mothers, but Jaspreet does not like to play outside with the other children. You recommend a parent drop-in program for Sonia and Jaspreet, but she refuses. She indicates Jaspreet needs individual counselling.

Neglect – Minimally Severe

Family Members:

- Subject of Referral – Sally (age 6)
- Subject of Referral – Flora (age 9)
- Father – John (age 36)

You are a social worker in a community housing cooperation. The Stone family have been tenants in the building for over 10 years. They are good tenants but keep to themselves and do not appear to have many friends in the building. Mary was a stay-at-home mom and cared full-time for Flora and Sally. You are aware that Mary died in a car accident a couple of months ago. You have not seen John since hearing the news. Over the past month, you notice Flora and Sally playing in the hallway more often and sometimes past the dinner hour. When you speak with Flora, she reports that she really misses her mother, and her father is sad all the time. When you ask how she knows her father is sad, Flora says he does not get out of bed much but makes dinner sometimes. She tells you she puts her sister to bed at night and gets her ready for school in the morning because she wants to help her father. You visit John, and he is appreciative that you have taken the time to speak with him. John admits to having a hard time coping with the death of his wife. Mary had been the primary caregiver for the children and managed all the household duties. John tells you he is having a hard time adjusting to this new role while grieving for his wife.

Neglect – Moderately Severe

Family Members:

- Subject of Referral – Sally (age 6)
- Subject of Referral – Flora (age 9)
- Father – John (age 36)

You are a social worker in a community housing cooperation. The Stone family have been tenants in the building for over 10 years. They are good tenants but keep to themselves and do not appear to have many friends in the building. Mary was a stay-at-home mom and cared full-time for Flora and Sally. You are aware that Mary died in a car accident a couple of months ago. You have not seen John since hearing the news. You see the children playing outside after school; however, the weather is getting colder, and the children do not wear warm clothes outside. Over the past month, you have noticed the children playing in the hallway more often and sometimes past the dinner hour. You approach Flora and ask whether she and her sister have eaten today, which Flora replies that she made sandwiches for lunch. They have not yet had dinner, as her dad is still sleeping. The children look a little unkempt. When you speak with Flora, she reports that she really misses her mother, and her father is sad all the time. When you ask how she knows her father is sad, Flora says he does not get out of bed much. She tells you that she puts her sister to bed at night and gets her ready for school in the morning because she wants to help her father. You visit John, and he is appreciative that you have taken the time to speak with him. John indicates having a hard time dealing with the death of his wife. Mary had been the primary caregiver for the children and managed all the house duties. John tells you he is having a hard time adjusting to this new role while grieving for his wife and has missed a rent payment.

Neglect – Extremely Severe

Family Members:

- Subject of Referral – Sally (age 6)
- Subject of Referral – Flora (age 9)
- Father – John (age 36)

You are a social worker in a community housing cooperation. The Stone family have been tenants in the building for over 10 years. They are good tenants but keep to themselves and do not appear to have many friends in the building. Mary was a stay-at-home mom and cared full-time for Flora and Sally. You are aware that Mary died in a car accident a couple of months ago. You have not seen John since hearing the news. You see the children playing outside after school; however, the weather is getting colder, and the children do not wear warm clothes outside. Over the past month, you have noticed the children playing in the hallway more often and sometimes staying out late into the evening. When you ask whether they have eaten, Flora says she made sandwiches for lunch, but dad is still sleeping and there is no food at home. The children ask if you will take them grocery shopping. The children look a little unkempt and emit a strong body odour. Their hair is dirty and matting. When you speak with Flora, she reports that she really misses her mother, and her father is sad all the time. When you ask how she knows her father is sad, Flora says he does not get out of bed much. She tells you she puts her sister to bed at night and gets her ready for school in the morning because she does not want them to bother him. You visit John, and he is appreciative that you have taken the time to speak with him. John admits to having a hard time coping with the death of his wife. Mary had been the primary caregiver for the children and managed all the house duties. John tells you that he has taken an unpaid leave from his contracting job which has caused him to miss a rent payment. You ask if he has any support, and he replies that he does not need any, and that everything will be fine.

Discussion Questions

In groups of 2 or 3, take a few minutes and discuss the following questions:

1. What type of maltreatment do you suspect in this vignette?
2. What information raises your suspicion that maltreatment is occurring or that a child is at risk of maltreatment?
3. What factors would you include in your decision making to report or not report suspected child maltreatment?
4. What additional factors would you include in your decision making to report or not report suspected child maltreatment, while considering how to maintain the therapeutic relationship?
5. How much weight or importance would you attach to each factor?
6. How does the information presented in the vignette relate to your provincial or territorial mandatory reporting legislation?
7. What strategies would you use to maintain the therapeutic relationship with the family during and after reporting to Child Protection Services?
8. In your opinion, why would these strategies be effective in maintaining the relationship?
9. What challenges, if any, would you face in implementing these strategies and how would you manage these challenges?
10. How do you feel after reading this vignette?
11. How do you understand these feelings?
12. How do you think you could manage your feelings when dealing with this maltreatment issue?

13. Do you think it would be of value to consult with another professional to make this decision? If so, who do you think you would approach?

Objective Structured Clinical Examination

Instructions for Implementing an OSCE

The following procedures for implementation of the OSCE are based on those recommended by Bogo, Rawlings, Katz, and Logie (2014). Each step can be modified depending on the context, goals, needs, and resources.

Preparing the OSCE Site

In universities with simulation centers or social / behavioural labs, social work educators may arrange to use these facilities at little to no cost. Many labs are equipped with audio and video-recording equipment. As a result, interviews can be recorded and students can review their performance, focusing on competencies and skills to be learned. Review of interviews can be done individually, in small groups, or by the instructor.

Faculty may also use their own offices or classrooms as interviewing sites. In these cases, the standardized client is already seated in the room. The rater sits either to the side or behind a desk and should be as unobtrusive as possible while observing the non-verbal reactions of the student as well as the interaction between the student and client. When rating, live interviews are preferable to recorded interviews as being present at the interview gives the rater a more authentic experience of the student's verbal and non-verbal interactions with the standardized client. As playing a client role multiple times increases fatigue, incorporate break times, lunch, and refreshments for the actors.

Recruiting and Training Raters

It is recommended to give careful consideration to the people who will be raters. To avoid the leniency bias which occurs when the rater and student have a relationship, one option is to have students not be rated by their own course instructor. This can be facilitated in multi-section courses. If only one course instructor exists, field instructors, local practitioners, or other

faculty can serve as raters. Raters with previous experience working with students are recommended as they can better grasp expected performance levels.

When using course instructors as raters, the focus should be on achieving sufficient agreement on the interpretation of the various points on the rating scale. Begin by examining the competencies to be measured on the rating scale. Have instructors view and rate a 10-minute segment of a student interview with a standardized client. Choose interviews that are similar to those they will be rating in the OSCE. After reviewing and rating the interview, each instructor reports their rating on each scale. Both commonalities and discrepancies are noted with discussion on the discrepancies to ensure common understanding of what the items on the scales mean. Use the same method to train use of the reflection rating scale providing a sample written reflection completed by the same student who conducted the simulated interview. It is recommended to use at least two scenarios during a day long training.

Prior to the OSCE

Provide students with the details of their OSCE (date, time, and location) at least one week prior to the session. Students are encouraged to be punctual. Five minutes prior to the start of the OSCE students take their seats outside the designated room. A bell or buzzer rings, or an announcement is made to alert students and raters that the examination is about to commence.

The OSCE

The rater greets the student who is seated outside the interview room and gives the student a half page written description of the case scenario. Another option is to provide this information to students in their class prior to the OSCE.

Students are provided with 2 - 3 minutes to read the case scenario. A bell or buzzer sounds, or a facilitator makes an announcement which signals that students are to enter the interviewing room and commence the interview.

Students conduct the interview for approximately 12 - 15 minutes. (The exact duration of the interview can vary based on the number of students to be examined on a particular day). A bell or buzzer sounds, or an announcement is made, to alert participants that the interview is over.

Various options regarding providing feedback exist. For example, the actor can 'come out' of character and provide brief feedback to the student, and/or the rater can provide feedback. Feedback can be given to a maximum of five minutes in total. This step is optional and based on whether there will be other opportunities for feedback, for example in class, from peers, or from the course instructor. Alternatively, the actor can prepare brief written feedback while the rater provides verbal feedback. The actor's written feedback will be given to the student after their self-reflection.

The rater collects the case scenario from the student so it can be provided to the following student. During the interview, the rater uses the rating scale to rate the student's performance and can complete the scale and write additional brief notes after the student leaves the room.

The Reflection Component

The reflection component permits the student and rater to evaluate additional components of competence, beyond those that can be observed in the students' performance in the interview. There are a number of variations in the way reflection can be conducted.

Example 1

After completing the interview and receiving brief feedback students can respond to the reflection questions which are already loaded on computers in a computer lab. Approximately 25 minutes is needed to write responses. Upon completion and printing the responses, raters use a Reflection Rating Scale for assessment.

Raters read and rate the reflections as soon as possible after observing the interview, to assist recall. Raters are advised to write notes on the Post OSCE Reflection Rating Scale, particularly when the students' reflections include comments about their performance which the rater did not observe, i.e. students believe and report particular behaviours on their part which actually did not occur.

Example 2

A reflective dialogue can be conducted with the rater asking the student reflective questions. Verbal responses are rated on the Reflection Rating Scale during this conversation.

Example 3

Video-record the OSCE. Students are provided with the recording and must view their performance and write a reflection paper within a set period of time, for example, seven days. The reflection is guided by the questions used in the reflection activities above. Students are advised to watch their videotape more than once prior to writing their paper.

After the OSCE

Raters and instructors benefit from debriefing the experience with each other, with students, and with actors. Areas for further development and refinement of the OSCE, of the curriculum, and ways of teaching can be identified.

Performance Rating Scale

OSCE FOR MANDATORY REPORTING

PERFORMANCE RATING SCALE

Please circle the number corresponding to the candidate's performance.

1. APPROACH TO CHILD MALTREATMENT ISSUE

Q.1 How do participants discuss the concerns of child maltreatment with the client?

Does not discuss child maltreatment issue.		Discusses child maltreatment issue in passing and does not pursue a line of questioning.		Discusses some aspects of child maltreatment issue but moves prematurely to other topics or their inquiry is ineffective.		Discusses child maltreatment issue but may move to other topics. Attempts are effectively made to approach the topic again.		Directly discusses child maltreatment issue firmly, clearly, and thoroughly in a focused approach.
1	1.5	2	2.5	3	3.5	4	4.5	5

Q.2 How do participants discuss the duty to report?

Does not discuss duty to report with caregiver.		Duty to report is discussed but unclear and vague.		Discusses duty to report but moves prematurely to other topics.		Discusses duty to report firmly and clearly.		Discusses duty to report firmly, clearly, and emphatically.
1	1.5	2	2.5	3	3.5	4	4.5	5

2. FOCUS ON RELATIONSHIP REPAIR

Q.3 How do participants maintain balance of content and process in the interview?

Exclusive focus of child maltreatment issue and gathering information.	Overly focused on child maltreatment issue with minimal attention to the relationship.	Moves too quickly from child maltreatment issue to relationship repair.	Movement from child maltreatment issue to relationship is appropriate but some transitions rough and not always	Balance between child maltreatment issue and relationship repair.	Not Applicable

				responsive to client concerns.					
1	1.5	2	2.5	3	3.5	4	4.5	5	N/A

Q.4 How do participants use strategies to maintain the relationship?

Does not use relationship repair strategies.		Uses relationship repair strategies but strategies are minimal or inappropriate for caregiver needs.		Uses relationship repair strategies purposefully but in a mechanical fashion or is limited to one strategy.		Uses some relationship repair strategies purposefully with some display of empathy and warmth.		Uses multiple relationship repair strategies purposefully, empathetically, and effectively based on caregiver needs.	Not Applicable
1	1.5	2	2.5	3	3.5	4	4.5	5	N/A

Q.5 How do participants manage affect (i.e., tears, anger, fear, protest) related to the duty to report?

Does not acknowledge client affect.		Appears overwhelmed by client affect.		Acknowledges affect but mechanically or in a blaming manner.		Acknowledges affect through validation and empathy.		Acknowledges affect through validation and empathy while asserting the need to report.	Not Applicable
1	1.5	2	2.5	3	3.5	4	4.5	5	N/A

3. **CONDUCTS A SYSTEMATIC ASSESSMENT**

Q.6 What factors do participants include in an eco-systemic assessment of child maltreatment issue (i.e. nuclear family, extended family, neighbourhood, friends, employment, school, housing, medical, immigration status, religion)?

Comprehensive systemic inquiry missing.		Struggles to focus on more than one system.		Identifies the obvious systems but no connection between them.		Identifies all relevant systems and some connection between problem and systems.		Complete systemic assessment with depths of linkages between them.
1	1.5	2	2.5	3	3.5	4	4.5	5

4. DEMONSTRATES CULTURAL COMPETENCE

How do participants include culture, race, age, or ability?

Q.7 Based on your impression of the participant's performance, this participant demonstrated competence at the level of…

Ignores the impact of culture on the child maltreatment issue.		Inconsistent recognition of the cultural impact on child maltreatment.		Displays some interest but exploration is limited to selected aspects of culture.		Frequent attempts to recognize the impact of culture on child maltreatment.		Consistent recognition and in-depth exploration of culture and child maltreatment.
1	1.5	2	2.5	3	3.5	4	4.5	5

5. OVERALL ASSESSMENT OF MANAGING A SUSPICION OF CHILD MALTREATMENT AND USING RELATIONSHIP REPAIR STRATEGIES

Q.8 Based on your impression of the participant's performance, this participant demonstrated competence at the level of…

No exploration of suspicion of child maltreatment issue or blames the caregiver and further diminishes the relationship.		Minimal attempts to explore child maltreatment issue and utilize relationship repair strategies.		Some exploration of the child maltreatment issue, mentions duty to report in passing, and minimal use of relationship repair strategies.		Generally consistent exploration of child maltreatment issue, discusses duty to report while also utilizing relationship repair strategies.		Consistent and in-depth exploration of child maltreatment issue and duty to report balanced with effective use of relationship repair strategies.
1-Poor	1.5	2-Requires Training	2.5	3-Minimal Competence	3.5	4-Good	4.5	5-Excellent

Post-OSCE Reflection Rating Scale

OSCE FOR MANDATORY REPORTING

POST-OSCE REFLECTION RATING SCALE

Please circle the number corresponding to the participant's performance.

1. CRITICAL REFLECTION

Q.1 To what extent is the participant's reflection accurate to the behaviours observed?

Does not apply a critical reflection of their strengths and limitations. Unable to draw upon specific action behaviours to support their reflective assessment. Their reflections are not aligned with the observed behaviours.		Some critical reflection of their strengths and/or limitations, but do not draw upon specific action behaviours to support their reflective assessment.		Some critical reflection of their strengths and/or limitations. Identifies some action behaviours to support their reflective assessment. Some of their reflections are aligned with the behaviours observed.		A critical reflection of their strengths as well as limitations. Identifies some action behaviours to support their reflective assessment. Their reflections for the most part are aligned with the behaviours observed.		Offers a balanced and comprehensive critical reflection of their strengths as well as limitations. Provides nuanced examples of their action behaviours to support their reflective assessment. Their reflections are aligned with the behaviours observed.
1	1.5	2	2.5	3	3.5	4	4.5	5

2. CONCEPTUALIZATION OF CHILD MALTREATMENT ISSUE

Q.2 How was the participant able to identify the type of maltreatment and what was the evidence?

Does not identify a child maltreatment issue.	Identifies child maltreatment but cannot specify the type.	Identifies child maltreatment but the type is incorrect and provides no supporting evidence.	Identifies the correct type of child maltreatment issue and provides no	Identifies the correct type of child maltreatment issue and can provide

						supporting evidence.		supporting evidence.
1	1.5	2	2.5	3	3.5	4	4.5	5

3. CONCEPTUALIZATION OF DECISION-MAKING/USE OF KNOWLEDGE

Q.3 How does information gathered in session inform participants' thinking of the child maltreatment issue?

Does not gather information around the circumstances of maltreatment.		Gathers information but discounts what is gathered.		Gathers some information around the circumstances of maltreatment but from limited perspectives (i.e. only parent or child).		Gathers information around the circumstances of maltreatment from multiple perspectives but does not assess severity.		Recognizes the complexity of circumstances and seeks to gather information from multiple perspectives and severity levels to inform decision-making.
1	1.5	2	2.5	3	3.5	4	4.5	5

Q.4 How does the participant engage in the decision-making process?

Was not engaged in a decision-making process.		Aware they were engaged in a decision-making process, but not able to articulate how.		Engaged in a decision-making process and begins to identify one decision-making factor.		Engaged in a decision-making process and can identify more than one decision-making factor.		Actively engaged in the decision-making process. Carefully considers and grapples with multiple factors in the decision-making process.
1	1.5	2	2.5	3	3.5	4	4.5	5

Q5. How do participants approach the client with regards to reporting child maltreatment?

Does not believe the situation is reportable and does not discuss reporting with the client.	Identifies a reportable situation. Attempts once to discuss reporting but moves to other topics.	Identifies a reportable situation. Attempts to discuss reporting but allows client to	Identifies a reportable situation. Discusses with client the need to report but does not articulate the reason.	Identifies a reportable situation. Discusses with client the need to report and reasons for the report.

			close the conversation.					
1	1.5	2	2.5	3	3.5	4	4.5	5

4. SELF-REGULATION

Q.6 How do participants manage their emotions to the child maltreatment issue?

Unaware of their emotions.		Self-focused, pre-occupied with own emotions which impede exploring the child maltreatment issue with the client.		Aware of their emotions but concerned about managing both theirs and the client's emotions in exploring the child maltreatment issue.		Raises child maltreatment issue but struggles to control their emotions while exploring child maltreatment issue.		Use emotions purposefully. The focus on self is balanced with exploring child maltreatment and remaining client-focused.
1	1.5	2	2.5	3	3.5	4	4.5	5

5. CLINICAL RELATIONSHIP

Q.7 How do participants recognize relationship rupture?

Unaware that a relationship rupture has occurred.		Recognize that the relationship has shifted but is not able to identify whether a relationship rupture has occurred.		Recognize that the relationship has shifted and is able to articulate the circumstances of this relationship rupture.		Recognizes a relationship rupture has occurred. Is able to articulate how client is presenting.		Recognizes a relationship rupture has occurred. Is able to articulate how client is presenting. Can identify their own position in this junction of the relationship.
1	1.5	2	2.5	3	3.5	4	4.5	5

Content:

Q.8 How do participants conceptualize relationship repair strategies?

Does not use relationship repair strategies or discounts the	Can identify relationship repair strategies but unable to	Lists one relationship repair strategy	Lists multiple relationship repair strategies	Considers strengths and challenges of multiple

value of repair strategies with the case.		apply them to the case.		without elucidation.		without elucidation.		relationship repair strategies from both self and client perspectives.
1	1.5	2	2.5	3	3.5	4	4.5	5

Process:

Q.9 How do participants utilize relationship repair strategies in continued work with the client?

Unable to identify future relationship repair strategies or would refer client.		Can identify future relationship repair strategies but unable to apply them to the case.		Lists one relationship repair strategy without elucidation or exclusive focus on either self or client.		Lists multiple relationship repair strategies without elucidation or exclusive focus on either self or client.		Reflective conceptualization of future relationship repair strategies from self and client perspectives.
1	1.5	2	2.5	3	3.5	4	4.5	5

6. PROFESSIONAL DEVELOPMENT

Learning:

Q.10 What do participants focus on and talk about regarding their performance in the OSCE?

Excuses or rationalizes performance due to examination factors. Focused on their reactions and emotions or the performance of the actor.		Exploration is limited to facts of the case.		Explores only strengths of their performance. No reflection on weaknesses.		Explores strengths and weaknesses of performance from cognitive, affective, or behavioural aspects.		Emphasis on what they can take from this experience and apply to their practice. Reflective conceptualization of practice strengths and weaknesses.
1	1.5	2	2.5	3	3.5	4	4.5	5

Growth:

Q.11 What do participants say about how they would integrate this experience into their practice?

Does not consider impact to future practice but focuses on present interview only.		Considers impact to future practice but focus is limited to facts of the present case.		Considers impact to future practice but does not link to child maltreatment.		Considers impact to future practice of a similar child maltreatment issue but is focused solely on either decision-making or relationship repair.		Considers how this experience could inform future understanding, decision-making, and management of a similar child maltreatment issue.
1	1.5	2	2.5	3	3.5	4	4.5	5

Post-OSCE Reflection Questions

OSCE FOR MANDATORY REPORTING

POST-OSCE REFLECTION QUESTIONS

You have just completed an interview with a standardized client. You now have up to 30 minutes to answer the following questions. The research assistants will alert you just prior to the time limit and you will stop writing at the 30-minute mark.

1. What did you think of your performance in the interview?
2. What was the type of maltreatment and what evidence raised your suspicion?
3. What information did you gather about the child maltreatment issue?
4. What contributed to the decision-making process of whether to report to Child Protection Services?
5. Do you believe the situation is reportable to Child Protection Services? If yes, how did you approach the client about reporting to Child Protection Services?
6. In the interview, how did you feel about the child maltreatment situation and how did you use these feelings in relation to the child maltreatment?
7. Was there a shift in your relationship with the client in the interview? If yes, what did this look like?
8. How did you attempt to repair/maintain the relationship between yourself and the client?
9. What would your next step(s), if any, in continuing to repair/maintain the therapeutic relationship?
10. What do you feel you learned from this interview?
11. How might this learning experience influence your approach to a future suspicion of child maltreatment?