**Why Is Reporting So Hard?**

**Barriers to Fulfilling the Duty to Report Among Community Nurses in Israel**

**Background**

“Child maltreatment” is the professional term accepted around the world to describe various types of abuse and neglect of, and harm to, children. Israel has yet to adopt any comparable and generally agreed-upon term. It is customary to distinguish four types of abuse, which Israeli law also recognizes: physical abuse, emotional abuse, sexual abuse, and neglect. Neglect can take a physical or an emotional form.

Child abuse and neglect are a difficult and complex social phenomenon, both in terms of its identification and treatment and in its implications for the individual, the family, and society as a whole (Gilbert et al., 2009a, 2015; NCANDS, 2007). Recent years have seen growing attention to this issue among professionals from a range of disciplines, policymakers, and the general public (ארזי, סבו ובן סימון, 2017). Although each type of abuse has a different definition, it can be difficult to delineate their boundaries, and often one type of abuse embodies characteristics of another. For example, physical abuse may contain many elements of emotional abuse, sexual abuse includes elements of physical abuse, and so forth (Goldstein, ). Child abuse can take the form of direct harm as well as indirect forms of harm, such as exposure to incidents of domestic violence, witnessing the abuse of another, or social and emotional isolation (Green, 2020).

The phenomenon of child abuse and neglect is prevalent in Israel and around the world (Herendeen et al., 2014). It is estimated that one in seven children in the United States experienced abuse or neglect in the past year (Centers for Disease Control and Prevention, 2021). In Israel, according to estimates by welfare authorities (Women’s International Zionist Organization, n.d.), one in five children has been maltreated by an adult, and the number of children who have experienced direct violence or been exposed to violence at home stands at about 600,000, accounting for 20% of the country’s total population of children. This is not a phenomenon that can be ignored or suppressed.

All types of child abuse have immediate and long-term consequences that can affect the entire lifespan of a child at the physical, health, psychological, emotional, and even economic levels (Van der Hart et al., 2006). The World Health Organization estimates that about 40,000 children die annually as a direct result of abuse and neglect. According to the same report, this figure does not reflect the full scope of mortality, which is apparently much greater (World Health Organization, 2020). There was no available data on child mortality due to abuse and neglect in Israel.

Studies show that children may develop severe feelings of guilt stemming from a sense of responsibility for the abuse, and they might resort to drugs and alcohol, prostitution, or attempted suicide (Gilbert et al., 2015). In the long term, abuse leaves its victims with emotional scars that, if not treated properly and in time, could undermine the victims’ interpersonal relations as adults (Green, 2020). The greater the duration and frequency of the maltreatment, the more intense the consequences, even if the acts themselves were not particularly severe. Adults who experienced maltreatment as children have a high probability of developing physical health problems and are twice as likely as the general population to develop severe depression. According to findings, men who experienced violence as children are likely to develop physical symptoms such as migraines and liver and vascular problems as adults and are at risk of developing psychosis. On the other hand, women who experienced violence are likely to suffer depression and find themselves in violent relationships (Costigan, 2016). The sooner the maltreatment is exposed and treated, the greater the likelihood of successful treatment and minimization of harm. Unfortunately, however, abuse is rarely discovered immediately or quickly (Waller et al., 1995).

In an effort to address the problem, many states have enacted laws and developed procedures to prevent and deal with child abuse (Mathews & Bross, 2015). Among other measures, professionals who come in contact with children are obligated to report incidents of abuse to the authorities (Gateway, 2016). Under Israel’s Penal Law (The Law for the Prevention of Abuse of Minors and the Helpless, 1989), every person – particularly and explicitly hospital and community health service professionals – is obligated to report to welfare officials (social workers) or the police on any incident in which there is reasonable suspicion that a crime has been committed against a minor or a helpless person. The offenses listed include: crimes that pose a threat to life or health, sex crimes, abandonment or neglect, assault or abuse, and crimes of human trafficking. Anyone who violates this provision is liable to six months’ imprisonment. The law specifies all the health professions to which the reporting obligation applies: “physician, nurse, social worker, psychologist, or a paramedical professional.” Importantly, the reporting obligation outweighs the confidentiality of the caregiving professions. Moreover, the reporting obligation is not only a legal duty but also a moral duty intended to save children from harm and abuse.

Under the law, upon receiving a report, a Youth Law social worker (child protection officer) investigates the suspected crime and tries to obtain additional information about the child and family from the educational and health services. The social worker then submits a report to the police, alongside a recommendation to take action or refrain from action, depending on the information obtained. In some cases a Youth Law social worker may turn to a special committee – an “exemption committee” – which has the authority to waive the submission of the report if it becomes evident that although the child is indeed exposed to abuse – even severe abuse – it also emerges that police intervention or legal proceedings could result in harm to the child. If a report is submitted directly to the police, then the police refers it to a Youth Law social worker and does not take action until after consulting with the latter, unless immediate action is imperative, in which case the welfare authorities take measures to protect the minor and handle the family. It should be noted that law enforcement authorities and welfare authorities operate along different channels: the police is responsible for investigating and prosecuting suspects, whereas welfare authorities are responsible for providing care for the child and the family (Goshen, 2020).

Following the adoption of a statutory obligation, and in conjunction with extensive public information efforts, awareness surrounding reporting increased dramatically, particularly among some of the professional sectors: in 1998 Youth Law social workers received 21,765 reports, whereas by 2009 the number had risen to 45,588 – an increase of 109% within a decade. However, reports submitted to the authorities by members of the general public account for only 10% of all cases. In 2018, about 50,000 new reports on minors were submitted to social workers or the police. The most frequent causes of reporting were neglect (31%), physical abuse (25%), and sexual abuse (12%). The data further indicates that most maltreatment of minors (72% of the cases) was committed by an adult family member who is responsible for the minor (Child and Youth Services, 2017). In effect, most cases of child maltreatment do not come to the attention of authorities. A large-scale national epidemiological survey that examined abuse and maltreatment of children and youth in Israel illustrates the fact that the scale of abuse and neglect of children is far greater than reported. The survey, conducted during 2011-2014, included 12,035 children and youth aged 12-17. The study’s findings indicate that more than half of the participants were exposed to one or another type of maltreatment, independent of the degree of severity. About a quarter of the victims reported that they experienced two forms of maltreatment, and a third reported on multiple forms (3-6 different forms of maltreatment) (Lev-Wiesel & Eisikovits, 2016). A tenth of the study’s participants reported that the abuser used an object of some sort. A quarter of the children reported that the maltreatment caused them injury, and about a fifth sought medical care.

Detecting the phenomenon and diagnosing it as early as possible are not only a necessary condition for rescuing the victimized child. They also reduce the need for ongoing medical care for injured parties who are liable to consume healthcare services throughout their lives as a result of the maltreatment. In primary care clinics within the community, as part of the Israel’s health management organization (HMO) system, nurses treat children who arrive for medical or preventive care, as well as parents and other family members, over the course of years. They watch the children grow and develop, form personal ties with the families, and earn their trust. The parent and child arrive for an appointment with the nurse as an organic family unit, which allows the nurse to observe the child, the parent, and the dynamic between them. Accordingly, nurses are in a uniquely important position that gives them an opportunity to identify cases of abuse or neglect and intervene as needed.

Despite the reporting obligation, and despite the opportunities nurses have to identify relevant cases, many studies indicate that professionals have difficulty reporting, and that the level of reporting is very low relative to the extent of the phenomenon (Davies et al., 2009b; Gilbert, 2011). Zusman (2017) examined nurses’ tendency to report, and found that less than half of them fulfill their legal duty when it comes to reporting child abuse and neglect. She presented the nurses with case studies constructed so as to arouse suspicion of abuse and neglect, expecting that most would be inclined to report; however, the tendency to report, according to this study, was only 44%. This figure is likely to be an overestimation of actual reporting – that is, actual reporting would be even lower (Feng & Levine, 2005). According to data from the Israel National Council for the Child (NCC) (2016), reports from health workers (hospital staff, HMOs, and early childcare centers) accounted for only about 6% of all reports to authorities that year. Moreover, from 2010 to 2015, the number of reports from health care professionals dropped from 3,654 to 3,371. Of the 3,173 children identified and reported, 1,428 were identified in hospitals, 873 in HMOs,and 473 in early childcare centers. Similar reporting rates were recorded in 2018 (National Council for the Child, 2019). A majority of the reports by community nurses are submitted to a Youth Law social worker, followed by community welfare services, with police in the last place.

The under-reporting by professionals in Israel is similar to what occurs in many countries across the world. In Australia, for example, doctors and nurses are required by law to report child abuse; however, only 2-4% of reports come from healthcare professionals, although the estimated prevalence of physical child abuse in Australia is between 5% and 18%. In the US it was found that in terms of the volume of reports on suspected abuse from various sectors, health care professionals, such as doctors and nurses, were in the fourth and final place (after teachers, law enforcement, and social workers and mental health workers) (Sedlak & Ellis, 2014).

Studies in this area point to a variety of factors and barriers that impede nurses’ fulfillment of their legal duty (Rolim et al., 2014). According to findings, nurses feel that they lack the necessary training and tools, both to identify suspicious signs and to intervene accordingly. These findings are consistent with Israeli research indicating that healthcare workers feel they have little or only moderate knowledge pertaining to the identification and treatment of cases, particularly in the areas of emotional abuse and neglect (Ben Natan et al., 2012), and with research indicating that many cases are not reported (Fraser et al., 2010).

Additional barriers to reporting include mistrust of the welfare and police bodies that handle investigations; nurses fear that the authorities responsible will mishandle cases, thereby causing additional harm to the child and the family. They also fear being exposed to lawsuits and bearing the legal responsibility for reporting (Ben Natan et al., 2012). In addition, the potential of sabotaging the therapeutic relationship between the nurse and the patient as well as the patient’s family might cause nurses to postpone or completely refrain from reporting (Kuruppu et al., 2018).

The Covid-19 pandemic created a new reality, introducing many changes in our lives. On the one hand, more time in the home environment increases the likelihood of women and children experiencing domestic violence, while on the other hand social distancing and work restrictions make it more difficult to identify individuals and families and to provide care and assistance to victims of violence (because of the constant presence at home of the perpetrators of violence, among other reasons) (Coulton et al., 2007; Haas et al., 2018; Warren & Font, 2015). According to NCC data, between 2019 and 2020 there was a 19% decrease in the number of minors whom HMOs identified as victims of domestic violence and sexual assault and reported to welfare authorities or the police (National Council for the Child, 2021).

Although various studies on barriers to reporting among nurses have been conducted around the world, there have been almost no qualitative studies on these barriers among community nurses. In light of the growing discrepancy between the frequency of abuse and neglect in the population and the identification of and reporting on such incidents as required by law, and considering the unique position of community nurses, it is important to conduct an in-depth examination of nurses’ perceptions of reporting difficulties. This is all the more important in light of reports about increased violence against children during the Covid-19 pandemic. The findings of the present study may contribute to the formulation of an appropriate training program for nurses.

**Objective**

The study aims to identify the barriers that prevent community nurses from reporting on cases of suspected violence against or neglect of children.

**Methods**

The nurses’ attitudes were examined by means of a qualitative research approach based on qualitative methods of information gathering, using semi-structured in-depth interviews. For this study, qualitative research methods were the most appropriate because the interview was fundamentally aimed at understanding interviewees’ perception and the significance they ascribed to dilemmas surrounding reporting on physical violence by parents against children. The interview enabled nurses to express themselves in their own language, in line with their own worldview, attitudes, and opinions. It was conducted on the basis of an interview guide that covered significant key areas while remaining flexible and allowing for interviewer-interviewee dialogue and substantive self-expression (Poth & Creswell, 2018). Indeed, the nurses were requested to share dilemmas and situations that often sparked feelings of guilt and insecurity among them. In order to obtain candid and reliable information as well as an in-depth understanding of the barriers, we approached them from a qualitative research perspective.

Twenty community nurses participated in the study, all of whom were employed in HMOprimary care clinics. Participants were recruited using the “snowball” method and word-of-mouth. This method of sampling has significant advantages for a study of this sort, given the need for in-depth investigation of attitudes on a sensitive issue. Because the nurses were being asked to discuss personal barriers and perspectives on abuse, which are not always aligned with the official positions of the establishment and on which there is no consensus, a personal conversation was appropriate. Another advantage of this method is the basis of trust created by receiving a recommendation from a fellow nurse, which increases the likelihood of collecting as complete and comprehensive information as possible from the interviewee. The interviews lasted about an hour. After coordination by telephone, which included an explanation by the interviewer regarding the purpose of the meeting and a guarantee of anonymity, meetings were scheduled at the nurses’ workplaces. Three of the nurses were interviewed by telephone.

The interview topics and guiding questions were formulated on the basis of international literature in this field, preliminary conversations with experts – including social workers who coordinate HMO committees on violence – and the director of a “protection center” for victimized minors in the community. The interview focused on the following subjects: knowledge of the law and reporting methods, barriers to reporting, the nurses’ outlook on child abuse, and their previous experience reporting to and interacting with authorities. Having obtained the nurses’ prior consent, all the interviews were recorded, transcribed, and analyzed using content analysis by categorization (classification and categorical analysis). This process allows for the identification of recurring patterns, themes, trends, and useful conceptual categories (Lincoln & Guba, 1985; Miles & Huberman, 1984; Strauss & Corbin, 1990).

The guidelines for data analysis in the present study were as follows: First, all the interviewees’ statements in response to the questions presented to them were assembled. Second, the statements were classified into a number of subcategories, reflecting the common basis of interviewees’ responses to each question. Third, the statements were analyzed in relation to each question separately, identifying the interviewees’ attitudes by subcategory. This analysis yielded a picture of the nurses’ attitudes.

**Findings**

**Relevant Demographic Data**

* Twenty nurses participated in the study.
* All the participants were women.
* The average age was 45.
* All had 14 or more years of experience as nurses in primary care clinics in the community.
* Five nurses worked in small clinics (one nurse per shift) and 15 worked in clinics with two or more nurses per shift.
* Twelve nurses had completed their nursing studies in Israel, and eight had studied abroad and subsequently completed the nursing licensing and practicing requirements in Israel.
* Seventeen nurses never reported on suspected violence against children; 10 of these nurses related that they had encountered cases in which they suspected maltreatment but did not report it. Only three participants reported on suspected violence against children.
* Over the past decade, all the participants had undergone workplace training on the issue of mandatory reporting at least five times. Seven nurses had completed about an hour of training once a year through Ministry of Health courseware. Nine nurses had completed about an hour of training once a year on issues of violence in general, in the context of a nursing staff meeting with a social worker. Four nurses had participated in workplace seminars of several hours on general issues of violence, including scenarios.

**Findings by Categories**

***1. Non-Familiarity With the Law and Means of Action Under the Law***

We presented nurses with the following question: “Are you familiar with the Law for the Prevention of Abuse of Minors and the Helpless and its requirements?”

Regarding the duty to report, *all* the nurses stated that they are aware of their legal duty to report to the police or a social worker on any case that arouses reasonable suspicion on their part of harm to a child or helpless person. When asked about the legal significance of non-reporting for the nurse, *all* the nurses replied that non-reporting is a crime that may result in imprisonment. One nurse, for example, noted, “I know that I must report to the authorities on any case of suspected abuse, and that if I do not report and something happens, I could be charged.”

In answer to our question about what legally constitutes a “reasonable” suspicion necessitating reporting, *most* of the nurses replied that reporting requires them to reach a high degree of certainty by gathering and consolidating “evidence” that supports their suspicion. One nurse, for example, recounted, “I had a case in which a father arrived with an injured girl, and he didn’t let her speak at all and he seemed anxious, which sparked my suspicion that something was not right, but I wasn’t sure, so I decided to summon him again to try to obtain more information before deciding to file a report.”

Regarding familiarity with how authorities handle the matter after a report is submitted, we found that the nurses do not know the nature of the process that authorities must follow under the law. *Most* of the nurses believed that the main remedy available to authorities is the removal of children from their home. One nurse stated, for example, “If I were to report a case to the police, I imagine a situation in which police officers come to the home and immediately take the children away.” Another said, “I don’t understand the difference between a welfare officer and the police; they will pounce on the family in the middle of the night.”

It appears, therefore, that despite the nurses’ having internalized their duty to report, their lack of understanding surrounding the legal definition of “reasonable suspicion” and of the procedure following reporting creates a barrier to the fulfillment of their legal duty.

***2. Lack of Knowledge and Training for Establishing Reasonable Suspicion***

On the subject of knowledge, we asked the participants, “Do you feel that you have the level of professional knowledge needed to identify incidents of abuse and neglect of children, in order to fulfill the duty to report?”

*Most* of the nurses believed that when there are more visible and tangible external physical signs, they are better able to establish a reasonable suspicion of violence. However, when it comes to other forms of violence, such as neglect or sexual violence, they require a higher level of certainty in order to report on a suspected incident. One participant explained, “When there are recurring visits to the clinic because of injuries or breaks that don’t clinically match the description of the incident, it is easier to form a suspicion than in other cases related to neglect.” Another nurse noted, “It is easy for me to spot incidents of physical violence because the marks on the body are evident, but emotional abuse and neglect are not visible, and it is hard to establish suspicion in such cases.”

The responses also indicate that nurses have only limited knowledge regarding the types of maltreatment recognized under the law. They do not have a clear definition of neglect. One nurse stated, “It is not clear to me what neglect is; whether it refers to the clothes a child is wearing, to weight, to cleanliness; there could be many things that might indicate [neglect], but it is not clear when exactly it should be reported.”

On the matter of training, we asked, “Have you undergone a training program dedicated to the issue? How often? What were the subjects and what could have helped you deepen your knowledge?”

The findings point to local, limited trainings that differed from one another and took place at the nurses’ respective workplaces. Most of the trainings lasted one hour and were held annually. Of the three nurses who had reported to the authorities in the past, one had participated in an annual training for the nursing staff, conducted by a social worker at the same facility, and two had participated in training as part of a seminar. Most of the nurses stated that they feel the training they have received is very limited, and they do not feel that they have acquired the tools to conduct an investigation with a child or the parents. For example, “even if I understood the definition, I do not know how to question the parents or the child, when, and what questions to ask of the parents.”

Most of the nurses said they would like to receive additional in-depth training in various aspects: conducting case simulations to understand the level of questioning required, having a detailed list of suspected signs of neglect or sexual assault, and developing a deeper understanding of the definitions and tools for establishing reasonable suspicion. Their overall impression is that they lack sufficient knowledge and training to identify the signs that qualify as a reasonable suspicion, and this poses a barrier to reporting.

***3. Nurses’ Concerns About the Repercussions of Reporting for the Patients, Their Families, and Themselves***

**A. Future Care for the Patient.** Question: “Do your relations with the family constitute a consideration in deciding whether to report?”

About *three-quarters of the nurses* believe that reporting will have a negative impact on their relations with the family. They fear that the family will be angry and no longer trust them specifically or the medical staff generally, which could prevent their seeking medical care in the future. Participants’ observation in this context included the following remarks: “I’ve known the family for years; I’ve been treating the parents and the children and they trust me. They would stop coming to me.” “If the family were to find out that I reported, next time the child was hurt they wouldn’t come to me.” “If it became known in the community that I had reported, whether the report were accurate or mistaken, they would simply be afraid to come to me.”

**B. The “Stain” on the Patient and the Family, Especially in the Event of a Mistaken Report.** Question: “Does the impact of reporting on the family constitute a consideration in deciding whether to report?”

*All the nurses* feel that the very act of reporting could cause harm to the family, especially if it is mistaken. One nurse noted, “They’ll come to the child’s school and everyone will see them being taken away.” Another added, “How will the child, who has already been hurt, view their parents being interrogated or arrested? It’s terrible. I’m afraid of leaving a stain on the family that will stay with it a long time and cause psychological harm both to the child and to the child’s environment.”

Thus, the nurses’ concerns about a negative impact on interpersonal relations and the repercussions of reporting for the family constitute a barrier to reporting.

**C. Repercussions for the Reporting Nurse.** Question: “Does the impact on you as a result of reporting constitute a consideration in deciding whether to report?”

*About half* of the nurses expressed concern that if the child’s family learned that they had submitted the report, they and their family would face a threat of violence, including physical violence. Some also mentioned concerns about the legal aspects of reporting. One participant, for example, noted, “If I am summoned to court, will I have to testify? I do not know how and that’s scary.” Another said, “If the report is mistaken, will the family be able to sue me? I do not want to get into trouble.”

The three nurses who had filed reports in the past noted that they never received feedback from the authorities or even from their place of employment, and they do not know what the investigations found or whether their reports turned out to be accurate. One of them added, “After reporting I tried to find out what happened and if the matter had been handled, but I was told that because of confidentiality I could not receive feedback.” Another nurse said, “I never learned anything about what happened with my complaint, and I also met with the family again later and felt awful.”

***4. Work Environment and Consultation With Colleagues***

On this issue, we asked, “Are there factors in your work environment that influence your decision to report?”

*Most* of the nurses noted that in seeking to establish a suspicion before reporting, they would prefer to consult with a staff member they trust. The nurses who worked in a small clinic, usually alone, expressed concern over the “size of the responsibility” entailed in reporting when there is no other staff member available for on-the-spot consultation. Moreover, participants reported that they are sometimes hesitant to consult with social workers. Nurses who work with staff social workers whom they know personally felt more comfortable in this respect.

Two key points characterized the reporting process among the three nurses who had submitted reports in the past: First, the case involved life-threatening circumstances or a situation that appeared to entail ongoing physical injury; second, they submitted the report only after having several additional meetings in which they gathered a great deal more information, and after speaking with the attending physician and other professionals so as to establish the suspicion before reporting.

**Discussion of Findings**

More than twenty years ago, in November 1989, the Knesset (Israeli Parliament) enacted Amendment No. 26 to the Penal Law, better known as the Law for the Prevention of Abuse of Minors and the Helpless. As part of this new legislation, Article 368D of the Penal Law established an obligation to report to the authorities on cases of suspected harm to or abuse of minors and the helpless. The legislation established a duty to report on harm to minors, as a norm of conduct required of every individual – citizens in general as well as professionals who come in contact with a minor – and its violation was defined as a criminal offense. The legal responsibility of professionals is, by its nature, greater than that of regular citizens, and so too is the penalty imposed on them for not reporting.

Studies show that the establishment of reporting as a legal duty significantly increased awareness surrounding the phenomenon, which had previously been suppressed, and that within Israeli society the overall rate of reporting on suspected abuse of minors has increased by several hundred percent. Moreover, as it turned out, a decisive majority (more than 90%) of the reports were found to be valid. Despite the increased scope of reporting among the general public, however, only a minority of reports come from community nurses, even though they are expected to be a primary source in identifying the phenomenon. Thus, although nurses are aware of the duty to report, implementing the law is apparently difficult and complicated.

**Understanding the Law in Detail**

One barrier that emerges from our study is a lack of understanding regarding the term “reasonable suspicion” under the law. While most of the nurses feel that in order to fulfill their legal duty, they must first *substantiate* their suspicion and refrain from misreporting, in fact the law does not necessitate certainty and does not require that informers confirm their suspicions. Indeed, the legislature did not provide any precise definition of “reasonable suspicion,” thus making it a matter of individual discretion. The test of reasonableness turns on the question of what a reasonable person would do in the same situation. The spirit of the law encourages reporting and investigating every suspicion, even if it is later refuted. A lack of understanding surrounding the law leads to substantial professional distress, which often results in valid cases not being reported. Our findings are consistent with other studies (Feng & Levine, 2005; Wu & Feng, 2005) that found that a decision not to report was attributable to “uncertainty about the evidence.”

Another difficulty is most nurses’ lack of familiarity with the post-reporting procedure; it appears that the failure to report stems in large part from a deep-seated fear that the authorities’ first response will be to remove children from their home. In fact, the law requires that upon receiving a report, social workers must investigate the suspicions and try to obtain additional information about the child and family from the education and healthcare systems and other bodies. Depending on the findings, the social worker then submits a report to the police, alongside a recommendation to either take action or refrain from action. As noted above, a Youth Law social worker may also approach an “exemption committee,” which is authorized to exempt submission of the report if it appears that although the child is indeed being subjected to abuse, perhaps even severe abuse, there is cause for concern that police involvement or prosecution could result in harm to a minor. If the report was submitted directly to the police, then the police refers to a Youth Law social worker and does not act before consulting with the latter, unless immediate action is warranted. Law enforcement officials and welfare authorities operate along different channels: the police are responsible for investigating and prosecuting suspects, while the welfare authorities are in charge of caring for and protecting the minor. In practice, most children who experience abuse or neglect are not removed from their home, but rather treated in the community context. It is important to note that in an international comparison, Israel has among the highest rates of children receiving care within the community rather than being removed from their home.

According to our findings, the belief that “if I report, the child will be removed from home” generates mistrust of institutions and authorities among nurses. They fear that a report, whether validated or not, will spark an immediate and disproportionate response that could unfairly harm the parents and/or the child. The fear of such a response is reflected in NCC data (2016) showing that children who were identified as possible victims of maltreatment by staff at hospitals, HMOs, and early childcare centers were referred for further treatment most frequently to a Youth Law social worker, followed by welfare services within the community, with only a minority referred to the police.

**Lack of Proper Training**

Our findings indicate that the nurses feel they lack the professional knowledge needed to identify suspicious signs. Similarly, a study by Ben Natan et al. (2012) found that many healthcare workers are aware of their legal duty but feel they lack the knowledge, training, and tools needed to identify and intervene professionally in such cases. Nurses noted that they do not have sufficient knowledge regarding normative psycho-sexual and psycho-social development among children, and therefore find it difficult to diagnose anomalous cases. Rolim et al. (2014) found that nurses’ perception of their inadequate training was the main barrier to fulfillment of their obligation to report.

These topics are taught as part of the core curriculum in nursing schools. However, our examination of several institutions revealed a great deal of variance in the curricular content and scope of time devoted to training, with the amount of time generally varying between a few hours and just one day dedicated to training throughout the entire program.

Moreover, the Penal Law does not provide a comprehensive definition of physical abuse. It merely presents the elements of the offense and the qualities that characterize abuse generally and physical abuse specifically. The vagueness of the definition makes it difficult to determine the cut-off point for improper or harmful care (in cases of abuse) and the point at which needs are considered unmet (in cases of neglect). Although the Ministry of Health director general issued a circular (03/25) in 2003 setting out ways of identifying minors who are victims of abuse or neglect, there is still no overall consensus among professionals regarding the precise definitions.

The lack of an agreed-upon definition leaves much room for different interpretations and value-based perceptions, which in turn affect the identification of cases, the tendency to report on them, and methods of treatment. This makes it difficult for nurses to meet the requirements of the law. Intercultural and gender differences affect the perception and interpretation of suspicious signs (Sedlak & Ellis, 2014). For example, a qualitative study in Australia (Fraser et al., 2010) examined the factors that influence decision-making among community nurses, and found that they consider neglect and emotional abuse harder to define.

Another qualitative study (Ho & Gross, 2015) examined how nurses decide what is acceptable parental behavior and what parental behavior constitutes child abuse. Although there was no consensus on the definition of acceptable versus unacceptable parental behavior, for various reasons, the nurses’ views were varied and inconsistent in all aspects of the use of physical power as a form of discipline. This fact can also affect the tendency to identify and report on child abuse.

Furthermore, it appears that when a concern does arise, it is difficult for nurses to clarify the situation with the parents and the child. Identifying some of the signs requires the nurse to ask questions proactively, for example in a conversation with the parents and/or the child. Establishing a reasonable suspicion requires uncovering information that neither the parents nor the child wish to share. Chen and Glasser (2006) found that among 80 staff members at Sheba Hospital, more than 30% expressed discomfort about discussing suspected harm with a child and the child’s family. Respondents felt that they lacked the necessary skills to do so, and that their training, both in questioning and in handling the family’s responses, was limited and insufficient. In a study by (X), nurses noted that it is not easy to ask parents direct questions, and that this requires training and communication skills. The nurses in that study voiced an interest in a checklist that would guide them in asking appropriate questions.

The nurses in our study stated that when the nature of harm to a child is physical, with visible signs, it is easier to establish suspicion and they feel more confident about reporting. Pediatricians, too, have noted that when there is no physical evidence it is harder for them to file a report (Runyan & Theodore, 2006). Professionals are not always familiar with the behavioral and psychological signs that characterize other forms of maltreatment, such as emotional neglect or certain forms of sexual assault. The more the abuse endangers the child, the greater the tendency to report (Lagerberg, 2004). The findings of a study by Fraser et al. (2010) indicate that emotional violence is significantly under-reported. Lack of knowledge and experience makes nurses hesitant, and all the more so in such cases.

Ministry of Health Director General Circular No. 03/25 from 2003 requires the implementation of a periodic training program for medical staff, including analysis of incidents and lessons learned from any case of suspected harm to a minor on the part of a person responsible for the minor. The aim is to have any possibility of abuse or neglect examined *as an inseparable part of the medical history taking*, including the medical and nursing anamnesis, the examination, and the differential diagnosis. Indeed, the Ministry of Health has been instituting many nationwide procedures aimed at promoting tools and training programs for all healthcare professionals. In this context it has developed a training kit for hospitals and another one for community healthcare professionals. However, a State Comptroller’s report (2015) found that although the ministries of education, health, and the economy have taken measures in recent years to train employees who are expected to identify such minors, the ministries did not map the needs that remained unmet by such training, and some of them did not set quantitative targets in this regard for the coming years. A reporting duty by itself, without appropriate training of professionals, is not enough to address and provide a genuine remedy for the scope of the phenomenon.

**The Repercussions of Reporting for Those Concerned**

Our research found that three-quarters of the nurses believe that reporting would undermine their relationship with the family. Nurses have reported that even when they encounter a situation that arouses their suspicion, the potential harm to their relationship with the family constitutes a significant consideration in deciding whether to report it. They are particularly concerned about repercussions in the event that it later turns out that the report was mistaken (Flaherty & Sege, 2005; Nayda, 2005; Wu & Feng, 2005). Such a breach of trust could, according to them, prevent abusive parents from bringing their children in for preventive and medical care, which could result in further harm to their health and impede their proper development. Within the healthcare discourse, the duty of confidentiality is at the heart of the “treatment contract” between the professional and the patient, and its violation undermines the trust that forms the basis of treatment. A study by Benbenishty and Dov (2010) found that 70% of physicians agree that reporting undermines a family’s trust in the physician, and the repercussions include not only an inability to help victims but also a worsening of their situation (Doron, 2012).

Community nurses maintain connections with patients and their families over the course of many years, and often they reside within the same community and know the family from other spheres of life as well. The personal connection can serve as a barrier in the sense that it creates a “blind spot” among professionals, causing them to lower their standards of adequate care (Schols et al., 2013). In our interviews, nurses recounted how they avoided reporting on families they knew well, especially in cases of personal acquaintance with members of the extended family. In a study examining barriers to reporting among nurses, one of the participants stated, “If the nurse knows the family, it becomes difficult. If she’s a friend of the family, especially in small places, she will think that she has to report, you know, friends of the family” (Scott & Fraser, 2015). Evidently, a fear of breaching the trust and the warm social support network that a nurse has built with children and their families, the foreseeable negative repercussions for the family, and the lack of certainty about whether a case justifies reporting, in combination, increase the likelihood that a nurse will decide to refrain from reporting (Flaherty et al., 2006; Francis et al., 2012).

Another issue is the repercussions of reporting for the nurses themselves. Israeli law does not offer the option of keeping an informer’s identity confidential. Consequently, a nurse may be exposed to severe reactions, including violence on the part of the child’s parents and relatives (Faber, 2010), particularly if the nurse and nurse’s family are part of the same community (Mathews, 2008).

Our findings regarding a barrier stemming from fear of reprisal by the family are similar to those of other researchers (Alvarez et al., 2004; Ken, 2105): in a study that examined reasons for not reporting among dentists, a third of the 306 respondents stated that they fear being subjected to violence (Carines, 2005). A survey of 56 physicians who specialize in abuse and neglect (Flaherty et al., 2013) found that 52% of respondents described feeling that their personal safety was threatened, 23% described concerns about negative publicity, and 16% described concerns about malpractice suits. In another study healthcare workers pointed to the need for focused training in the following areas: how to appear in court proceedings, how to speak with abused children, and how to treat parents who react angrily to their child being questioned (Benbenishty et al., 2010).

In the current reality, professional, legal, and practical factors prevent social workers and the police from providing information about an investigation. Yet without feedback and information about the outcome of reporting, an informant nurse cannot draw lessons from one case for the next one (Pesach, 2010). Nurses might therefore feel that they lost control or that events unfolded in an undesirable way. In the United States nurses described a sense of mistrust in working with welfare services because the child welfare service does not update nurses on the progress and outcome of investigations; consequently they also have less faith that reporting can help children (2014).

**The Importance of Consulting With Colleagues**

The findings of our study indicate that a nurse who works alone, having no colleagues with whom to consult, will find it difficult to report on a case that has aroused suspicion of abuse or neglect. When the suspicion arises during an encounter in the clinic, the nurse also experiences emotional turmoil and feels the need to discuss the matter with another staff member. On the other hand, in clinics that employed a number of nurses, the option of consulting with another nurse or with a physician facilitates decision-making on reporting. Our findings in this regard are consistent with those of Paavilainen et al. (2000), who found that in cases of suspected child abuse or neglect, a nurse or physician will consult with another professional, usually on the same staff. They almost never consult with a professional outside of the hospital (Paavilainen et al., 2000). Zusman (2017) found that early childcare center nurses prefer to approach a social worker on staff at the same clinic.

**Summary and Conclusions**

Reporting on abuse and neglect is a professional duty enshrined in law. The enactment of this law in Israel in 1989 created a new reality, designating a legal and moral obligation, on the part of society in general as well as professionals, to break the code of silence surrounding child abuse. Despite this, the rates of reporting among community nurses continue to be very low. There seems to be a continuous difficulty, from the point of identification through the stage of reporting to authorities. As presented in this study, a duty to report by itself, without training that is dedicated to the matter and supplemented by appropriate resources, is not sufficient to increase the rate of reporting.

In order for nurses to fulfill their legal and moral duty, policymakers must formulate clear and agreed-upon rules for identifying various forms of harm and determining the existence of a “reasonable basis” to believe that a crime has been committed. It is necessary to develop and implement a policy that includes in-depth training and the provision of tools to nurses for every stage in the process. These should be taught both at nursing schools and in community health organizations. In addition, every organization should have a mechanism for protecting the nurses, helping them cope with fear of family reprisals, and providing them with support for any type of case – whether the report turns out to be valid or mistaken.

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