An Exploration of the Relationship Between Poverty and Child Neglect in Canadian Child Welfare

by Katherine Schumaker

A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Factor Inwentash Faculty of Social Work
University of Toronto

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Abstract

Objectives

Concerns have been raised that child welfare systems may inappropriately target poor families for intrusive interventions. The term “neglect” has been critiqued as a class-based label applied disproportionately to poor families. The objectives of the study are to identify the nature and frequency of clinical and poverty-related concerns in child neglect investigations and to assess the service referral response to these needs; to examine the contribution of poverty-related need to case decision-making; and to explore whether substantiated cases of neglect can be divided into subtypes based on different constellations of clinical and poverty-related needs.

Methods

This study is a secondary analysis of data collected through the 2008 Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2008), a nationally representative dataset. A selected subsample of neglect investigations from the CIS-2008 (N = 4,489) is examined through descriptive analyses, logistic regression, and two-step cluster analysis in order to explore each research objective.

Results

Children and caregivers investigated for neglect presented with a range of clinical and poverty-related difficulties. Contrary to some previous research, the existence of poverty-related needs
did not influence case dispositions after controlling for other relevant risk factors. However, some variables that should be, in theory, extraneous to case decision-making emerged as significant in the multivariate models, most notably Aboriginal status, with Aboriginal children having increased odds of substantiation, ongoing service provision and placement. Cluster analyses revealed that cases of neglect could be partitioned into three clusters, with no cluster emerging characterized by poverty alone.

**Conclusions**

The majority of children investigated for neglect live in families experiencing poverty-related needs, and with caregivers struggling with clinical difficulties. While poverty-related need on its own does not explain the high proportion of poor families reported to the child welfare system, nor does it account for significant variance in case decision making, cluster analysis suggests that there exists a subgroup of “neglected” children living in families perhaps best characterized by the broader notion of social disadvantage. These families may be better served through an orientation of family support/family welfare rather than through the current residual child protection paradigm.
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Chapter 1: Introduction

A Picture of Child Neglect

A young mother of three children under the age of six lives in an apartment above a strip mall in a neighbourhood known for high crime. She had her first child when she was 17 and left high school after she gave birth to the baby boy. The whereabouts of the boy’s father are unknown. At 19 she married and had two more children, but has since separated from her husband, who is currently incarcerated. She recently moved from a northern community—where the family had an open file with the local child welfare agency—to a large urban centre to be closer to her mother. Their relationship is often strained but the grandmother occasionally helps with the children.

A young, inexperienced child welfare worker is assigned to the case. She reviews the file, which gives the reason for service as “neglect” without much further detail. The case was opened twice previously, due to concerns related to alcohol, and the mother is also listed as one of the children in a file opened in the grandmother’s name 15 years earlier. During her first visit, the worker notes that the home is untidy and dirty, with piles of toys and clothes on the floor and unwashed dishes covering the counter. The garbage can is overflowing and the house has an unpleasant odour. It is two o’clock in the afternoon and the children are not dressed. The oldest child is watching television and does not look when the worker says hello. In response to the worker’s questions, the mother says that her son only speaks in two- or three-word sentences and that his behaviour is challenging, with frequent angry outbursts. All three children appear pale and tired.

The worker visits the home every month and discusses the mother’s personal and parenting struggles. The mother seems happy to have someone to talk to. She describes her earlier difficulties with alcohol but says that it is now under control, although sometimes she feels “really down.” She receives social assistance and hopes to go back and complete high school when the children are older. She asks about respite services so that she can get a break from her parenting responsibilities,
particularly with the oldest son who is “driving her crazy.” The mother says she has few friends who can help out and speaks of wanting to be able to go out on weekends with other young people, like a “normal 21-year-old.” The worker advises that respite is not available but arranges for a family support worker to assist the mother in establishing routines for the children and to teach child management techniques. She schedules a developmental assessment for the oldest child and talks to the mother about proper sleep and nutrition for the children. She leaves information about a drop-in centre that runs a parent support group and worries vaguely that she hasn’t really helped this young mother, feeling overwhelmed by her many problems.

Service continues in this way for several months, with little improvement in the children’s routines, the mother’s reported ability to manage her eldest child and the state of the household. The mother misses the developmental assessment for her son, explaining she was unable to get anyone to watch the two other children and couldn’t find the number to call to reschedule. One day, the worker arrives to find the apartment door ajar and the children home alone. The oldest child says that “Mommy’s friends” are there to watch them. He points out the window to the parking lot, where two men are standing, smoking cigarettes. The apartment is cold and dirty. The worker calls her supervisor and a decision is made to apprehend the children.

* * *

This vignette is an illustration of what child welfare authorities in Canada call “child neglect.” The complex difficulties faced by the family, the absence of the father from the formulation of the problem and the intervention, the chronic rather than acute nature of many of the issues, the lack of discernible improvement over time, and the family’s poverty and social isolation are all common factors in cases of child neglect. So too is the worker’s uncertainty about how to meaningfully help this family.
Background

Child neglect is one of the most common forms of child maltreatment reported to child welfare authorities in Canada, comprising an estimated 34% of all substantiated investigations (PHAC, 2010). Despite these data, there is no consensus on exactly what constitutes neglect, with scholars noting that definitions of neglect are culturally rooted and evolve and change over time (Garbarino & Collins, 1999). Neglect is typically distinguished from abuse as an act of omission (the failure to act) rather than commission (a deliberate, intentional action), posing difficulties for both identification and substantiation as the focus is on the absence of desirable behaviours rather than the presence of undesirable ones (English, Thompson, Graham, & Briggs, 2005). Unlike physical or sexual abuse, neglect is often characterized as a chronic rather than incident-driven condition, with substantiation frequently requiring that a pattern has been established over time (Minty & Pattinson, 1994). Although talked about as a unified, binary construct that is either present or absent, neglect refers to a wide range of conditions (e.g., inadequate food, clothing, shelter, hygiene, supervision, stimulation or nurturing) ranging in both severity and duration, with potentially different etiologies and sequelae (Dubowitz, Pitts, & Black, 2004). Considerable debate exists about exactly who or what is responsible for the neglect of children, with theories emphasizing both the responsibility of parents and the complicity of a society that does not adequately (or equitably) support all parents in caring for their children.

Given these complexities and ambiguities, child welfare workers are often unsure about when and how to intervene in cases of neglect (Daniel, 2005; Horwath, 2007) and research into effective interventions with families is in its infancy (DePanfilis & Dubowitz, 2005). Researchers have characterized neglectful families as multi-problem and hard to engage (Gaudin, 1993) and have frequently described their problems as entrenched and intractable (Wilson & Horner, 2005). Some evidence suggests that child welfare workers may be simultaneously under- and overwhelmed by neglect; on the one hand, underestimating its seriousness due to the lack of immediately observable
harm while on the other hand, experiencing a sense of hopelessness due to the chronicity and pervasiveness of the problems experienced by many of these families (Horwath, 2007; Wilson & Horner, 2005).

**Scope and Impact of the Problem**

Neglect is one of the most common reasons for referral to child welfare agencies in both Canada and the United States, comprising the second largest category of substantiated cases in Canada and the largest in the United States (Sedlack & Broadhurst, 1996; Sedlack et al., 2010; Trocmé et al., 2005). According to the 2008 Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2008), there are an estimated 28,939 substantiated reports of neglect each year in Canada, making up 34% of all substantiated cases. Of these, an estimated 4,081 children (14%) are placed in out-of-home care (PHAC, 2010).

Data from the United States’ fourth National Incidence Study (NIS-4) indicated that of the estimated 1,256,000 children maltreated during the study period (2005–2006), approximately 61% (or 771,700) were victims of neglect, according to the Harm Standard. Under the Endangerment Standard, this number increases to 2,251,600 neglected children (over 77% of the 2,905,800 children estimated to have been maltreated under the Endangerment Standard (Sedlack et al., 2010). Statistics from the United Kingdom indicate that neglect is the largest single category of harm on child protection registers in England and Wales, comprising approximately 44% of cases where a child was the subject of a child protection plan (Department for Education, 2010). In Australia,

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1 These data refer to cases where neglect was the primary reason for substantiation.

2 The Harm Standard is “relatively stringent and generally requires that an act or omission result in demonstrable harm to the child to be classified as abuse or neglect. It permits exceptions in only a few specific maltreatment categories, where the nature of the maltreatment itself is so egregious that one can infer that the child was harmed” (Sedlack et al., 2010, p. 3).

3 The Endangerment Standard includes all children who meet the Harm Standard but adds others as well. The central feature of the Endangerment Standard is that it counts children who were not yet harmed by abuse or neglect if a sentinel thought that the maltreatment endangered the children or if a child protection services investigation substantiated or indicated their maltreatment (Sedlack et al., 2010, p. 3).
neglect is the second most common type of child maltreatment dealt with by child protection authorities, comprising 37% of all substantiated referrals to child welfare services (Lamont, 2011).

Although historically viewed as less serious than abuse, a substantial body of evidence indicates that outcomes for neglected children are poorer across several developmental domains than for children who have been abused (Egeland & Sroufe, 1981b; Erickson & Egeland, 1996, 2002; Garbarino & Collins, 1999; Gauthier, Stollak, Messe, & Arnoff, 1996; Kaplan, Pelcovitz, & Labruna, 1999). In their review of developmental outcomes for neglected children, Hildyard and Wolfe (2002) concluded that neglect has a “pervasive, negative impact on children’s early competence across major developmental dimensions” (p. 685), with neglected children suffering from more severe cognitive and academic deficits, social withdrawal, limited peer acceptance, and internalizing problems than children who are physically abused. In general, research suggests that children labelled as “neglected” are at risk for a host of troubling short- and long-term outcomes including anxiety, depression, social and behavioural problems, low self-esteem, poor educational progress, and future parenting difficulties (English, Upadhyaya et al., 2005; Springer, Sheridan, Kuo, & Carnes, 2007). Neglect may also result in physical harm; referencing American statistics, DePanfilis (2006) has noted that neglect is more likely than any other type of maltreatment to be a contributing factor to serious injury and death.

Like other maltreatment typologies, the consequences of neglect often differ based on the age and stage of development of the child and the severity, pervasiveness, and duration of the experience. Neglected infants and young children are particularly vulnerable to poor developmental outcomes due to the impact of neglect on the developing brain (Dubowitz et al., 2004; Egeland & Sroufe, 1981b; Erickson & Egeland, 2002). Research focusing on early brain development indicates that caregiving experiences in the first three years of life directly influence the parts of the brain that develop and those that do not. These early years represent a time when neural synapses grow at a

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4 This is a reasonably new phenomenon, believed to be due to the recent inclusion of exposure to domestic violence in the definition of emotional maltreatment in the statutes (Lamont, 2011).
rapid rate and nurturing, stimulation, and proper physical care directly influence the developing
pathways (Perry, 2002). Neuroscientists have concluded that there are “critical periods” during
which the brain is open to stimulation to support healthy growth and development of its specific
components (i.e., the stem, mid brain, limbic system, and cortex). These components are each
responsible for particular functions, such as respiration, sleep, appetite, and emotional regulation
(Glaser, 2000). Although the brain continues to develop for several years, by age three, a period of
pruning begins and the neural pathways that are not well-used may be discarded (DePanfilis, 2006).
The result is that early life experiences of deprivation may have profound effects continuing into
adulthood even if a child’s environment later improves.

Understanding neglect is particularly important to the child welfare field as research has
demonstrated that cases of neglect, whether substantiated or not, are more likely to be re-referred to
child protection services than any other type of maltreatment (Jonson-Reid, Drake, Chung, & Way,
2003), suggesting that despite identification and/or child welfare intervention, children in these
cases continue to grow up in environments that do not meet their basic needs. Further, subsequent
referrals to child welfare are more likely to be for reasons of neglect, regardless of the original reason
for referral (Jonson-Reid et al., 2003), indicating that neglect is likely to be part of the picture for
many chronic cases of child maltreatment, regardless of their original reason for identification.

Once known to the child welfare system, children in cases of substantiated neglect are more likely
to be removed from their homes than are children for whom another form of maltreatment is
predominant (Trocmé et al., 2005; Walsh, 2010). Further, some studies show they are less likely to
be reunified following removal (Eamon & Kopels, 2004). As a result, child neglect is a particularly
costly social problem, both in terms of personal costs to children, families, and communities and in
terms of dollars spent on supporting children in out-of-home care.
Poverty and Neglect

One of the most commonly noted features of families in which neglect is a concern is their impoverished socio-economic condition (Pelton, 1978, 1981, 1994; Shook Slack, Holl, McDaniel, Yoo, & Bolger, 2004; Wolock & Horowitz, 1979). Although poverty is also correlated with abuse, it is more strongly associated with neglect than with any other maltreatment typology (Carter & Myers, 2007; Drake & Pandey, 1996; Garbarino & Collins, 1999; Horwath, 2007; Knutson, DeGarmo, Koeppl, & Reid, 2005; Sedlack & Broadhurst, 1996; Wolock & Horowitz, 1979). Historically, policies have been put in place to protect families from intrusive child protection interventions when problems exist due to poverty per se. Swift (2005) notes that at the Canadian Social Service Congress in 1914, reformers succeeded in advocating for a principle that “no child should be removed from his or her home on grounds of poverty alone” (p. 53). Similar policies were already in place in the United States, stemming from the White House Conference on the Care of Dependent Children, held in 1909. Although Pelton (1978; 1994) has contended that this principle remains strong in contemporary child welfare systems, he acknowledges that in practice, poverty is often difficult to disentangle from neglect; indeed, some scholars have noted that “poverty is often considered a de facto indicator of neglect” (Cash & Wilke, 2003, p. 401).

Based on this concern, some writers have questioned the appropriateness of a maltreatment lens for child neglect (Besharov & Laumann, 1997; Blackstock, 2008; Lindsey, 2004; Wilson & Horner, 2005). In a recent critique of the NIS-4, one advocacy group has asserted that “the very definition of neglect in this study is a definition of poverty” (Wexler, 2010, p. 7). Arguing that neglect should be thought about differently from other forms of maltreatment, Lindsey and Shlonsky (2008) have contended that neglect, unlike abuse, is “primarily a result of poverty and unemployment” (p. 232), and they have attributed the lack of discernible improvement for children and families to the failure of the child welfare system to tackle poverty head-on (p. 377). Swift (1995b) has proposed that poverty is a prerequisite for membership in a socially constructed group called neglect.
which “is not and never has been intended to catch out ordinary [non-poor] people in parenting lapses” (p. 11). Speaking specifically of neglect among First Nations children in Canada, Blackstock (2008) has noted its strong connection to structural inequalities such as poverty, poor housing, and substance misuse concluding: “I cannot understand the difference between social disadvantage and child maltreatment” (p. 202). While these contentions all share a belief that poverty is somehow intimately connected with what the child welfare field refers to as neglect, each has something quite different to say about why and how poverty and neglect are related, with distinct implications for intervention.

To further complicate matters, the strong relationship between poverty and neglect is not an exclusive one. For example, even scholars who stress that the majority of neglectful families are poor—“often dirt poor”—have contended that most chronically neglectful caregivers known to the child welfare system also have “severe psychological and emotional impairments” including histories of substance abuse, mental health problems, domestic violence, and criminal activity (Wilson & Horner, 2005, p. 472). Writing in 1981, Norman Polansky and his colleagues argued that intervention designed solely to increase income “will not solve the problem of child neglect” as parental personality and functioning are directly related to both income levels and how parents manage their money (Polansky, Chalmers, Buttenwieser, & Williams, 1981, p. 25). Through more recent study, Crittenden (1993; 1999) similarly proposed that it is the characteristics of the neglectful caregiver (namely, deficits in mental processing) that explain both poverty and the phenomenon of child neglect, making caregiver deficits rather than the poverty that often accompanies these problems the most critical factor in determining neglect.
In trying to unpack the relationship between poverty and child neglect, significant questions emerge. What are the poverty-related and clinical concerns of families presenting to child welfare for reasons of neglect? To what degree does intervention with families focus on the clinical problems of parents and children rather than the deprived circumstances in which they live? To what extent does family poverty compared to clinical concerns influence decision-making in cases of neglect? Are there families involved with child welfare for reasons of poverty alone? Is neglect a social justice issue that calls for change at the structural level alongside of the individually based interventions most common through the child welfare system? And if so, how might child welfare workers contribute to these changes while at the same time meeting the immediate individual needs of affected children and their families?

These questions are significant for policy and practice, but their exploration is limited by gaps in theory and available data. However, the CIS-2008 dataset provides an opportunity for a series of smaller analyses that will lay the groundwork for tackling these broader questions, using recent Canadian data. Specifically, this dissertation will document the clinical and poverty-related needs of children and families investigated for neglect by Canadian child welfare services and the extent to which the service response takes an individual (i.e., clinical) versus a structural or ecological approach to families’ needs. It will also assess the contention that neglect is better characterized as a classless phenomenon whose strong relationship to poverty in child welfare samples is an artefact of class-based biases in reporting and/or case decision-making. Further, it will assess whether families substantiated for neglect can be classified into subgroups with different constellations of clinical and poverty-related needs and explore the extent to which there exists a subgroup known

5 In this dissertation, poverty-related concerns are those associated with low income and material deprivation. For example, the adequacy and source of income and housing are measured in the CIS-2008 dataset, and serve as proxy indicators of poverty in the absence of data regarding actual household income. Poverty-related concerns, although measured at the individual family level, are also positioned as macro-level issues insofar as they are affected by Canadian social and economic policy. This is discussed further on page 81.

6 Clinical concerns are conceptualized as those issues experienced by individual children and caregivers, such as mental health problems, addictions, developmental disabilities, etc., which may require some form of therapeutic treatment. Although conceptualized as individually-based problems, they may have origins at a more structural level, for example, the experience of addictions for First Nations people, discussed further on page 49.
to child welfare for reasons of poverty alone. These examinations will increase understanding of the relationship between poverty and child neglect in Canada, as well as how Canadian child welfare services might respond to the often complex needs of families where neglect is a concern.

**Study Rationale & Objectives**

**Study Rationale**

The concern expressed by Charlow (2002, p. 788), that the child welfare system has “rationalized and institutionalized [intrusive intervention with poor families] in the name of neglect to the point where we can no longer see it for what it is,” has provided part of the impetus for this dissertation. This is a troubling statement, and understanding its validity should stem from careful assessment of available data. Although there is general consensus that families investigated for neglect by child welfare authorities are disproportionately poor, as are the majority of children placed in care as a result, Drake (2011) has proposed that the significant policy question is whether bias rather than risk and need is a larger factor driving this disproportionality. Although several writers (see Drake & Zuravin, 1998; Jonson-Reid, Drake, & Khol, 2009; Moraes, Durrant, Brownridge, & Reid, 2006; Pelton, 1994) have found limited support for poverty-related biases in child welfare services, other research has supported this contention (Ards & Harrell, 1993; Hampton & Newberger, 1985; Lindsey, 1991) and there is a persistent concern that there are inherent biases in the selection of those reported to the child welfare system and in how the system responds to poor families, particularly regarding neglect.

The second issue addressed by this dissertation is the criticism that child welfare, despite its status as a primary social work setting, responds in a predominantly “rehabilitative” fashion—one designed to treat or change individuals—to the needs of marginalized and disadvantaged families (Pelton, 2008). Scholars note that services to families in which neglect is a concern typically represent an individualized (clinical) approach to the problem, with referrals to parenting skills, addictions,
and mental health being among the most common services offered to these families (Duva & Metzger, 2010). Although many child welfare workers can and do acknowledge the often profound deprivation of the families with whom they work (Horwath, 2007; O’Brien, 2002), there is a concern that workers may have simply accepted poverty as the context in which they do the “real” work of treating deficient parents (Cameron & Freymond, 2003; Swift, 1995b). Thus, while individual risk factors posed by parents are usually targeted for intervention, the impoverished conditions in which families live may not be. The extent to which these critiques hold true in current practice in a Canadian context is an empirical question that can be assessed using available data.

**Study Objectives**

The objectives of this thesis are:

1. to identify the nature and frequency of clinical and poverty-related concerns in both substantiated and unsubstantiated child neglect investigations;

2. to examine the nature of service referrals for both substantiated and unsubstantiated cases of neglect as a way of assessing whether the child welfare response reflects an individual, structural, or ecological understanding of the problem;

3. to examine the extent to which reporting biases and/or worker biases in decision-making might explain the predominance of poor children reported to and substantiated by child welfare services for reasons of neglect, along with their high rate of placement; and

4. to explore whether there are subtypes of “neglectful” families characterized by different levels of poverty-related and/or clinical difficulties.

Documenting the various needs experienced by these families will provide a basis for more effectively targeting services by delineating the extent of specific poverty-related and clinical needs. Some poverty-related needs (in the absence of other risk factors) may be addressed through the provision of material or financial assistance in lieu of more intrusive interventions. The inclusion of
unsubstantiated cases in the analyses provides information about a group of families that represents an opportunity for workers to broker supportive services to address family needs, which may reduce the risk of re-referral and future maltreatment.

The exploration of whether there are subtypes of families characterized by different levels of economic and clinical needs will further understanding of neglect as a diverse rather than unified phenomenon. Interventions for neglect may thus be more appropriately tailored to the neglect context, including the clinical and material/concrete needs of children and families, rather than to the subtype of neglect itself. Further, this analysis will examine the contention that there may be a subgroup of families known to child welfare authorities for reasons of poverty alone—an important question that has significant implications for policy and practice.

Preliminary analyses of the nature of service referrals for both substantiated and unsubstantiated neglect will allow for an assessment of the extent to which both clinical and poverty-related problems are targeted for support. There is limited research that documents the services provided in cases of neglect. In fact, many studies have highlighted the lack of services provided to families where neglect is a concern (DePanfilis & Zuravin, 2001). Although limited by available data, this analysis will document the initial service referrals made for cases of investigated neglect in Canada and the extent to which these services are characterized by an individual, structural, or ecological understanding of families' needs.

Findings from this study will provide evidence about shared poverty-related concerns among families and children served by the child welfare system that may be used to advocate for social and child welfare policy changes.

**Study Contribution**

The majority of scholarly work exploring the relationship between poverty and child neglect has been conducted by American researchers using United States data. Seminal bodies of work by American scholars such as Leroy Pelton, Duncan Lindsey, and Douglas Besharov have come to
similar conclusions about how the system responds to disadvantaged families and call for large-scale reforms to the American child welfare system. For example, each of the aforementioned has advocated forcefully for changes to the current residual child protection model in the United States so that the focus of the system is on providing support to children and families in need rather than the protection of children who have already been harmed at the hands of their parents (see Besharov & Laumann, 1997; Lindsey, 1994, 1996, 2004; Pelton, 1981). Both Lindsey and Pelton have gone so far as to suggest that child neglect should be separated out from cases of severe physical abuse and sexual abuse, with the latter investigated by the police and dealt with by the courts, leaving child welfare workers free to adopt a “compassionate ear and helpful hand” to the majority of cases of neglect (Lindsey, 2004, p. 190). However, it is unclear whether American findings regarding poverty and child neglect and the proposed system reforms to better meet the needs of disadvantaged families are applicable in the Canadian context due to differences between the two countries. For example, while both countries have an approach to child welfare that is protection-driven and residual (Gilbert et al., 2009) there are potential differences in the incidence of neglect between Canada and the United States and in how neglect may be understood in each country. Further, there are dissimilarities in the policies that impact universally available services to families and the rate and depth of poverty in the countries, making conclusions based on American data not necessarily an appropriate fit to the Canadian context. A brief examination of these issues follows.
Child Protection versus Family Support

Despite the different legislation and service delivery structure between Canada and the United States, both countries have a policy approach to child welfare that has been characterized as residual (Kadushin, 1967; Lessard, 2002; Lindsey, 1996) and focused on child safety (Gilbert et al., 2009). In a residual model, providing for children’s needs is seen as the responsibility of individual families and the private market. State intervention is limited to instances where families have demonstrated an inability to meet minimally acceptable levels of care. In this way, residual models frame the intervention of the State into private family life as negative, with services offered to specific families only when they have failed to meet minimum standards. Kadushin (1988) notes that a residual model “may leave the child without protection until such harm has been done since it is essentially crisis-oriented and reactive, remedial rather than preventive in approach” (p.7). Consequently, once intervention occurs in a residual model, it is protection-oriented and focused on investigating and substantiating allegations of maltreatment and preventing recurrence rather than on addressing the holistic needs of the family (Gilbert et al., 2009). Investigations are conducted by mandated agencies that focus on child maltreatment, making entry into the child welfare system based on notions of harm or substantial risk of harm rather than child and family difficulties. This residual, protection driven approach is in contrast to New Zealand and many European countries, where a family welfare framework is used to respond to child maltreatment concerns, in which a broad array

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7 In Canada, child welfare describes a group of government operated and privately run services designed to protect children from abuse and neglect. These services are legislated and funded through the provincial and territorial governments. As a result, reference to “the Canadian child welfare system” is a misnomer, as each province has a different set of governing laws, funding approaches, and operational structures through which child welfare services are delivered. Similar to the Canadian model, primary responsibility for child welfare service delivery in the United States rests with individual states, each of which has its own legal and administrative structures that address the needs of children and families. States make their own policies about reportable abuse and neglect, timelines for investigation, and how much to pay placement providers for children in out of home care (Pecora, 2009). States and localities also provide approximately half of all child welfare funding, with the United States federal government providing most of the rest. Unlike Canada, the United States also has federal legislation and guidelines that must be followed in order for states to receive federal funding (Child welfare Information Gateway Fact Sheet, 2011). Federal funding is provided under Titles IV-B and IV-E of the Social Security Act and supports both state and tribal efforts related to child welfare, foster care services, and adoptions. Funding is administered by the U.S. Department of Health and Human Services. As a result, states have accountabilities to both the federal and state governments for funds spent and service outcomes. At the state level, despite legislative variations, child welfare services have certain fundamental elements in common. As in Canada, all state child welfare services include the receipt of reports of suspected child abuse and neglect, investigative functions, the provision of protection services for cases in need, foster care, and adoption. In both countries, the extent to which preventative services are part of the core mandate of child welfare services differs across states and provinces.
of child and family needs are assessed and services provided without substantiation determining eligibility for services (Trocmé et al., in press).

Despite similarities in child welfare policy orientation between Canada and the United States, in practice, there is some question about whether the threshold for entry into child welfare in the United States is more stringent, with evidence of harm playing a larger role in the framing of neglect. For example, a comparison of national statistics suggests that approximately 17%\(^8\) of child protection services (CPS) investigated cases of neglect in the United States involve harm to the child whereas an estimated 3.7% of substantiated primary neglect cases investigated by Canadian child welfare services show evidence of physical harm requiring medical treatment (Trocmé et al., in press).

Further, while research in both countries has illustrated that evidence of harm is a primary driver of substantiation (Scannapieco & Connell-Carrick, 2005a; Trocmé, Knoke, Fallon, & MacLaurin, 2009; Winefield & Bradley, 1992), analyses of Canadian data demonstrate that clinical risk factors for investigated caregivers (e.g., alcohol, drugs, and mental health concerns) and reports from police are also among the strongest predictors of substantiation decisions (Trocmé et al., 2009). These estimates may mean that circumstances investigated as neglect by American child welfare services represent more serious situations than in Canada, where investigated neglect may be better characterized in the vast majority of cases as “family difficulties”—families struggling with problems that raise concerns about whether children’s needs are met.

**The Incidence of Neglect in Canada and the United States**

The CIS-2008 estimated the annual incidence of child neglect in Canada at 5.37 per 1,000 children, which includes all substantiated neglect, whether it was the primary, secondary, or tertiary reason for the substantiation of maltreatment. An estimated 1.04 children per 1,000 experience neglect resulting

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\(^8\) The overall percentage of neglect presenting with harm identified by the NIS-4 is 34% (771,700 cases of neglect identified under the Harm Standard, divided by 2,251,600 cases of neglect identified under the Endangerment Standard, which includes all Harm Standard cases plus those where the child’s health or safety are thought to be endangered). However, researchers estimate that only an approximately 20% of cases identified under the Harm Standard and 41% of cases identified under the Endangerment Standard in the NIS-4 are investigated by CPS. Thus the proportion of CPS investigated cases presenting with harm was estimated using the following calculation: (771,700 x .2) divided by (2,251,600 x .41).
in either physical and/or emotional harm requiring medical and/or therapeutic intervention.\(^9\)

The most comparable statistics from NIS-4 indicate that an estimated 7.08 children per 1,000 are investigated by CPS and substantiated for either physical or educational neglect as defined by the Endangerment Standard and that an estimated 1.5 children per 1,000 investigated by CPS are either physically or educationally neglected under the Harm Standard. These data suggest that there may be a higher incidence of child neglect in the United States compared to Canada, although the incidence of more severe neglect—that resulting in harm to the child—may be only slightly higher in the United States. It is important to note that data between the countries are not directly comparable due to both definitional and methodological differences between the CIS and the NIS.

Data collected through the National Child Abuse and Neglect Data System (NCANDS) provide another source of American incidence data that can be used as a rough comparison to Canadian statistics. Unlike the NIS data, NCANDS data include only CPS reported cases, making it more directly comparable to CIS-2008 data. *Child Maltreatment 2009*, the most recent report from the Department of Health and Human Services, indicates that in the United States in 2009, 7.1 children per 1,000 were victims\(^{10}\) of neglect.\(^{11}\) This rate is similar to the estimate derived from the CPS sample of the NIS-4 noted above (7.08 per 1,000). Further, in a recent comparison of the CIS-2008 to NCANDS data from 2004 to 2006, researchers note the dramatically higher incidence of neglect among children under 1 year of age in the United States (14.62 per 1,000) compared to the same age group in Canada (6.23 per 1,000); although less pronounced, the incidence of neglect for children 1–5 years and 6–9 years is also considerably higher in the United States compared to Canada (Fallon et al., in press). This finding suggests that not only is the problem more widespread in the U.S.

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\(^9\) The “harm requiring treatment” classification in the CIS-2008 is most directly comparable to the Harm Standard in the NIS-4, as neglected children included under the harm standard in the NIS are generally those who experienced serious harm, which is defined as involving “a life-threatening condition, a long-term impairment of physical, mental or emotional capacities, or requires professional treatment aimed at preventing such long-term impairment” (Sedlack et al., 2010, section 3, p. 9). Examples include loss of consciousness, stopped breathing, broken bones, diagnosed cases of failure to thrive, third degree burns, etc.

\(^{10}\) “Victims” include children with substantiated or indicated reports, or those considered victims under an alternate response.

\(^{11}\) NCANDS defines “neglect or deprivation of necessities” as “a type of maltreatment that refers to the failure by the caretaker to provide needed, age-appropriate care, although financially able to do so, or offered financial or other means to do so.” (U.S. Department of Health and Human Services, 2000)
compared to Canada, but also that the aggregate impact of neglect may be more profound for both affected children and the American child welfare system in light of research showing that neglect occurring during the first years leads to particularly detrimental developmental outcomes and places children at high risk of out-of-home care (Manly, Cicchetti, & Barnett, 1994; Wulczyn, 2009).

**Social Policy and Poverty in the United States and Canada**

The residual model is often associated with a neo-liberal approach to social policy that stresses the responsibility of the individual and holds families responsible for the welfare of their children. This is in contrast to an institutional approach to social welfare policy, which is premised on the belief that all citizens should be afforded basic economic, health, and social security (Lessard, 2002; Lindsey, 1996) and that State-provided services are a normal way of helping people reach these goals. Countries in which an institutional approach to social policy dominates include northern European nations, where often there are universal systems in place for health and child care, rather than the privatization of these services with subsidies for a select group of families. Canadian social policy reflects a combination of residual and institutional elements with the universal provision of health care but a privatized approach to child care in most provinces. The United States, in contrast, has a social welfare policy orientation that is predominantly residual, evidenced by the lack of universally available health care and with targeted programs to assist only the poorest children and families (i.e., Medicaid) and strict eligibility requirements. Further, critics have argued that even universal programs in the United States (e.g., education) have a residual flavour to them due to the gross inequity in both expenditures and quality between wealthy suburban neighbourhoods and those in the inner city, characterized by high concentrations of poor Black and Hispanic children (Drake & Rank, 2009; Kozol, 1991).

Although comparing poverty rates between countries is difficult due the use of different measures in reporting official statistics, international research has attempted to produce comparable data for the purposes of policy reform. In a recent study conducted by UNICEF (2010), the United
States ranked 23rd out of 24 OECD12 countries with respect to the material well-being of its children. The study assessed countries on three indicators: after-tax household income, access to educational resources, and housing living space. The same study ranked Canada 17th, well behind the top performing nations (Switzerland, Iceland, and the Netherlands). The analysis used income data to compare the income of the child at the 50th percentile (the median) to the child at the 10th percentile (poorer than 90% of other children) to allow researchers to determine how far behind the poorest children are being allowed to fall. Although data on after-tax income were not available for the United States, researchers estimated that gross (before tax) income for children at the 10th percentile was approximately 30% of the income available to children at the median. Canadian data indicate that children at the 10th percentile had an (after-tax) income equal to 56% of the median income.

On measures of adequate living space (assessed using the average number of rooms per person in households with children, not including kitchens and bathrooms), the United States and Canada both performed poorly: in Canada children whose households were below the median averaged living space that was 27% below the median; in the United States this statistic was 29%.

Child poverty rates between the countries are another source of comparison. Recent estimates place the rate of child poverty in Canada at approximately 15% compared to 22% in the U.S (OECD, 2011).13 Coupled with the findings noted above, these data suggest that both the rate and depth of material deprivation in the U.S significantly exceeds the rate in Canada. Given the strong association between poverty and child neglect, these differences might be expected to contribute to both differences in the rate of neglect between the two countries and the nature and depth of poverty-related needs experienced by poor families referred for neglect to child welfare services.14

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12 OECD: Organisation for Economic Cooperation and Development, whose mission is to "promote policies that will improve the economic and social wellbeing of people around the world" (see http://www.oecd.org/pages/0,3417,en_36734052_36734103_1_1_1_1_1,00.html).
13 Measured using the OECD measure of poverty: the share of all children living in households with an equivalised disposable income of less than 50% of the median for the total population.
14 The extent to which rates of child maltreatment differ between countries is difficult to ascertain due to a lack of comparable data. Further, in instances where data are available, the degree to which differences can be attributed to social policy has not been well-researched. Those studies that have attempted to address these questions have been inconclusive (see for example Gilbert et al., 2011).
The Need for Canadian Research

A major contribution of the current research is its use of recent Canadian data to explore the relationship between poverty, child neglect, and the response of child welfare systems in this country. Exploring the relationship between neglect, poverty, and child welfare response will assist not only in furthering understanding of these issues in Canada, but will also help in determining the applicability of American studies and their findings to the Canadian context.

Organization of the Dissertation

This dissertation is organized under eight chapters. Chapter 1 has introduced the topic and provides the rationale, focus and objectives for the study, including the need for research that takes into account the Canadian context. Chapter 2 explores the history of child neglect as a recognized social and legal phenomenon in Canada and reviews competing approaches for defining neglect for the purposes of research, practice, and policy. Chapter 3 provides a comprehensive analysis of theoretical frameworks used to understand the etiology of child neglect and its relationship to poverty. It also presents three different paradigms for understanding poverty and its root causes and concludes with the presentation of a framework that forms the theoretical basis for the dissertation. Chapter 4 presents a review of the empirical literature examining the ecological correlates of neglect and previous studies that assessed class-based biases in child welfare decision-making. Chapter 5 describes the methods of study. Chapters 6 and 7 provide the results of the descriptive analyses and the multivariate analyses, respectively. In Chapter 8, the implications of these findings for practice, research, and policy are discussed. This chapter also summarizes and concludes the dissertation.
Chapter 2: Discovering and Defining Child Neglect

What is known as child neglect in Canada and other nations has evolved and changed over many decades. Swift (1995) has noted that neglect, both historically and currently, is first and foremost a legal concept; it emerged through the development of a succession of legal principles and specific legislation relating to the family and to the welfare of children within families. However, like all other forms of child maltreatment, it is also a social construct (Gelles, 1975), shaped by shifting ideologies about childhood, children's developmental needs, and socially recognized definitions of adequate and inadequate parenting. Although legislation may have legalized the concept of the neglected child, it was the recognition of neglect as a social problem, championed by a group of middle class reformers, which provided the impetus for this legislation.

The first section of Chapter 2 explores how child neglect came to be recognized as both a social and legal phenomenon in Canada. This section will chronicle the evolution of significant Canadian legislation pertaining to the welfare of children from 1799 to the present, along with evolving social beliefs and attitudes about children, families, and parenting. As the focus of this dissertation is on the relationship between poverty and child neglect, particular attention is paid to way in which the construct of child neglect grew out of a middle class reaction to the struggles of the poor, and the extent to which vestiges of these origins are found in present day definitions and practice.

The second section of the chapter will review two competing current day approaches to defining and understanding child neglect: parental omissions in care versus children's unmet needs. These two conceptualizations stem from different theoretical bases (which will be discussed in more detail in Chapter 3), and have distinct implications for policy and practice in terms of the emphasis placed on the role of poverty and other structural inequalities when intervening in families where neglect is a concern.

Finally, attempts to define neglect have been stymied, not only due to debate around which of the two definitional approaches noted above is most appropriate, but also due to a range of factors...
that may be taken into account, such as minimally acceptable levels of care, culture, poverty, and intent, as well as the heterogeneity within what has often been presented as a binary (present or absent) or unified construct. The final section of the chapter will explore some of these factors. The purpose of this section is not to land on a preferred definition of neglect but to highlight the range of salient factors that impinge on attempts to do so. The chapter concludes with a discussion of the implications of both historical and current day definitions for policy and practice.

**The Discovery of Child Neglect in Canada**

The neglect of children has been present for thousands of years. Throughout history, some children have been abandoned, unsupervised, under-clothed, underfed, raised in inadequate housing, and lived in other circumstances where their basic needs were not met (De Mause, 1975). However, referring to these phenomena as *child neglect* and making them acts worthy of State intervention into the family is a relatively new idea.

In 1893, Ontario became Canada’s first province to introduce comprehensive child protection legislation, the *Children’s Protection Act*, which focused on providing services to neglected children. Recognition of neglect as a social and legal phenomenon in need of public intervention evolved over the previous century, culminating in the introduction of this legislation. Ontario’s Act consolidated previous legislation and initiatives related to disadvantaged children and provided the legal mechanisms for identifying and intervening with these children and their families. Developments in Ontario,\(^\text{15}\) strongly influenced by similar reforms in Great Britain and the United States (Bala, Zapt, Williams, Vogl, & Hornick, 2004), led the way for how much of the rest of the Canada thought about and responded to child neglect. In particular, Canada’s leading advocate for child welfare work and legislation, J.J. Kelso, lived and worked in Ontario, and was both directly and indirectly involved in the enactment of child welfare legislation in many other provinces. Although this chapter will focus on the pathway taken by the Province of Ontario, examples will be drawn from

\(^{15}\) Known as Upper Canada from 1791-1840.
other provinces to highlight both similarities and differences across Canada in the emerging social and legal construction of child neglect.

**Paupers, Orphans, and Apprentices**

Upper Canada was first recognized as a British colony in the late 1700s and as such, English legal institutions and common law informed the foundation of its legal structure, with adaptations based on the experiences of the neighbouring United States (Neff, 2008). Patriarchal authority within the family was an accepted part of English common law at this time, with fathers considered to be heads of their households and having the authority to manage their children and wives as they saw fit (Mcintyre, 1993). Although the British Poor Laws, first introduced in 1601 in England, made provisions for “deserving” poor children and adults, the introduction of English civil law in Upper Canada “specifically forbad inclusion” of these laws16 (Rooke & Schnell, 1983, p. 35). Historians have vigorously debated why these provisions were excluded, with many scholars contending that the puritan work ethic of pioneer Canada was that the poor should fend for themselves and public assistance would only make them “dependent, lazy, and immoral” (Iozzo, 2000). This attitude towards charity is exemplified in an excerpt from *The Globe*, dated February 27, 1874:

> In a new country we ought to find the problem [poverty] comparatively easy. Promiscuous alms-giving is fatal—-it is the patent process for the manufacturing of paupers out of the worthless and improvident. A poor law is the legislative machine for the manufacture of pauperism. (cited in Jones & Rutman, 1981, p. 16)

Iozzo (2000) notes that even extending charity to poor children was viewed as undesirable, as a population relying on handouts from the State would lead to children growing up expecting charity as adults instead of finding gainful employment.

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16 They were, however, included in the laws of New Brunswick and Nova Scotia (Rooke & Schnell, 1983).
Instead, assistance was given to those in need in piecemeal fashion and in Canada’s early settlement history, the response to children in need (defined as those who were orphaned or abandoned) was placement in a workhouse or almshouse, where they were often “treated as chattels and subjected to much abuse” (Mcintyre, 1993, p. 23). There were no separate institutions for children and they were housed alongside adults, including “the indigent, the able bodied ‘potent’ poor, the able-bodied unemployed, the ‘impotent’ poor, the lewd, the dissolute, the lunatic, and the vagrant” (Rooke & Schnell, 1983, p. 36). In Newfoundland, where no such institutions existed, pauper children over the age of eight were auctioned off to provide domestic and agricultural labour (Rooke & Schnell, 1982), in keeping with the belief that poor children should grow up knowing hard work and be skilled in a trade to make them productive citizens.

The first law in Canada directed specifically at the welfare of children was Upper Canada (which later became Ontario)’s Orphan’s Act, passed in 1799 (King, Leschied, Whitehead, Chiodo, & Hurley, 2003). The Act introduced the pauper apprenticeship program, which made provisions for orphaned children or those who were fatherless, despite the limited administrative structures in place to provide this aid (Neff, 2008). This law allowed town wardens to apprentice children whose parents had died or abandoned them, although there was minimal monitoring of these placements and no requirements in the Act for proper care of the child-apprentice (Splane, 1965). Children who could not be apprenticed for various reasons continued to be sent to almshouses, poorhouses, or to penitentiaries or asylums along with adults (Peikoff & Brickey, 1991).

The Orphan’s Act is notable as it represents the emerging sense of public responsibility for disadvantaged children in Canada (Splane, 1965), although the requirement of children to be orphaned—or, at minimum, without a father—maintained the prevailing social status of fathers as the ultimate authority in families. Consequently, during the early 1800s, “poverty, denial of basic amenities of life (apart from a home), a poor home environment, or ill-treatment” did not yet justify state intervention into the family home for children living with their parents (Neff, 2008, p. 179).
By the mid-1800s, in addition to apprenticeships, homeless and needy children “whose families had fallen on hard times” (Bullen, 1991, p. 138) were also cared for in orphanages and children’s homes founded by private philanthropists and churches and funded by local charitable endowments (King et al., 2003). According to Splane (1965), children’s homes were initially established to house children waiting for an apprentice contract; however, it soon became apparent that a long-term system of care was needed. These homes were not regulated or inspected until 1857 and only some received financial assistance from government. Similar initiatives were taking place in parts of Canada as well. For example, in Nova Scotia, while workhouses were the most common solution for parentless or abandoned children, concerned citizens campaigned for better conditions, resulting in the establishment of a series of orphanages and children’s homes mostly operated by the church (Mcintyre, 1993). In Quebec (Lower Canada), orphanages, set up and run through the Catholic Church were the predominant approach to child welfare in the province for several decades.

**The Discovery of Childhood and Children’s Needs**

At the turn of the twentieth century, Canada entered into a period of significant growth and change. For example, in Ontario, the population rose from approximately 10,000 in the late 1700s to over two million, with rapidly expanding urban centres (Bullen, 1986). In the cities, urbanization, industrialization, and mass immigration of peasants from Britain and continental Europe created the existence of an impoverished underclass of citizens, living in poor, overcrowded housing and struggling to meet the basic needs of their families (Swift, 1995a). The parallel emergence of what became known as the middle class, comprised mostly of urban families headed by men engaged in medicine, law, or business marked the beginning of a separation of Canadians into different social strata (Holman, 2000).

Many rural families were also struggling to adapt to the changes in late nineteenth century living. Instead of labouring on farms alongside their families as had been the norm in the 1700s (Bullen, 1986), children born into farming families in the late 1800s were frequently sent to work in
factories in the city and many ended up living on the streets. Additionally during this period, a large number of orphaned, abandoned, or delinquent children were transported to Canada from Britain and France, ostensibly to provide a better life for them. However, these children were often used as indentured servants in the homes in which they were placed (West, 1984). Many of these children left their placements and drifted to urban centres, increasing the presence of unsupervised children in the cities. Some of these children became involved in petty crime and were seen as a threat to the social order.

By the mid-1800s, concern about the growing ranks of these “street urchins” (Bullen, 1991, p. 140) was prevalent. In addition to concern for street children, a new group of children was becoming the focus of public attention: those who had parents and a home but were thought to be victims of inadequate parental care and mistreatment. The children of these families became the focus of a group of middle class reformers—known as the child savers—who sought to establish agencies, services, and legislation designed specifically for needy children. As Peikoff and Brickey (1991) note, the period from the mid-nineteenth to the early twentieth century marked a time when social reformers “devoted more energy to children than at any other period in history” (p. 29).

Central to this emerging concern was the shifting notion of childhood taking place in Canada and the rest of the Western world. Although there is much scholarly debate about the history of childhood, many writers assert that before the 16th century, children in Western cultures were considered miniature adults and “youth were rarely the subject of public concern” (Tanner, 1996, p. 19). According to Ariès (1962), in medieval times, the concept of childhood as a unique stage with distinct developmental needs did not exist. With the Protestant Reformation in the 16th century, children were cast as “filthy bundles of original sin” and in need of strong corrective action, often including physical punishment (Heywood, 2001, p. 22). By the 17th century, this attitude had softened slightly, with educators arguing that children were worthy of attention and in need of instruction (Heywood, 2001). In 1693, John Locke’s influential work entitled Some Thoughts Concerning Education was published, putting forward the idea that children were born a blank
slate (*tabula rasa*), and their outcome would be determined by how they were treated: treated well, they would flourish; treated poorly, they would fall from grace (Heywood, 2001). By the eighteenth century, the philosopher Jean Jacques Rousseau declared that children were naturally good but could be corrupted by negative outside influences (Duschinsky, in press). He contended they required minimal interference in order to develop in a positive way.

It was not until the late nineteenth century that a sense of children as vulnerable people requiring protection and with distinct needs for care began to develop in Canada (Peikoff & Brickey, 1991). This new concern for children’s welfare was linked to Canada’s focus on nation building, which brought with it an emerging belief that children represented the future of the young dominion, and their healthy growth and development became inextricably linked to the welfare of Canadian society. Nation building included the desire of middle class citizens to shape the future generation and prevent it from falling victim to the vices associated with poverty and life on the street, such as alcohol and prostitution (Iozzo, 2000). In part, these concerns led to the introduction of several legislative initiatives aimed at ensuring that children received adequate protection and care. Children’s educational needs were considered through compulsory education legislation and laws were developed in the latter half of the century to restrict child labour and set standards for the employment of children to protect them from exploitation.

**Compulsory Education and Industrial Schools**

Compulsory education was first implemented in Canada in the Province of Ontario and was presented in several draft bills beginning in 1854, but did not pass until 1871 due to the reluctance on the part of government to interfere with parental rights (Neff, 2008). By 1905, all provinces except Quebec had passed laws requiring children of a certain age to attend school for a minimum period of time. Once passed in Ontario, education became a right for all children aged seven to 12, and parents could be penalized for not sending their children to school. The legislation made it mandatory for all children to attend school for at least four months of the year.
The impact of the legislation was felt primarily by poor, working class families, as the priority of education for children of the middle and upper classes was already well-established, with many of these children receiving instruction in their own homes through private tutors. Several scholars have attributed a complex set of motives to the social reform movement that advocated for compulsory education. In particular, compulsory education has been cast as a way of not only providing for children's development, but as a means of social control by subjecting children of the poor to instruction in middle class values and work ethic and Christian morality (Peikoff & Brickey, 1991). As Neff (1994) notes, compulsory public education was positioned as the primary mechanism for saving neglected children “from a life of poverty and crime” (p. 171).

Contained in education legislation was the authorization for public school boards to establish industrial schools for any child who could not be managed by the regular school system. Industrial schools, already prevalent in Great Britain and the United States and previously established in Halifax in 1864, were public institutions funded by government where delinquent or neglected children could be sent to save them from adult poor houses or penitentiaries and to teach them the benefit of a trade (Iozzo, 2000). The combined mandate of these institutions to serve both children thought delinquent and those who were neglected—generally referring to children living on the street who were not found guilty of petty crime—resulted in children with a history of criminal activity being served alongside those children “whose only crime” was their destitute status (Iozzo, 2000). This lumping together of delinquent and neglected children was not surprising; as Powelson (2001) notes, the common ideology of the day held that neglected children were either criminals or criminals in the making in the making and many child savers and members of the general public did not distinguish between the phenomena of juvenile delinquency and neglect.

In 1874, the Industrial Schools Act was passed in Ontario, which outlined in detail how this system worked. Under the following specific circumstances, a child under the age of 14 could be admitted and kept until age 16:
1) Who is found begging or receiving alms, or being in any street or public place for the purpose of begging or receiving alms;

2) Who is found wandering, and not having any home or settled place of abode or proper guardianship, or not having any lawful occupations of business, or visible means of subsistence;

3) Who is found destitute, either being an orphan or having a surviving parent who is undergoing penal servitude or imprisonment;

4) Whose parent, step-parent, or guardian represents to the police magistrate that he is unable to control the child and that he desires the child to be sent to an industrial school under this Act;

5) Who, by reasons of the neglect, drunkenness, or vices of parents, is suffered to be growing up without salutary parental control and education, or in circumstances exposing him to lead an idle and dissolute life (Statutes of the Province of Ontario, 1874, ch.29, s.4).

These criteria represent the first legal definition of the *neglected child* in Canada. Both the *Industrial Schools Act* and compulsory education legislation are notable as they mark the first authorization of the State’s intrusion into the family in the interests of protecting the welfare of children. The definition of a neglected child outlined by the *Industrial Schools Act* cemented the notion that poverty, homelessness, and/or parental deficiencies were justification for the intrusion of the State into family life on behalf of children and entrenched in legislation the socially held belief that the work ethic and moral development of neglected children, considered to be at risk through exposure to parental vice, were matters of primary concern. As Swift (2003) notes, although modern historians generally understand the destitution and vices of these parents as consequences of the harsh realities of nineteenth century living, common ideology of the day framed these issues as personal failings.
Aboriginal Communities and Residential Schools

Any examination of the history of child welfare in Canada is not complete without acknowledgement of the experience of First Nations communities with industrial and residential schools. Although the ability to fully describe this history and its legacy is outside the scope of this chapter and has been discussed in detail elsewhere by Aboriginal scholars (see for example Bennett, Blackstock, & De la Ronde, 2005; Blackstock, 2003; Ing, 2000), Canada’s approach to nation building, which involved teaching the religion, morals, and values of middle class, white Anglo-Saxons to the “dangerous” or “inferior” classes had a particularly profound impact on First Nations communities.

Tait (2003, p. 58) writes that in 1844, after a two-year review of the conditions of Aboriginal people on reserve, a report by the Bagot Commission concluded that “indigenous communities were ‘in a half-civilized state.’” The position of the Commission was that progress would only ensue if Aboriginal people were “civilized” and taught the (superior) social and political customs of their white neighbours (Milloy, 1999). Although originally both First Nations children and adults were the focus of assimilation strategies, government officials soon felt that little could be accomplished with adults. To be most effective, it was decided that children should be the focus of assimilation strategies as they were seen as more malleable. Over a period of several decades, attempts were made to provide assimilative schooling to Aboriginal children, most of which were considered failures as young people would return to their communities upon graduation and “backslide” into their old customs through proximity to family and to elders (Tait, 2003, p. 59).

With the passing of the Indian Act (1878), all Aboriginal people in Canada became wards of the federal government, sharing the same status as children or the “mentally incompetent” (Mercredi, 2008). In the same year, Nicholas Flood Davin, a parliamentary backbencher, was sent by Sir John A. MacDonald to assess the American Indian boarding school system in the United States. His subsequent report to Parliament in 1879 (the “Davin Report”) praised the American system as a way of preventing First Nations children from becoming an “undesirable and often dangerous element in society” (Fournier & Crey, 1997, 55–56, as cited in Tait, 2003) and secured subsequent
government funding for the residential school system in Canada. Unlike the non-Aboriginal children sent to industrial schools who were often homeless, parentless, and/or involved in petty crime, First Nations children were forcibly removed from their homes and their parents threatened with fines or imprisonment if they did not send their children willingly (Blackstock, 2005). Although attendance at the schools was initially “voluntary,” by 1920 changes to the Indian Act made it compulsory for all children between the ages of seven and 15 to attend the schools.

One unifying factor across the experience of Aboriginal and non-Aboriginal children who entered residential or industrial schools was the moral judgment made about their parents and the notion that these children were being saved from unhealthy environments. As noted by the criteria of the neglected child in the Industrial Schools Act, the moral failings and vices of parents were grounds for sending a child to an Industrial school. In a similar vein, Milloy (1999) notes that government-appointed Indian agents often made their decision about which children would be sent to a residential school based on their perception of the home environment. As Tait (2003, p. 62) writes, “truancy, alcoholism, and violence were common factors invoked…to declare parents unfit,” resulting in the removal of the child.

Multiple reports and accounts from survivors of the residential school system have noted the deplorable conditions in the schools, including over-crowding, poor ventilation, inadequate heat, water, and nutrition, physical, sexual, and emotional abuse of the students and an approach to Indigenous young people designed to “kill the Indian in the child” (Bennett & Blackstock, 2002; Ing, 2000). Children were forbidden from speaking their language or practicing their cultural traditions and if caught doing so, were punished severely. Kelm (1996) has noted the paradox that these schools, set up to save First Nations children from their unhealthy home environments resulted in widespread disease, illness, and even death of thousands of Aboriginal young people. At the system’s peak in 1931, there were approximately 80 residential schools across Canada. It is estimated that 150,000 children attended residential school and approximately 50,000 never returned home (Mercredi, 2008). Legacies of the residential school system are felt to the present day and include
continued cultural erosion and loss of language, community, and spirituality for many generations of Aboriginal people (Bennett et al., 2005).

**The Influence of J. J. Kelso and the Development of Children’s Aid Societies**

By the late 1800s, advocates began to question the appropriateness of long term placement in orphanages for parentless or abandoned children (Neff, 2009). Rooke and Schnell (as cited in Bullen, 1991) argue that there was a growing emphasis on keeping children and families together whenever possible; in cases where the family was deemed unwholesome or inadequate, foster homes where the children could be treated as a member of another family were the placement of choice, as they were seen as conducive to the development of proper social and moral values (McCullagh, Aitken, & Bellamy, 2002). The replacement of institutional settings with foster homes for abandoned or neglected children was the particular cause of the young journalist, John Joseph (J.J.) Kelso. How Canadians thought about and responded—both informally and through legal means—to child neglect in the late nineteenth and early twentieth centuries was greatly influenced by this central figure to the child-saving movement.

In 1887, Kelso wrote a series of newspaper articles about his experience of finding two young children begging on the streets of Toronto and his subsequent struggle to find accommodations for them for the night. Shortly thereafter, he assisted in the creation of the Toronto Humane Society, established for the protection of women, children, and animals. This society was modeled on the New York Society for the Prevention of Cruelty to Children, established in 1874, and the American Humane Association, founded in 1877. He served as secretary to the society and in this position, he created several other initiatives to assist Toronto’s poor and/or neglected children, such as programs that provided excursions for youth living in urban settings (the Fresh Air Fund) and the Santa Claus Fund—initiatives that both remain in place to the present day.

In 1888, Kelso collaborated in drafting Ontario’s *Act for the Protection and Reformation of Neglected Children*, a piece of legislation that provided legal authority to make dependent children
(those placed in orphanages and other institutions) permanent wards of the Province until age 18 and outlined a separate process for prosecuting children than the one used for adults (King et al., 2003). The Act was premised on the concept of *parens patriae*, the notion that the State has a responsibility to intervene on the behalf of a child whose welfare is jeopardized.  

At this time, it also became clear to Kelso that combining the focus of both children and animals in the mandate of the Toronto Humane Society was not adequate to deal with the growing ranks of neglected children, particularly those living with their families (McCullagh et al., 2002). To address the needs of these children specifically, Kelso advocated for and founded the country’s first children’s aid society (CAS) in Toronto in 1891. The introduction of the *Children’s Protection Act* in 1893 provided the legal mandate for the Toronto CAS and was the first explicit child welfare legislation in the country. The Ontario Act was modeled after the *Child Protection Act* of New York State, which was preceded by earlier legislation created in Australia and Britain (Dornstauder & Macknak, n.d.). It further provided legislative authority for the establishment of foster homes to replace institutionalized settings for the majority of neglected children (those not considered delinquent), and gave powers to the CAS to removed neglected children from their home. Parents convicted of neglect could be fined or imprisoned. The significance of the Act was that it dealt explicitly with the rights and protection of non-delinquent children.

Ontario’s legislation called for the establishment of other children’s aid societies across the province. The Act also created the position of Superintendent of Neglected and Dependent Children, to which Kelso was appointed, due to his lengthy and passionate involvement in the plight of Toronto’s neediest children (McCullagh et al., 2002). The Act defined a *neglected child*, carrying forward many of the criteria found in the *Industrial Schools Act*, gave the State the right to intervene when children were mistreated and stressed placement with foster families as opposed to institutional care when children were homeless or could not be safely cared for in their own homes.

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17 *Parens patriae* underscores the principles that form the backbone of Canadian child protection legislation: *best interest* and *need of protection* (Mcintyre, 1993).
Although the 1893 Act went through several amendments over the subsequent years, it remained the legal basis for child welfare work in the province for the next 60 years (McCullagh, Aitken & Bellamy, 2002).

As a vocal champion of child welfare and the first government employee working in the field, the views of J.J. Kelso greatly influenced the discourse around neglect and the evolution of the child welfare system, both in Ontario and in other provinces. Writing in 1911, Kelso noted that:

…”the children who are a blot and a menace to our civilization are those whose parents are selfish, vicious, lazy, drunken, and self-indulgent good-for-nothings, who are glad to have their young ones on the street or anywhere else so that they may not be troubled with their noise or be burdened by their support. Reformatory training and industrial schools are, in short, quite as much needed for parents as for children. (Kelso, 1911, p. 48)

This focus on the individual deficits of parents resulted in child welfare interventions targeting change in parents’ morals and behaviours rather than the deprived circumstances in which they lived. Case records from the Toronto CAS and the Vancouver CAS indicate that the style and direction of much early child welfare intervention with neglectful families included a strong leaning towards the British moral traditions of individual responsibility, the primacy of the nuclear family, and the appearance of proper morality (Swift & Callahan, 2006; Walmsley & Callahan, 2006). Intervention, carried out initially through “friendly visits” from mostly middle class female volunteers, often focused on raising the morals of mothers, who were viewed as primarily responsible for the care of children and as a result, culpable for instances of child neglect. As Chen (2005) notes, it was not until the 1920s that the emergence of the social sciences as a recognized discipline, the professionalization of social work, and the institution of provincial funding gradually shifted child protection away from this style of practice. However, several scholars argue that there are still strong elements of this approach in child welfare practice today (Swift, 1995b).
Although protecting children from neglect was the stated purpose of the *Children’s Act*, the concern of the child savers was not only for the difficult conditions endured by the street urchins and children of the poor, but also for the safety of their own children, accumulating property, and preservation of social stability (Herrick & Stuart, 2005; Swift & Callahan, 2006). Neff (2008) notes that one of Kelso’s explicit concerns was reducing crime in urban centres and thus, focusing on the children of the poor served dual humanitarian and self-preservation goals as poor and/or neglected children were considered at high risk for criminal behaviour. This concern is exemplified in the early motto of the Toronto CAS: “It is wiser and less expensive to save children than to punish criminals” (Kelso papers, 1890s, as cited in Swift & Callahan, 2006, p. 119). This ideology was not unique to Ontario and was expressed in the official records of many other child saving initiatives and institutions across the country. For example, the first annual report of the Halifax Industrial and Ragged School noted that “in all large cities there are a number of boys and girls growing up under influences that mould and shape them for evil and not for good….these form the dangerous class in every community.” (as cited in Rooke & Schnell, 1982, p. 91).

Other provinces soon followed Ontario’s example with the enactment of specific child welfare legislation focused on protecting neglected children and the establishment of children’s aid societies. In several provinces (British Columbia, Manitoba, Prince Edward Island, and Nova Scotia) this was done under the direct guidance of Kelso (Mcintyre, 1993). In British Columbia, child welfare work began in earnest in 1892 with the foundation of the Alexandra Orphanage in Vancouver by group of community women concerned about orphaned and “friendless” children (Walmsley & Callahan, 2006, p. 11). In March 1901, noting that these voluntary efforts could not be sustained without government support and regulation, the Local Council of Women of Vancouver petitioned the provincial Legislative Assembly to pass child welfare legislation. The *Children’s Protection Act* (1901) was passed soon after, and the Vancouver Children’s Aid Society was incorporated the same year. Calgary established Alberta’s first CAS in 1909 under the province’s new *Child Protection Act*, with the help of Kelso and Alberta’s Superintendent of Neglected Children. Saskatchewan’s *Child*
Protection Act, enacted in 1908, was modeled after Ontario child protection legislation (Dornstauder & Macknak, n.d., p. 4).

The last province to establish specific child protection legislation was Quebec in 1977; prior to this, children requiring protection had been provided for through the Catholic Church (Swift, 2005). The primary influence for the Quebec social service system, unlike the rest of Canada, came from France, where government did not assume responsibility for families in need; rather, citizens with means made large donations to the Catholic Church, which was responsible for a range of activities that provided care and relief to families needing services. It was not until 1921, with the passage of the Quebec Public Charities Act, that the government gave direct financial assistance to private religious institutions, laying the foundation for government involvement in social welfare (Mcintyre, 1993, p. 26).

**Neglect in the Twentieth and Twenty-First Centuries**

Throughout the first half of the twentieth century, child welfare services continued to expand in Canada. During this period there was a gradual shift in the workforce of child welfare as social work created schools and training programs. Workers were no longer friendly visitors, but part of the fledgling profession of social work, which was trying to establish “an internal professional confidence and coherence” (Parton, 1999, p. 113).

Although amendments were made from time to time, Ontario's 1893 Act remained in place until the mid-1950s when the Children's Protection Act, the Children of Unmarried Parents Act and the Adoption Act were consolidated to form the Child Welfare Act of Ontario in 1954 (Manson, 1967). In the 1954 Act, neglect remained the focus of child welfare intervention, with neglected children defined as those who were orphaned, deserted, found in unfit living conditions or company, begging, truant, delinquent, in receipt of inadequate affection from their caregiver, or in the care of someone whose conduct may endanger the child’s “life health or morals.” However, in 1965 the Child Welfare Act changed its terminology and referred to children in need of protection as opposed to neglected children.
The Neglect of Neglect

This change in terminology in Ontario’s legislation mirrors a sudden and significant shift in focus within the broader field of child welfare. With the “discovery” of the battered child syndrome in the 1960s by Kempe and his colleagues, the issue of severe abuse became the focus of child welfare attention and child neglect, the original reason for the development of child protection legislation, “moved to the far background” (Swift, 2003, p. 2). Throughout the 1960s, 1970s, and early 1980s, concerns regarding physical abuse and later, sexual abuse, dominated interest in the field (Bala, 2004). The common phraseology for discussion of these phenomena became child abuse, with neglect treated as a subset of abuse. In Ontario, with the introduction of the Child and Family Services Act (CFSA) in 1984, explicit reference to neglect disappeared from the legislation. The definition of child in need of protection in this Act also included a child who has suffered or is at risk of suffering sexual harm or emotional harm. Neglect was alluded to insofar as several of the conditions involve the failure of the caregiver to provide treatment, either medical or psychological, or lack of supervision of a child who has committed a serious criminal offence.

Several researchers have written about the “neglect of neglect,” a term coined by Wolock and Horowitz in their 1984 paper about the emergence of child neglect as a recognized social problem. Since then, hypotheses for the neglect of neglect have been elaborated by many scholars. For example, Garbarino has suggested the possibility that researching and treating abuse is simply more attractive, as visible scars from abuse are more attention-grabbing than the often invisible ones left by neglect (Garbarino & Collins, 1999). McSherry (2007; 2011) expands on this, suggesting that it is the underestimation of the negative impact of neglect compared to the more “emotionally charged problems of child abuse” (2007, p. 611) that explains the neglect of neglect. Finally, many writers have suggested that due to its close association with social and economic deprivation, neglect requires the political interest and will to address the issue of poverty (Garbarino & Hershberger, 1981; Hearn, 2011; Wolock & Horowitz, 1984) and that currently, poverty is “déclassé” except insofar as it points to the moral inferiority of poor people (Garbarino & Collins, 1999, p. 2).
The Rediscovery of Neglect

Although researchers often continue to reference the neglect of neglect to the present day, significant scholarly efforts to understand this phenomenon began in earnest in the last quarter of the twentieth century and continue to date. In part, the resurgence of interest in neglect can be attributed to mounting evidence of the negative outcomes for affected children even when compared to children who had been physically abused. The Minnesota Longitudinal Study of Parents and Children (discussed in more detail in Chapter 4), which began in 1975, provided some of the first longitudinal data about neglected children as separate from abused children and shed light on the distinct developmental outcomes associated with different patterns of maltreatment. In particular, the study was among the first to document the extremely high rate of insecure attachment (both anxious-resistant and anxious-avoidant) among children who had been physically or emotionally neglected (see for example Egeland & Sroufe, 1981a; Egeland & Sroufe, 1981b; Egeland, Sroufe, & Erickson, 1983; Erickson & Egeland, 1996) both compared to otherwise maltreated (i.e., physically abused) and to non-maltreated children in the sample. Researchers including Byron Egeland, Alan Sroufe, and Martha Erickson and their many colleagues have written extensively about the findings of the study and, as the study is a prospective, longitudinal design spanning over 30 years, have been able to examine the pathways between the nature of mother-infant interactions, subsequent attachment style, and later child, adolescent, and adult functioning (see for example, Egeland, 2009; Sroufe, 2005). A review of these findings is presented in Chapter 4.

Other researchers’ contributions during the last part of the twentieth century have added to the growing body of knowledge concerning the theory, etiology, and sequelae of neglect. Norman Polansky and his co-researchers conducted in-depth studies of neglectful mothers and their children in both southern Appalachia (beginning in 1964) and later replicated their research in Philadelphia (commencing six years after the conclusion of the Appalachian study). Although their work focused on the intra-psychic problems of poor, white mothers, first in a rural and then in an urban setting, Polansky et al. specifically acknowledged the important work of James Garbarino and his colleagues
An Exploration of the Relationship Between Poverty and Child Neglect in Canadian Child Welfare 38

(discussed in detail in Chapters 3 and 4) also occurring at the same time, focusing on community impoverishment and high risk neighbourhoods as important contributors in the etiology of neglect. Leroy Pelton’s work, also beginning in the 1970s, examined in-depth the “myth of classlessness” and positioned neglect firmly as a structural issue stemming from poverty and its attendant stressors. The later work of Howard Dubowitz and his co-researchers was greatly influenced by these earlier studies. Dubowitz and others writing during the last 25 years have added significantly to both the theoretical and empirical knowledge base about neglect. Most notably, Dubowitz, along with colleagues Maureen Black, Raymond Starr, and Susan Zuravin (1993), proposed an alternative to the focus on parent-blaming so prevalent in the study of neglect, stating that a child-centred lens based on children’s needs rather than parental omissions is the most appropriate one for tackling this problem. Expanding on this, these writers have advocated for an understanding of neglect that is framed by a continuum, ranging from children's needs being fully met to not being met at all (discussed later in this chapter).

Despite this rediscovery of neglect and its serious consequences for children, some researchers continue to call for more attention to this maltreatment typology. Buckley (2005), summarizing current research conducted in the United Kingdom, Ireland, the United States, and Australia concludes that the majority of referrals for neglect are “filtered out, often without a service, at an early stage” (p. 116). Wilson and Horner (2005) state that the amount of attention neglect receives by child welfare agencies, as measured by hours of specialized training and numbers of specialized units, is “in inverse relation to frequency… sexual abuse receives the most specialized attention, followed by physical abuse, and then neglect” (p. 471). Scholarly interest in neglect, as measured by the number of studies in academic journals continues, to trail that of abuse (McSherry, 2007) and research into effective interventions with this population still lags behind that of both physical and sexual abuse (DePanfilis & Dubowitz, 2005).
Defining Child Neglect in Canada and Other Jurisdictions

Child Neglect and Child Protection Legislation in the Present Day

From the 1960s until recently, Swift (2003) notes that child abuse was the “framing concept for all [child protection] legislation in Canada;” however, due to some of the developments noted above, neglect has made a comeback in terms of public and professional consciousness in recent years, leading to explicit references to neglect once again in policy and legislation. For example, in 2000, following a review of the Child and Family Services Act by a panel of experts, amendments were made to Ontario’s legislation that broadened the definition of a child in need of protection to include a pattern of neglect as grounds for intervention, along with emotional abuse (Bala, 2004). In part, impetus for these changes has been attributed to a series of high profile inquests in the province into the deaths of children in the mid and late 1990s in which neglect was found to play a significant role. Similar reforms had been made to British Columbia’s legislation in the mid-1990s in response to an in-depth inquiry by Justice Gove into the death of Matthew Vaudreuil, (MacDonald, 1995). Today, neglect is explicitly mentioned in the statutes of 11 provinces and territories in their definition of child in need of protection, and included implicitly in the statutes of the remaining two jurisdictions, insofar as these criteria refer to specific instances of omissions in care.

Table 1 outlines the nature of the definition of neglect found in the provincial and territorial statutes and legislation across the country.

Table 1
Provincial and Territorial Child Welfare Legislation

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<tr>
<th>Province/Territory</th>
<th>Name of Legislation</th>
<th>Child Neglect Included/Defined in Legislation?</th>
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<tr>
<td>British Columbia</td>
<td>Child, Family and Community Service Act (1996)</td>
<td>Yes. Included in s. (13)(1)(d): “if the child has been, or is likely to be, physically harmed because of neglect by the child’s parent.” Also includes specific references to parental acts of omission, e.g., deprivation of necessary health care, refusal to provide or consent to treatment, parent unable or unwilling to care for the child, and abandonment.</td>
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<td>Alberta</td>
<td>Child, Youth and Family Enhancement Act (2010)</td>
<td>Yes. Included in s. (2.1): “For the purposes of subsection (2)(c), a child is neglected if the guardian: (a) is unable or unwilling to provide the child with the necessities of life, (b) is unable or unwilling to obtain for the child, or to permit the child to receive, essential medical, surgical, or other remedial treatment that is necessary for the health or well-being of the child, or (c) is unable or unwilling to provide the child with adequate care or supervision.”</td>
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<tr>
<td>Saskatchewan</td>
<td>The Child and Family Services Act (1989–90)</td>
<td>Does not explicitly use the term neglect but includes caregiver omissions in care as grounds for finding a child in need of protection including: failure to provide/consent to medical or remedial care/treatment; and absence of a caregiver who is able or willing to provide for the child’s needs.</td>
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<td>Manitoba</td>
<td>The Child and Family Services Act (1985)</td>
<td>Yes. Included in s. 17(2)(b)(iii) which states that a child is in need of protection where the child is in the care, custody, control or charge of a person who “neglects” or refuses to provide or obtain proper medical or remedial care. Implicitly alluded to through references to omissions in care, e.g., physical and supervisory care.</td>
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<tr>
<td>Ontario</td>
<td>Child and Family Services Act (2000)</td>
<td>Yes. A child is in need of protection where, “(a) the child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person’s, (i) failure to adequately care for, provide for, supervise, or protect the child, or (ii) pattern of neglect in caring for, providing for, supervising, or protecting the child; (b) there is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting form that person’s (i) failure to adequately care for, provide for, supervise, or protect the child, or (ii) pattern of neglect in caring for, providing for, supervising, or protecting the child.”</td>
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<tr>
<td>Quebec</td>
<td>Youth Protection Act (2009)</td>
<td>Yes. Chapter IV, Division I, s. 38 states that “the security or development of the child is considered to be in danger if the child is abandoned, neglected, subjected to psychological ill-treatment, or sexual or physical abuse, or if the child has serious behavioural disturbances. Section 38 b) further defines neglect as (1) a situation in which the child’s parents or the person having custody of the child do not meet the child’s basic needs, (i) failing to meet the child’s basic physical needs with respect to food, clothing, hygiene, or lodging, taking into account their resources; (ii) failing to give the child the care required for the child’s physical or mental health, or not allowing the child to receive such care; or (iii) failing to provide the child with the appropriate supervision or support, or failing to take the necessary steps to provide the child with schooling; or (2) a situation in which there is a serious risk that a child’s parents or the person having custody of the child are not providing for the child’s basic needs in the manner referred to in subparagraph 1.”</td>
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<td>New Brunswick</td>
<td><em>Family Services Act</em> (1993)</td>
<td>Yes. S. 30(1) identifies that children should be reported to the child protection authority when a person suspects or has reason to believe that a child has been: “abandoned, deserted, physically, or emotionally neglected…etc.”</td>
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<tr>
<td>Nova Scotia</td>
<td><em>Children and Family Services Act</em> (amended 2002)</td>
<td>Yes. S. 22(2)(j) states that a child is in need of protection when the child has “suffered physical harm caused by chronic and serious neglect by a parent or guardian of the child, and the parent or guardian does not provide, or refuses, or is unavailable or unable to consent to services or treatment to remedy or alleviate the harm; (ja) there is a substantial risk that the child will suffer physical harm inflicted or caused as described in clause (j).” Also makes reference to specific acts of omission such as inadequate supervision (s. 22(2)(a)), failure to provide medical treatment (s. 22(2)(e), and/or therapeutic services (s. 22(2)(f)).</td>
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<tr>
<td>Prince Edward Island</td>
<td><em>Child Protection Act</em> (2003)</td>
<td>Yes. S. 9(c)(i) indicates that a child is in need of protection when the child has suffered harm caused by “neglect of the child by the parent.” S. 9(c)(ii) further indicates circumstances where the parent has failed to supervise or protect the child. Sections 9(o) and (p) include instances of failure to provide medical or therapeutic treatment.</td>
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<tr>
<td>Newfoundland</td>
<td><em>Children and Youth Care and Protection Act</em> (2010)</td>
<td>Yes. S. 10(1)(c) states that a child is need of protective intervention where the child: “is being, or is at risk of being, emotionally harmed by the parent’s conduct and there are reasonable grounds to believe that the emotional harm suffered by the child, or that may be suffered by the child, results from the actions, failure to act, or pattern of neglect on the part of the child’s parent.” Also includes reference to failure to supervise or to provide medical/therapeutic treatment.</td>
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<td>Nunavut</td>
<td><em>Child and Family Services Act</em> (1998)</td>
<td>Does not specifically use the term neglect but lists a number of acts of omission, including: S. 7(3)(a) indicates that a child is in need of protection where “the child has suffered physical harm inflicted by the child’s parent or caused by the parent’s unwillingness or inability to care and provide for or supervise and protect the child adequately; or (b) there is a substantial risk that the child will suffer physical harm inflicted by the child’s parent or caused by the parent’s unwillingness or inability to care and provide for or supervise and protect the child adequately. Also includes specific acts of omission such as failure to provide therapeutic treatment (g) medical treatment (j).”</td>
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<tr>
<td>Yukon</td>
<td><em>Children Act (2002)</em></td>
<td>Yes. S. 118(1) states that a child is in need of protection where: “(a) the child is abandoned; (b) the child is in the care of a parent or other person who is unable to provide proper or competent care, supervision, or control over the child; (c) the child is in the care of a parent or other person who is unwilling to provide proper or competent care, supervision, or control over him; (d) the parent or other person in whose care the child is neglects or refuses to provide or obtain proper medical care or treatment necessary for the health or well-being or normal development of the child.”</td>
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<tr>
<td>Northwest Territories</td>
<td><em>Child and Family Services Act (1997)</em></td>
<td>Yes. S. 3(a) outlines the grounds for finding a child in need of protection, including: “(h) the child has been subject to a pattern of neglect that has resulted in physical or emotional harm to the child; (i) the child has been subject to a pattern of neglect and there is a substantial risk that the pattern of neglect will result in physical or emotional harm to the child. Also makes references to acts of omission including failure to provide medical and therapeutic treatment (n), (e) and (g), failure to protect from sexual harm (c), and abandonment (p).”</td>
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As Table 1 demonstrates, neglect is defined in most provinces as the failure of parents or guardians to provide for children’s needs, including physical and supervisory care, medical care, psychological/psychiatric treatment (where warranted), and in some provinces, school attendance. Unlike earlier provincial legislation in Canada, only one province’s statutes (Quebec) currently references the need to take into account caregivers’ resources before making a determination of neglect based on failure to provide for the child’s material needs, although many provincial statutes do make vague references to parents’ resources (both financial and personal) where neglect is indicated by a parent who is either unable or unwilling to provide for the child’s needs. In all of these cases, both scenarios (unwillingness or inability to provide) place a child “in need of protection.”

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18 For example, in 1934, an amendment to British Columbia’s *Infant’s Act* included in the role of the Children’s Aid Societies the “ameliorating of family conditions that lead to the neglect of children” (McIntyre, 1993).
Defining Neglect: Parental Omissions or Children’s Unmet Needs?

Currently, there is no agreed-upon definition of child neglect despite concerted efforts over the past several decades (Dubowitz, 1999; Smith & Fong, 2004; Zuravin, 1999). To further complicate this matter, Garbarino and Collins (1999) note that definitions of neglect differ both within and between cultures, and evolve and change over time. The lack of an accepted definition for neglect has been cited as one of the most significant limitations with research on this subject as researchers differ widely in how they have conceptualized and operationalized this phenomenon, making comparability across studies difficult (Harrington, Zuravin, DePanfilis, Ting, & Dubowitz, 2002). Further, Dubowitz (1994) posits that the lack of attention paid to this topic by researchers may be due to the “inherent vagueness of what constitutes neglect” (p. 558).

Despite these difficulties, scholars, clinicians and policy makers have defined neglect for the purposes of research, practice, and policy. This section of the chapter outlines two competing philosophies for defining neglect—*parental omissions in care* versus *children’s unmet needs*—and the different paradigms of child welfare services with which they are associated. This section will also outline a number of other factors taken into account in definitions of neglect such as the age and developmental stage of the child, culture, and notions of minimally acceptable care.

Parental Omissions in Care

Rose and Meezan (1993) note that neglect was first formally defined as separate from abuse by Leontine Young in her 1964 book *Wednesday’s Children*, a study of 300 abuse and neglect cases served through child welfare agencies in the eastern, Midwest, and Pacific regions of the United States. Young (1964) defines neglect as parental omissions in care such as inadequate feeding—which she calls severe neglect due to the centrality of food for survival—and lack of cleanliness, adequate clothing, or medical care, referred to as moderate neglect (p. 9). To date, defining neglect as parental omissions in care remains the most common way of conceptualizing neglect (Smith & Fong, 2004). For example, the World Health Organization (WHO), defines neglect as “the failure of a parent to provide for the development
of the child” (WHO, 2002, p. 50). Other definitions use more generic terms for the persons responsible for neglect—such as Minty and Pattinson (1994, p. 736), who indicate that neglect occurs when “a person having care for a child” fails to provide for the child’s basic needs.

Definitions stemming from the omissions in care approach usually represent narrow definitions (Dubowitz & Black, 2002). They identify a perpetrator (almost always the parent), and typically delineate specific behaviours (e.g., a failure to provide food, clothing, treatment) that are considered neglectful. These definitions have led to debate as to whether such omissions are, in and of themselves, neglectful, or whether demonstrable harm to the child must result for neglect to have taken place (Besharov, 1985; Rose & Meezan, 1993). As illustrated by Table 1 (pages 39–42), most provincial legislation in Canada employs a “parental omissions in care” approach to defining neglect.

Legal advocates have argued that definitions of neglect focusing solely on parental actions or inactions are still too broad and as a result, most statutes also include reference to identifiable physical or emotional harm (or risk of such harm) to the child that has occurred as a consequence of parental behaviour (Gaudin, 1993). Narrow definitions such as these are favoured by legislation as they make clear who is responsible and for what, and provide a threshold above which coercive intervention is justified (Hutchison, 1990). Some scholarly definitions employing a parental omissions in care approach also reference evidence of harm as an important threshold. As an example, Minty and Pattinson (1994) define neglect as “a severe and persistent failure by a person having care for a child to provide food, hygiene, warmth, clothing, stimulation, supervision, safety precautions, affection, and concern…to such an extent that the child’s well-being and development are severely affected” (p. 736, emphasis added).

Identifying specific omissions in care considered neglectful has created some complexity for the field. While some basic needs, such as adequate food, clothing, and shelter may seem intuitive, the ways in and extent to which the absence of specific needs leads to negative outcomes for children is not always clear. For example, while dirty homes and/or children’s inadequate hygiene are frequently cited as a reason for referral to child protection services, they have also been scrutinized
as a potentially class-based reaction to children who may be “dirty but happy” but whose parents do not adhere to middle class standards of physical care (Taylor & Daniel, 2005). Mnookin (1973, p. 621) writes that “some ‘dirty homes’ may endanger a child’s growth and well-being, but most merely offend middle class sensibilities.” To address this, some scholars have argued that acts must only be considered neglectful if empirical evidence can demonstrate that they lead to negative outcomes for children (Slack, Holl, Altenbernd, McDaniel, & Stevens, 2003). Recent research attempting to link specific subtypes of neglect to children’s outcomes has found a “modest” association between several subtypes—including inadequate hygiene—and later child functioning concerns (see for example Dubowitz et al., 2004; Dubowitz et al., 2005).

On an individual, case-by-case basis, outcomes as a result of specific parental behaviours or inactions differ. For example, specific acts that might seem obviously neglectful (e.g., leaving an infant alone for an extended period of time) may result in no immediate or long-term harm to the child. Indeed, some writers have cautioned that harm itself is dependent on a variety of issues beyond specific caregiver actions, such as chance or luck (Gelles, 1978; Gil, 1971). To address this issue, many definitions of neglect include both harm and risk of harm. For example, Trocmé et al. (2005) state that neglect has occurred if “the child has suffered harm or the child’s safety or development has been endangered as a result of the caregiver(s) failure to provide for or protect the child” (p. 120). The statutes of Quebec include not only the child in need of protection criteria but also the notion that a child’s health or security has been endangered as a threshold for considering child protection intervention. Thus, according to this type of definition, the parent who leaves an infant alone is neglectful regardless of intent or whether or not the child suffers any harm (Zuravin, 1999).

One of the most comprehensive attempts to clearly define neglect is found in the work of Slep and Heyman (Heyman & Slep, 2006; Slep & Heyman, 2006). These researchers developed definitions of four maltreatment typologies (physical abuse, sexual abuse, emotional maltreatment, and neglect) in an attempt to increase the reliability of the substantiation decision regarding allegations of abuse and neglect. In particular, the interest of the authors was in helping the field make a distinction
between problematic parenting and actual maltreatment. Using an approach similar to psychiatry’s *Diagnostic and Statistical Manual* (DSM), their process for developing definitions relied on a combination of literature/legislation reviews, interviews with experts in the field, focus groups, and subsequent field testing to advance concrete definitional criteria. A determination of maltreatment required the following two conditions: an initial qualifying act (or in the case of neglect, omission) along with significant impact or high potential for significant impact (e.g., “throwing a knife at a child but missing,” p. 220). The result of their work is a set of definitional criteria for six forms of neglect: lack of supervision, exposure to physical hazards, educational neglect, medical neglect, deprivation of necessities, and abandonment. The main conditions for determining neglect include “*egregious act(s) or omission(s)* on the part of the child’s caregiver that deprives the child of needed age-appropriate care” that also results in “significant impact on the child” in all cases except abandonment, which is thought to meet the criteria regardless of impact (Slep & Heyman, 2006, p. 233). Their work defines in detail what is meant by egregious and significant impact and includes a “first time exclusion” for instances of lack of supervision and/or exposure to physical hazards if certain other conditions are absent. Field testing of these definitions increased the reliability of the substantiation decision19 and the use of the criteria was not perceived as overly burdensome by the participating sites (Slep & Heyman, 2006).

Currently, narrow definitions based on parental omissions in care leading to harm or endangerment dominate the field of child welfare. Advocates of narrow definitions argue that they guide legal and social work decision-making, and limit discretion (and, it is thought, bias) in interpreting eligibility for services, and policy and practice guidelines. Further, narrow definitions have the effect of limiting the number of cases referred to child welfare, focusing workers’ efforts on the most serious cases and reducing the overall cost of child welfare services (Hutchison, 1990).

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19 Measured by the percentage of agreement between field sites determination and an expert master reviewer’s determination regarding the same case, $\kappa = .80$. 

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Children’s Unmet Needs

In contrast to narrow definitions of neglect based on parental omissions in care, some scholars have advocated for broad definitions that imply the need to attend to structural issues along with case-specific caregiver inactions (Hutchison, 1990). As an example, Dubowitz and colleagues (1993) argue that “neglect occurs when basic needs of children are not met, regardless of cause” (p. 12, emphasis original). This type of broad definition of neglect stems from the use of an ecological framework, which stipulates that contributing factors to neglect are found at multiple levels—the individual caregiver, family, community, and societal levels—and although parents are most likely responsible for meeting the needs of their children, factors at all of the other levels either help or hinder their ability to do so.

An important difference between this type of definition and one centred on parental omissions in care is that defining neglect in terms of unmet needs results from a focus on supporting children’s healthy development and well-being and less on assigning blame or identifying a perpetrator. Broad definitions speak to the need for an institutional approach to child welfare services and social policy—one that positions welfare services as “a normal and acceptable means to assist individuals and their collectives fulfill social needs” (Hutchison, 1990, p. 76).

Definitions of neglect centred on children’s unmet needs introduce the notion that different societal conditions may also constitute neglect. As Spencer and Baldwin (2005) state: “societies, through social, economic, and educational policies, can be supportive or neglectful of children, providing an environment in which the capacity of families to care for their children is either strengthened or undermined” (p. 26). If children’s needs go unmet with respect to affordable and safe housing, food security, adequate minimum income and access to health care, child care, and education, these are all instances of neglect. Several writers have argued that dominant Western cultural beliefs that stress the individual over the collective and hold individual caregivers solely responsible for meeting the needs of their children, along with the relative disinterest of privileged groups in the welfare of poor families, contribute to societal neglect (Smith & Fong, 2004).
A children’s needs approach to defining child neglect urges policy makers and practitioners to take into account many factors that impinge on meeting these needs, from parental problems that impair caregiving, to the role of community, culture, and society in providing for children and families. The strength of an ecological perspective to define child neglect is that it directs child welfare professionals to consider a range of salient factors outside of the individual parent or child and acknowledges that the same parental behaviours may have very different consequences for children depending on their environments. For example, Pelton (1981) notes that a child left unsupervised in a poor neighbourhood where household and environmental hazards are common is far more likely to suffer harm than a child from a middle class neighbourhood. Garbarino (1995) stresses that “socially toxic neighbourhoods”, those characterized by high crime, violence and poor social services and support networks, are a major contributor to how well parents are able to manage their role as caregivers.

**Implications for Practice**

Definitions of neglect have direct implications for the role of child welfare agencies charged with investigating and intervening in these cases. As Hutchison (1990) reminds us, “the way in which a social problem is defined determines both the range of feasible solutions to the problem and the types of specific strategies that will be used to accomplish these solutions” (p. 61). The competing approaches to defining neglect are associated with different paradigms for child welfare practice. An approach characterized by parental omissions in care is associated with a residual and protection-driven orientation to child welfare (i.e., help is only offered after inadequate care has been established and takes the form of protecting children from future harm) and a paradigm of risk that focuses on the deficits of caregivers rather than any contextual social issues (Wharf, 2002). An approach stemming from children’s unmet needs is more consistent with a family welfare conceptualization of service, focusing on assessing family needs holistically and providing services to meet them.
It is important to note that even when services are offered through a family welfare/family support paradigm, assessment of needs and intervention usually take place at the individual family level. However, some needs experienced by families may be better understood as having roots in structural inequalities. For example, the overrepresentation of Aboriginal children in Canada in substantiated cases of neglect is thought to stem from the increased structural risk factors experienced by First Nations families and communities, such as substance misuse, unsafe housing, poverty, and community isolation (Sinha et al., 2011; Trocmé et al., 2006). The question that arises is the extent to which child welfare services can and should address these issues alongside the individual needs of families.

Although Dubowitz et al. (1993) contend that understanding neglect from the point of view of children’s needs is most appropriate, they stress that societal neglect—neglect which occurs due to inequities at the macro level—has not been, nor should be, a focus of child protection agencies. This view is strongly countered by several writers. For example, Blackstock (2003) notes that the most important interventions to address high rates of neglect in Aboriginal communities are those that attend to structural issues and provide support for Aboriginally-driven socio-economic development. Barter (2001, p.258) contends that the “protection of children must move beyond just protection in their own families to include their protection from the social, economic, and political forces that affect families and communities.”

Swift (1995b) argues that child protection workers can intervene at both the micro and macro levels through collecting accurate statistics regarding shared difficulties (such as poverty and inadequate housing) among families known to child protection services and using these data to advocate for social change. Further, she argues that through situating parents’ individual difficulties within the context of their shared histories of oppression (e.g., racism, sexism, and other forms of

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20 Although substance abuse is often seen as an individual problem, it has also been framed as a problem with structural roots in Aboriginal communities. Aboriginal peoples’ experiences of the residential school system and the “sixties scoop,” which separated children from parents, community, and culture has left a legacy of intergenerational trauma that affects not only those who experienced it first-hand, but subsequent generations still dealing with the loss of language, community, culture, and spiritual identity (Bombay, Matheson, & Anisman, 2009).
discrimination and exclusion) child welfare workers can begin to understand how the influence of society at large plays both a direct and indirect role in children’s quality of care (Swift, 1995b). Similarly, Riggs (2008) states that schools of social work and other leaders in the field must advocate to make social justice “a significant component of the paid work of child protection” (p. 382).

Other Definitional Considerations

Definitions of child neglect differ not only based on which broad theoretical approach is privileged but also in the extent to which they take into account a number of other salient factors. Although these factors may not be addressed by legislation, they have been taken up by those scholars attempting to bring a developmental or cultural lens to the problem of defining neglect and researchers attempting to achieve more precision in understanding this heterogeneous phenomenon. The section below reviews a number of important considerations affecting how neglect is currently defined and understood.

Child Age and Developmental Stage

As DePanfilis (2006) notes, “what is considered neglect varies based on the age and developmental level of the child, making it difficult to outline a set of behaviours that are always considered neglect” (p. 10, emphasis original). To address this issue, some definitions of neglect explicitly reference the context of children’s age and development. For example, Minty and Pattinson (1994) argue that omissions in care “appropriate to the age and needs of the child” (p. 736) are considered neglectful. In her detailed definition of supervisory neglect, Horwath (2007) divides her examples by chronological age group, including infancy (under 12 months), preschool (under five years), primary school (five to 11 years), and secondary school (11 to 16 years). An act that is considered neglectful for infants, e.g., “baby left alone in bath,” is not included in the definition of supervisory neglect of a secondary school aged child (Horwath, 2007, p. 35). Similarly, Dubowitz et al. (1993) note that children’s needs vary based on age and developmental stage, and conditions that are neglectful for infants
and toddlers (e.g., lack of adult supervision) may be developmentally appropriate for teenagers. Scholars agree that as children age and become more independent, neglect becomes more difficult to define, and there may be different conceptual issues, trends, effects, and interventions needed (NSPCC, 2007). Consequently, to more fully flesh out developmentally appropriate definitions of neglect, more research is needed to identify and understand the impact of conditions thought to be neglectful for older children, but for which empirical evidence is lacking (Dubowitz et al., 1993).

The Continuum of Neglect: Severity and Chronicity

Dubowitz, Pitts, and Black (2004) state that “neglect has generally been defined as a dichotomous variable” (p. 346), one that is either present or absent. They argue that it is more helpful to look at neglect along a continuum, ranging from children’s needs being fully met to not being met at all. Some families along this continuum may be best supported through referrals to community agencies, while others may require child welfare involvement, and the most severe cases may involve criminal charges (Dubowitz et al., 1993).

Few studies have defined neglect based on a continuum. In part, this may be due to the fact that neglect is most often studied using child protection services data, where cases are either substantiated or unsubstantiated, with little or no distinction between them with regard to level of unmet needs. However, some scholarly work has introduced the notion of severity and/or chronicity, which fleshes out an understanding of neglect beyond a binary neglect–no neglect construct. In developing the Child Neglect Index (CNI), an instrument designed to be used by child welfare practitioners as a substantiation tool and measure of severity, Trocmé (1996) notes that it is important for workers to have a shared understanding not only of what it means for a child to have been neglected, but also of the difference between mild and serious neglect (p. 145).
Minimally Acceptable Care and the Intervention Threshold

The ability to define neglect rests on the notion that there are agreed-upon standards of acceptable care for children and a universal understanding of children’s physical, emotional, and developmental needs. Although Western society has developed an understanding of much of what children need for optimal development—for example, food, clothing, shelter, cognitive stimulation, affection, safety and protection—“the minimal dosage of caregiving has not been established” (English, Thompson et al., 2005, p. 193). Similarly, Daniel (2005) argues that although we have acquired considerable knowledge about the environment in which healthy emotional and physical development take place, we “struggle to formulate a clear definition to describe the absence of such a milieu” (p. 13).

When it comes to decision-making about caregiving practices poor enough to require intervention, even professionals differ as to where the threshold lies for referral to child protection agencies (Goodman, 1999). While Stevenson (1998) argues (perhaps controversially) that practitioners know a neglected child when they see one, Daniel (2005, p. 13) notes that in recognizing that a child is hungry, dirty and tired, they are “often catapulted straight into asking ‘is this a situation in which I can and should legitimately intervene?’” In this way, definitions of child neglect rest either implicitly or explicitly, on the notion that there is a threshold that delineates suboptimal care from neglect.

Goodman (1999) notes that various factors affect human service professionals’ sense of whether a potentially neglectful incident is serious enough to merit referral to or intervention by a child protection agency. These include a worker’s level of knowledge about child neglect, the socio-economic status of the population served by their neighbourhood, and workers’ experience with child protection work. Wolock (1982) found that workers who were employed in the lowest socio-demographic neighbourhoods and who had the highest level of severe cases, had a higher threshold for minimally acceptable care than did those who saw comparatively less severe cases in neighbourhoods where clients had higher socio-economic status (Wolock, 1982). What this suggests is that there is no universal standard, even among professionals, of what constitutes good enough
parenting and that judgments about acceptable care are influenced by several factors, including individual worker characteristics and the broader context of the environment in which the case is being assessed.

**Poverty and Intent: Are These Important Qualifiers?**

As noted in the previous section, although poverty and neglect usually co-occur, Canadian legislation does not exempt circumstances in which parents’ failure to provide for children’s basic necessities stem from poverty rather than the deliberate withholding of care. However, in the United States, some jurisdictional statutes make an attempt to take into account financial ability. For example, the Arkansas Code states that a finding of neglect “applies except when the failure or refusal is caused primarily by the financial inability of the person legally responsible” (Ark. Code Ann. s. 12(b), 2001).

The desire to separate out poverty from neglect is also evident in some non-legal definitions. For example, the World Health Organization notes that “neglect is thus distinguished from circumstances of poverty in that neglect can occur only in cases where reasonable resources are available to family and caregiver” (WHO, 2002, p. 60). Horwath (2007) similarly stresses that neglect results from the failure to complete the parenting tasks required to meet a child’s developmental needs “despite reasonable resources being available” (p. 38). Slack and her colleagues suggest that a distinction should be made between poverty or the absence of community resources and parental neglect, as the former issues are out of the parents’ control and could explain issues such as food insecurity (Slack et al., 2003).

The question of intent is raised by the poverty versus neglect debate. For example, if neglect is not neglect when it arises due to poverty, then does it follow that neglect that is unintentional is also not really neglect? Golden, Samuels, and Southall (as cited in Daniel, 2005, p. 14) suggest that a distinction should be made between neglect as a “non-deliberate failure to provide the child’s needs” perhaps due to poverty, and “deprivalional abuse…the deliberate or malicious failure to supply the needs of the child.” However, Dubowitz and colleagues (1993) caution that “intentionality is very
difficult, if not impossible to assess” (p. 15) and they note that clinical research suggests that most neglect is not intentional. For this reason, they conclude that it does not seem useful to include intentionality in a conceptual definition of child neglect.

**Neglect and the Influence of Culture**

Many scholars who have tackled definitional conundrums in the field of child neglect have noted the importance of the cultural lens in defining what is and what is not neglectful child care practice. Korbin (1997) notes that: “In reality, it is the dominant culture in any society that sets the prevailing child rearing standards…the greater the divergence in child care practices and beliefs, the greater the potential for cultural conflict in definitions of maltreatment” (p. 32). As a result, an awareness of how dominant cultural values about child rearing influence what is considered inside and outside of acceptable standards of care is critical to understanding how child neglect has been defined, both in Canada and other jurisdictions.

Korbin and Spilsbury (1999) identify two common pitfalls when contemplating the role of culture in definitions of child maltreatment: ethnocentrism and cultural relativism. Ethnocentrism refers to the belief that one’s own cultural beliefs and practices are both preferable and superior to all others, while cultural relativism positions all cultures as equal, including the notion that culturally sanctioned practices cannot be judged from the standpoint of another culture (Korbin & Spilsbury, 1999, p. 135). These authors advocate for a balance between the two extremes, noting that unmoderated ethnocentrism imposes the beliefs and behaviours of the dominant group on all people and runs the risk of misidentifying cultural practices as maltreatment, while unmoderated cultural relativism “suspends all standards” and runs the risk of explaining away practices that are harmful to children because they are identified—rightly or wrongly—as culturally rooted (Korbin & Spilsbury, 1999, p. 135).

Fontes (2005) provides several examples of child care practices considered the norm in other cultures that come into conflict with mainstream Western values about adequate child care. For example,
the supervision of younger children by siblings is common in many cultures and can have benefits for children’s development. In cultural settings where this is an accepted practice, adults are often within earshot while siblings are supervising. Similarly, allowing children to play in the street unsupervised is common practice in many cultures, where neighbours look out for each other’s children. Fontes (2005) argues that it is not these practices in and of themselves that are inherently neglectful, and she asserts that these same practices may have worked well to keep children safe in a family’s community of origin. However, when immigrant families apply these practices in an urban North American context, they may no longer work to keep children safe due to hazards in the neighbourhood and/or the lessened sense of community responsibility for children in mainstream culture.

To address questions of whether a cross-cultural definition of neglect is possible, several studies have been conducted to assess the extent to which an understanding of neglect is similar across different racial groups. Results of these studies have been mixed. For example, Giovannoni and Bercerra (1979) found significant differences among White, Hispanic and Black mothers in the perceived seriousness of several potentially neglectful acts, with White mothers rating 94% of acts as less serious than the other two groups. These results were then refuted by those of Polansky, Ammon, and Weathersby (1983), who found minimal differences in severity rating between Black and White mothers, although White mothers rated scenarios as more serious compared to these other two groups.

In 1995, Rose and Meezan conducted a similar study, adding a comparison group of child protection workers. Their results concerning mothers were similar to those of Giovannoni and Bercerra, with White mothers rating acts as less serious than Black or Hispanic mothers, particularly those related to physical care and exposure to unwholesome circumstances (Rose & Meezan, 1995). Of interest is the fact that child protection workers rated acts as less serious than mothers as a whole, lending credence to the notion put forward by Fontes (2005) that cultures associated with one’s profession may also account for differences in perception regarding child neglect. Finally, in 1998, Dubowitz and his colleagues replicated the study by Rose and Meezan, but analysed their data in two
subgroups defined by income. Although they found some between-group differences based on the intersection of race and class (e.g., middle class Black and White mothers rated psychological care as more important than lower class Black mothers; both lower and middle class Black mothers rated physical care as more important than the middle class White group), they conclude that there is considerable agreement between laypeople groups across race and class regarding what constitutes neglect. By comparison, professionals had a higher threshold for concern (Dubowitz, Klockner, Starr, & Black, 1998).

A significant critique of research to date is that while the vast majority of literature in this field ignores issues of culture altogether, those studies that do address culture usually reduce it “to a racial or ethnic label” (Fontes, 2001, p. 84), using skin colour as a proxy for the much more complex construct of culture. As a result, questions of how to define neglect while respecting cultural differences may require studies that operationalize culture as the shared beliefs and values held by distinct groups rather than the more socially constructed notion of race. Further, criticism of existing research notes that those studies that have addressed racial or cultural differences do not explore the reasons why, when group differences are found (Fontes, 2001).

**Separate Versus Combined Subtypes**

Dubowitz, Klockner, Starr and Black (1998) note that neglect is a heterogeneous phenomenon encompassing several subtypes that have potentially unique etiologies and consequences for children. However, most studies have collapsed neglect into a general binary category, obscuring the fact that neglect encompasses multiple, disparate conditions (Slack et al., 2003). As Dubowitz, Pitts, and Black (2004) write: “not having enough food (i.e., physical neglect) is a very different experience compared to not having an affectionate, nurturing parent (i.e., psychological neglect)” (p. 344). Although some research suggests that different subtypes of neglect often co-occur—for example, Minty and Pattinson (1994) found a strong co-morbidity between what they term physical neglect and emotional neglect—the question remains whether it enhances our understanding of
An Exploration of the Relationship Between Poverty and Child Neglect in Canadian Child Welfare

When a category includes diverse behaviours, division into subtypes is necessary. Failure to formulate separate conceptual and operational definitions for subcategories will subvert the development of knowledge by making it impossible to determine if clinically diverse phenomena subsumed within a single category are a function of different etiologies, lead to distinctive sequelae, and require unique treatments. (p. 102)

In an attempt to empirically evaluate relationships among subtypes of neglect, Dubowitz et al. (2004) measured three major subtypes of neglect: physical, psychological, and environmental neglect. They concluded that there was only modest overlap between the three subtypes with the exception of a moderate correlation between physical and psychological neglect, supporting the idea that “these phenomena…represent somewhat unique experiences” (p. 351). Validation of these phenomena as distinct experiences was further supported by their differential associations with children's behaviour at age six.

Several classification systems that operationalize specific subtypes of neglect have been developed. Wolock and Horowitz (1977) conceptualized neglect into three subgroups: (1) health care, hygiene, and physical needs neglect; (2) environmental and physical care neglect; and (3) supervision neglect. Zuravin and Taylor (1987) classified neglect into eight subtypes, each denoting a specific area of children's needs: (1) physical health care; (2) mental health care; (3) supervision; (4) substitute child care; (5) household hazards; (6) household sanitation; (7) personal hygiene; and (8) nutrition. In 1991, Zuravin revisited this classification and asserted that neglect may be operationalized better using 14 subtypes instead; this revised classification included many of the original eight described by Zuravin and Taylor, with a distinction between refusal and delay in providing physical and mental health care, and the addition of abandonment, custody refusal, custody related neglect, educational neglect, and failure to provide a permanent home (Zuravin, 1991a).
Study of Reported Child Abuse and Neglect each define neglect as a phenomenon comprised of the following eight subtypes (or forms): (1) failure to supervise (leading to) physical harm, (2) failure to supervise (leading to) sexual harm, (3) permitting criminal behaviour, (4) medical neglect, (5) physical neglect, (6) failure to provide psychiatric/psychological treatment, (7) abandonment, and (8) educational neglect (Trocmé et al., 2005).

Classification systems for neglect have become increasingly detailed, with some researchers further classifying the various subtypes. For example, Coohey (2003) asserts that although neglect can be understood as comprised of three major subcategories (physical, supervisory, and emotional), these subcategories themselves can be further broken down. In her 2003 study, she used 228 substantiated neglect cases to classify 10 types of supervisory neglect, including not watching a child closely enough (29.8% of her sample); leaving a child alone without a caretaker (24.5% of the cases studied); and leaving a child with an unsuitable caretaker (19.7% of cases). Coohey (2003) argues that “unless it is established that different behaviours have similar etiologies, they should be kept separate in a typology” (p. 146). Limited research has been done to empirically establish etiological factors either for subtypes of neglect (e.g., physical, emotional, supervisory) or the subcategories of these subtypes, such as those suggested by Coohey.

Subtypes, Inclusions, Exclusions, and Exposure to Domestic Violence

Several classification systems have been developed that separate neglect into various subtypes, with significant overlap between the various systems. Some subtypes have enjoyed relatively uncontested inclusion in definitions of neglect, in particular, omissions in physical care (e.g., food, clothing, shelter, hygiene), supervision, medical/psychological care, and abandonment. There are, however, some subtypes of neglect that remain debated in the field, and their inclusion in definitions of neglect in some studies and exclusion in others makes comparability across studies particularly problematic. For example, some studies include emotional neglect as a subtype of emotional abuse rather than neglect (for example, see Trocmé et al., 2005). Some writers have used failure to thrive
as interchangeable with neglect (see Theodore & Runyan, 1999); however, other writers have taken pains to point out that although it may arise as a manifestation of neglect, it should be viewed as a distinct category, which may have poverty at its root rather than neglect per se (see Black et al., 2006).

One form of maltreatment that has been inconsistently classified and has sparked considerable debate is children’s exposure to domestic violence. There is a body of literature that argues that the presence of domestic violence in a home in which children live constitutes child maltreatment (Edleson, Gassman-Pines, & Hill, 2006; Holden, 2004), although it has been variably framed as either abuse and/or neglect. The rationale for including this subtype under the typology of neglect is related to two separate issues. First, some authors argue that a parent (usually the mother) who is the victim of violence may have an emotional response to her own traumatic situation that may render her incapable of meeting the needs of her children (Antle et al., 2007). The second rationale for including this subtype under neglect stems from the notion that a parent (again, usually the mother) who remains in a violent relationship has failed to protect her child(ren) from witnessing violence, which, it is argued, constitutes a form of neglect (Kaufman Kantor & Little, 2003). There has been significant debate around the failure to protect argument, with many advocates in the violence against women sector noting that this standpoint has the effect of blaming the victim and in essence, holding women responsible for men’s violence (Alaggia, Jenney, Mazucca, & Redmond, 2007; Nixon, Totty, Weaver-Dunlop, & Walsh, 2007). Ongoing debate remains within the field about whether or not exposure to domestic violence represents a form of child maltreatment at all given that demonstrable harm to the child is not always present (Edleson et al., 2006; Kaufman Kantor & Little, 2003)

Chapter Summary

In tracing the history of neglect as a recognized social and legal issue in Canada, several issues were highlighted. First, despite the fact that neglect was the impetus for the introduction of child protection legislation and the focus of public concern for more than a century, the relative importance ascribed
to neglect has waned considerably. In addition to chronicling the shift away from neglect by the field, the history of neglect in Canada highlights the roots of an assumption that remains to a certain extent to the present day: the implicit or explicit understanding that neglect is first and foremost caused by individual parental inadequacies, most notably, mothers’. As Hutchison (1990) articulates, “the people who initially identify a social problem have great influence on how others will comprehend the problem” (p. 65). As will be illustrated in Chapter 3 (Analysis of Theoretical Perspectives), a focus on parental (maternal) problems is a theme that runs through much of the theoretical work developed to understand child neglect. As Chapter 4 (Review of the Research Literature) will outline, it also remains the underpinning of a vast amount of research done in this field.

The strong relationship between neglect and poverty and the subsequent focus on society’s poorest and most vulnerable families is evident from the earliest formulation of neglect. In tracing the history of neglect as it emerged on the social and legal radar, it becomes clear that the construct of the neglected child, initially reserved for children without parents, quickly became intertwined with notions of poverty and destitution. In understanding its origins, it is evident that neglect, in its earliest conception, was not a classless phenomenon but one defined by middle class child savers and applied to poor families and children. Although the language related to class and destitution has all but disappeared from Canada’s legislation, concern remains that neglect continues to be synonymous with social disadvantage (Blackstock, 2008).

More recent developments of the past 25 years have underlined the significant impact of caregiving considered neglectful on child development. Prospective longitudinal research focusing on attachment difficulties brought about by insensitive or inconsistent mothering have noted the long-term sequelae of children who were labelled neglected as infants. These include significantly higher rates of difficulties across multiple domains such as school achievement, peer relationships, behaviour and emotional regulation, romantic relationships, and parenting, compared to children who have not suffered neglect. Neuro-psychological research of the last several decades has underscored the importance of appropriate and sensitive nurturing and stimulation for infants
and young children in particular, and the ways in which these early experiences influence neuro-developmental processes on an ongoing basis.

This chapter has also outlined some of the significant issues considered in the attempt to define child neglect. As presented, there are a multitude of factors that influence how neglect is defined and definitions vary in terms of their depth, breadth, specificity, and purpose. What this review highlights is that the way in which neglect is defined has far-reaching implications and it is not just a neutral, technical exercise, but one which directs both practitioners’ and policy makers’ attention in a particular direction when seeking solutions and interventions. This is evident in the omissions in care versus unmet needs debate, where the former definition supports the current services usually offered parents known to child welfare agencies for reasons of neglect, most notably interventions aimed at increasing parenting knowledge and skill and remedying clinical problems (Pelton, 2008). Conversely, when neglect is defined from the standpoint of children’s unmet needs, a wide range of interventions at varying levels may be called for, including those aimed at alleviating material hardships for disadvantaged families, providing equitable access to resources and services, and advocating for social change.
Chapter 3: Analysis of Theoretical Perspectives

The objectives of this dissertation are concerned with the role of poverty in investigated cases of child neglect in Canada. Specifically, the dissertation examines not only the nature and frequency of poverty-related needs (e.g., adequacy of income and housing) experienced by families investigated for neglect, but also the influence of these needs on case decision-making after controlling for a number of relevant clinical (e.g., alcohol, drugs and mental health) characteristics. The dissertation also assesses the extent to which poverty needs alone characterizes a subgroup of cases known to child welfare as “neglect”, and explores the nature of the service referral response to the various presenting concerns of these cases. Theories relevant to these issues are those that articulate an etiological framework for child neglect and the role of poverty within that framework. Understanding how different theories position poverty and other factors in the etiology of neglect is of particular relevance as it is assumed that the framework used to understand why a problem occurs has a direct relationship to the nature of interventions proposed to ameliorate it (Hutchinson, 1990). Dominant paradigms or theories of poverty that seek to define the construct of poverty and understand why poor people are poor are also presumed to influence the child welfare response to child neglect and families’ poverty-related problems. As a result, these theories are also briefly reviewed. In the final section of this chapter, a theoretical framework for the current research is presented.

Wilson and Horner (2005) note that theory regarding child neglect is underdeveloped and poorly understood. Those theories that do exist are not discrete entities, but overlapping models with shared constructs and hypotheses (Smith & Fong, 2004). Further, theory generation for neglect as separate from abuse is limited, despite research findings that suggest distinct etiologies and outcomes for different maltreatment typologies. As a result, theory concerning neglect is often drawn from models developed for abuse specifically or maltreatment more generally, the latter of which can be categorized according to the following theoretical orientations: (1) Parental Deficit models; (2) Environmental Deficit models; and (3) Ecological-Transactional models that
incorporate interaction between parent, child, family, community, and broader social structure variables. In this the first part of this chapter each of these models will be reviewed, with specific reference to theoretical work about neglect, where available.

**Parental Deficit Models**

As discussed in Chapter 1 of this dissertation, viewing neglect as caused by parental deficits was the earliest way of thinking about this problem. While there were no formal, academic theories regarding the causes of child neglect in the nineteenth century, Swift (2003) notes that the common ideology of the day framed neglect as the result of parental vices, drunkenness, poor morals, and work ethic. As the twentieth century unfolded, the fledgling profession of social work became more established and formal theoretical models were proposed to explain child maltreatment. Parton (1999) notes that the early theoretical foundation for social work in the period after the Second World War came in the form of borrowed knowledge, adopted from neo-Freudism and ego psychology. This approach supported a focus on the intra-psychic processes of individual caregivers receiving child welfare services as a way of understanding and treating abusive and neglectful parents.

**Psychiatric Model**

The earliest formal model used to explain the phenomena of maltreatment was the psychiatric model (Belsky, 1978). This approach frames abuse and neglect as the result of individual parental traits or upbringing. The psychiatric model holds that maltreating caregivers have certain personality traits that set them apart from non-abusive parents, and thus maltreatment occurs as a result of the psychopathology of the abuser. Research into this topic began in earnest after the publication of the landmark article, The Battered Child Syndrome, in the *Journal of the American Medical Association*, by Kempe and his colleagues (Kempe, Silverman, Steele, Droegemuller, & Silver, 1962).

Kempe and his team were paediatric radiologists and noted through the use of x-rays that some children presented with a constellation of unexplained injuries in various stages of healing,
suggesting an ongoing pattern of maltreatment of these children by their caregivers. After examining multiple cases they concluded that abusive parents had personality deficiencies that could be detected, and by studying these “deviant” cases, physicians could learn to predict which caregivers might abuse their children in the future (Kempe et al., 1962). Common traits attributed to abusive caregivers included mental illness; inappropriate or inaccurate developmental expectations of the child (e.g., seeing an infant’s crying as deliberate; expecting an infant to be toilet trained); and a history of maltreatment as a child leading to unmet needs and attachment disorders in childhood that are then passed on to subsequent generations through poor parenting (Belsky, 1978), the latter of which has been the foundation of the notion that child maltreatment is intergenerational.

Although Kempe and his colleagues’ work focused initially on the phenomenon of physical abuse, other scholars, influenced by this work, branched out to look at other forms of maltreatment. The work of Norman Polansky and his colleagues throughout the 1960s and 1970s, resulted in the book entitled Damaged Parents: An Anatomy of Child Neglect, published in 1981 and cemented the notion that like abuse, parental psychopathology was also the cause of child neglect. These researchers were strongly influenced by psychoanalytic theory and viewed neglect as caused by intra-psychic issues within the mostly female subjects they studied. From their study of mothers in the Appalachian Mountains of New York, they describe in detail a profile of the “neglectful mother”, concluding, albeit “reluctantly” that “chronically neglectful mothers are very likely to be character-disordered” (Polansky et al., 1981, p. 37). Describing a syndrome they call apathy-futility, they note that the personalities of these mothers are characterized as “infantile, passive, withdrawn, disorganized, expressionless, with several schizoid features” (p. 39).

Polansky et al. attributed apathy-futility syndrome to very early deprivations in the mothers’ own lives, usually within the first year. Drawing on attachment theory, they noted an inter-generational cycle of neglect, “from the passing on of infantilism, mother to daughter, through processes of deprivation leading to detachment… failure to provide stimulation, and the child’s identification with an inadequate role model” (Polansky et al., 1981, p. 43). Although Polansky and
his colleagues noted the extreme poverty of the families they were studying, they concluded that poverty in and of itself was not the root cause, stating that “programs aimed simply at increasing income will not solve the problem of child neglect (p. 25).” In their view, it was the pathologies of the parents, including personality disorders, poor work ethic, mental health problems, and limited emotional regulation that contributed to both parents’ impoverished condition and to the inadequate care provided to their children. The notion that neglect is intergenerational, first proposed by Polansky, is a tenet still popular today (Swift, 1995). Several studies have noted the association between neglectful parenting and caregivers’ own histories of either emotional or physical neglect (Helfer, 1987).

**Distortions in Mental Processing**

Scholars whose work falls under the parental deficit model were often, but not always influenced by psychodynamic theory. In her more recent work, Crittenden (1993, 1999), puts forward an alternate explanation for why individual parental deficiencies may account for child neglect. Crittenden’s work regarding parental distortions in mental processing arose in response to the body of literature citing socio-economic issues as the main causes of child neglect. Arguing that “interventions to remediate these root causes have not effectively improved families’ social or economic status, nor have they reduced the incidence of neglect” (1999, p. 47), she proposes that something else might be the underlying cause of both poverty and child neglect—namely distortions in how parents mentally process information. Her theory outlines three types of child neglect—disorganized, emotionally neglecting, and depressed—and elucidates the different disorders in mental processing that might lead to each.

In cases of disorganized neglect, families are characterized as multi-problem and crisis-prone; in these families, children are cared for, but in a chaotic and unpredictable environment. Mental processing of caregivers is affectively organized, with manipulation or coercion the favoured approach in interpersonal relationship in order for these parents to meet their emotional needs.
At the opposite end of the spectrum, emotionally neglecting families are cognitively organized, with parents often able to provide materially for their children but without emotional warmth or connection. Family life in these households is characterized as highly structured, and children present as pseudo-mature adults. In each of these two subtypes (disorganized and emotionally neglecting) Crittenden argues that “half of the necessary information—either affect or cognition—is missing from processing” (p. 61) and the job of the professional is to capitalize on the processing strengths while simultaneously raising awareness about and building the weak areas.

Crittenden’s theory describes a third neglect type, depressed neglect, in which caregivers defend against both affect and cognition. Parents are characterized as withdrawn and dull, and seem hopeless and helpless in the face of intervention. And unlike “ordinary” depression in which those who suffer from it often have strong feelings of despair or anger, Crittenden suggests that parents in depressed neglect families fail to use either affect or cognition to process information and may experience little feeling or thought. She contends that this third subtype of neglect may be the most challenging for professionals, who will need to “restart” the mental system of these caregivers and help them understand both the consequences of their behaviour, and trust that feelings can be shared by empathetic others (Crittenden, 1999, p. 64).

Although parental deficit models dominated thought about child maltreatment throughout the 1960s, critics have questioned the appropriateness of this model, stating, for example, that “it is theoretically naïve to assume that the individual abuser, who is the focus of the psychiatric model, exists independently of the society in which he is imbedded” (Belsky, 1978, p. 38). In part, this criticism resulted from the failure of the model to adequately predict which parents would maltreat their children. One of the main tenets of the psychiatric model is that parental psychopathology, caused by parents’ own histories of inadequate parenting, is the main contributing cause of maltreatment and leads to the intergenerational transmission of abusive or neglectful parenting practices. However, many studies exploring this issue have concluded that the vast majority of
parents maltreated as children do not go on to repeat the behaviour (Kaufman & Zigler, 1987; Oliver, 1993).

While mainstream discourse in the study of child abuse and neglect has always held that certain parental traits are associated with child maltreatment, beginning in the 1970s, scholars noted that they did not seem to be “sufficient to cause child maltreatment in the absence of other predisposing factors within the family and larger social systems” (Goldstein, Erne, & Keller, 1985, p. 24). As a result, various thinkers advocated for a “sociological critique and reformulation” (Gelles, 1973) of child maltreatment. This work gave rise to what are known as sociological or environmental deficit models of maltreatment, which were a response to the individual, intra-psychically focused parental deficit models.

**Environmental Deficit Models**

In contrast to the parental deficit model, an environmental deficit model of child maltreatment looks to issues at the socio-cultural level to explain this phenomenon. This model turns the spotlight on factors in families’ environments that are theorized “to provide both the necessary and sufficient conditions under which neglect takes place” (Smith & Fong, 2004, p. 47). While an environmental deficits model does not ignore the existence of parental difficulties that are associated with the neglect of children, supporters of this model take the position that these deficiencies are often the result of social, cultural, and/or situational factors and are therefore only indirectly related to the etiology of child maltreatment. A significant difference between the two approaches is that a parental deficit model assumes that parents are pathological, whereas an environmental deficit model frames parents as normal, but subject to extreme stressors. As Pelton (1978) summarizes: “These parents’ behaviour problems are less likely to be symptoms of unconscious or intrapsychic conflicts than of concrete, antecedent environmental conditions, crises, and catastrophes” (p. 616).

The environmental deficit model brings to the forefront multiple socio-environmental stressors experienced by families—such as poverty, unemployment, poor housing, unsafe neighbourhoods,
single parenthood, the erosion of community, and a broader societal acceptance of violence as a legitimate means of solving conflict (Precora, Whittaker, Maluccio, & Barth, 2000)—that are thought to explain why maltreatment occurs. Specific to neglect, supporters of this model have stressed the influence of variables such as social class, unemployment, unwanted pregnancies (Gelles, 1973), and the absence of a community sense of responsibility for child rearing (Garbarino & Collins, 1999)—all of which increase pressure on parents, undermining their ability to provide adequate care. Hutchison (1990) contends that theories based on environmental deficits can be further classified into socio-situational and socio-cultural. Advocates of a socio-situational perspective stress the way in which social structures and situational stressors contribute to maltreatment, whereas a socio-cultural lens focuses on how cultural values affect parent-child interactions. While the former may look to factors such as poverty and social isolation, the latter highlights issues such as the value contemporary culture places on children, and “the degree to which the culture prescribes collective responsibility for the welfare of children, the availability of multiple caregivers, and expectations regarding paternal involvement in child care” (Hutchison, 1990, p. 66).

**The Socio-Situational Environment**

**Poverty**

The environmental deficit model has identified poverty as perhaps the single-most important contributor to child maltreatment. The study of child neglect in particular has been influenced by the emergence of interest in the role of poverty in child maltreatment. While several studies have examined the relationship between low income and child maltreatment in general, many studies have concluded that the strongest association is found with neglect as opposed to abuse (Drake & Pandey, 1996; Lindsey, 1994; Pelton, 1981; Wolock & Horowitz, 1979). In 1981, Wolock and Horowitz famously referred to families in which neglect was a concern as “the poorest of the poor.”
According to an environmental deficits model, the contribution of poverty to maltreatment cannot be overstated and this has enormous implications for interventions proposed to address child neglect. Gelles (1973) writes that the relative poverty of low income families compared to the resources enjoyed by the average family in North America has created extreme stress for poor families; consequently, any efforts to address child maltreatment must understand and alleviate the “disastrous effect of being poor in an affluent society” (p. 620). Lending further support to this, Pelton (1978) contends that “there is good reason to believe that the problems of poverty are causative agents in parents’ abusive and negligent behaviours” (p. 614) and that “it is these root causes that must be addressed” (p. 616). He further argues that the single most effective way to reduce the rate of abuse and neglect would be to increase family income levels.

Although there has been limited theoretical work exploring how and why poverty is related to neglect (Hearn, 2011), a few theories have been proposed. These range from the simple causal model that material hardship makes it difficult for parents to provide for children (Pelton, 1994) to more complex models in which parental stress associated with poverty (and parents’ inability to cope with this stress) provides the mediation between poverty and neglect (Eamon & Kopels, 2004; Leschied, Chiodo, Whitehead, & Hurley, 2003; Pelton, 1994). In their 2004 study, Slack and her colleagues found some evidence for a direct relationship, with unemployment and perceived material hardship predicting cases of substantiated neglect even after controlling for parental concerns and characteristics such as alcohol and drug abuse, parenting stress, and the relative warmth of parent-child interactions (Shook Slack et al., 2004). Although there is a dearth of studies testing the poverty-stress-neglect pathway, several studies have demonstrated a link between poverty and parenting stress (Cain & Combs-Orme, 2005; McDowell, Saylor, & Taylor, 1995) and between parenting stress and maltreatment generally (Dyk, 2004).

Scholars also note the close association between poverty and several parental difficulties such as substance abuse and mental health problems (Black, Heyman, & Smith Slep, 2001), suggesting that the relationship between poverty and neglect may be better accounted for by their shared close
association with caregiver clinical concerns. For example, Carter and Myers’ 2007 study comparing substantiated and unsubstantiated cases of neglect found a significant relationship between poverty and neglect in bivariate analyses; however, once alcohol and drug use were controlled for in their multivariate model, poverty ceased to be a significant predictor. These findings are somewhat contradictory to those of Cash and Wilkes (2003) who found that in a sample of substance abusing women, poverty (measured as being a recipient of public assistance) remained a significant predictor of the number of neglectful behaviours reported by mothers.

Other theories have been proposed that question the relationship between poverty and neglect, suggesting that it may be a result of several biases in reporting, either through conscious or unconscious prejudice about poor people (called the labelling or reporting biases), or through the increased scrutiny of the poor by social services professionals, (called the visibility bias) that lead to the referral of mostly poor families to child welfare services for a phenomenon that, in reality, affects all classes (Eamon & Kopels, 2004; Drake & Zuravin, 1998). The existence of class-related biases in child welfare reporting and decision making has been supported by some previous studies (Ards & Hardell, 1993; Hampton & Newberger, 1985), yet more recent research has found limited evidence for such biases (Jonson-Reid, Drake, & Kohl, 2009).

The labelling bias suggests that people have “an increased tendency to look for or suspect—and therefore to find—maltreatment among specific groups” (Drake & Zuravin, 1998). In their review of the empirical literature examining evidence for the labelling bias, Drake and Zuravin review the findings of three studies designed to assess the extent of labelling bias in professionals who work with children. In each of these studies, vignettes were developed to portray scenarios of abuse or neglect and participants were asked to assess whether the depicted scene constituted maltreatment, the seriousness of the event, and the likelihood that they would report it to child welfare authorities. Vignettes given to participants were identical save for indicators of social class (i.e., lower versus middle class) and occupation of the alleged perpetrator (e.g., attorney versus carpenter) which were
randomly varied to determine the influence of socio-economic status on the probability that the child is considered maltreated. After reviewing these studies, they conclude that:

The consensus of the empirical literature is clear. Of five studies, three failed to find bias and two found very minimal bias, and then only in some experimental conditions. Taken as a whole, this evidence cannot be interpreted as supporting a meaningful level of labelling bias in the CPS reporting system (p. 298).

The reporting bias is differentiated from the labelling bias in that the former stipulates that potential reporters are more likely to look for maltreatment in poor families, whereas the latter asserts that once maltreatment is suspected, potential reporters are more likely to report suspected maltreatment to child protection authorities if the family is poor. The reporting bias was supported by analyses of the first National Incidence Study in the United States, which showed that in cases in which sentinels either suspected or knew about maltreatment, higher family income reduced the likelihood of a formal report to child welfare authorities (Ards & Harrell, 1993). However, analyses of more recent NIS cycles have refuted these findings.

Finally, the visibility bias contends that due to their frequent use of public services, poor families are more noticeable to professional reporters, accounting for their overrepresentation on child welfare caseloads. This rationale has been vociferously refuted by Pelton (1978, 1981, 1994), who notes that even with the significant increase in reports of neglect over the past several decades due to mandatory reporting laws and other policies, these changes have failed to unearth more referrals of families living above the poverty line. Further, he notes that even among the poor, maltreatment reports have a linear, negative relationship: as income goes down, the rate of reporting goes up—a finding which holds true even for very small increments of change in income. He concludes that such a relationship is not adequately explained by personal biases, noting that “it is hard to imagine that prejudices are that fine-tuned” (1994, p. 141).
Several reasons have been given for the limited theoretical and empirical work exploring how poverty and neglect are connected. First, the nature of the relationship between poverty and neglect is complicated due to the close association between poverty and several caregiver personal problems, such as substance abuse and mental health. There is no definitive conclusion with respect to the direction of these relationships; e.g., does poverty and its stressors lead to substance abuse or does substance abuse lead to poverty through its impact on educational achievement and/or employment? Second, the apparent lack of scholarly interest in the poverty-neglect connection may have a political basis. As Hearn (2011) states: “If results were to suggest that poverty were the root influencer in child neglect, the suggested intervention would be to reduce family poverty, an intervention that would require a great deal of cost and a shift in ideology of many of those in positions to change policy and the way the system works with poor families” (p. 716–717).

**Social Isolation/Community Impoverishment**

Under an environmental deficits framework, social isolation is hypothesized to have a direct effect on the risk of maltreatment. From a social learning perspective, when families have few social contacts with others in their communities, they do not interact with other parents who might model good parenting and/or provide feedback on parents’ less appropriate approaches. As a result, socially isolated parents may not learn positive parenting skills and may not correct faulty parenting (Smith & Fong, 2004). The early work of James Garbarino and colleagues expands on these hypotheses and explores how communities with high rates of social isolation, rather than the isolation of individual caregivers, presents a particular risk for neglect.

Garbarino and Crouter’s (1978) research on community correlates of maltreatment led them to conclude that two low income neighbourhoods matched for socio-economic status could vary considerably in their levels of child maltreatment based on the strength of the human ecology of the neighbourhood. In identified low-risk neighbourhoods (those with relatively lower rates of child maltreatment), parents more readily shared child caring duties with other parents, used the
neighbourhood professional services for their children more often, and perceived themselves to have a higher number of people (both professional and informal) on whom they could count for assistance compared to parents in high-risk neighbourhoods. Parents in low-risk neighbourhoods also viewed their children as easier to manage and were characterized as “free from drain” (Collins and Pancoast, as cited in Garbarino & Sherman, 1980, p. 194)—a concept meaning that, on the balance of things, their resources outweighed their needs, making them able to give and share with others. In summarizing this relationship between social impoverishment and risk for maltreatment, Garbarino and Sherman (1980) note that “those who need the most tend to be clustered together in settings that most struggled to meet those needs” (p. 194).

**The Socio-Cultural Environment**

An environmental deficits model of maltreatment also looks to the contribution of the broad socio-political environment and ideologies associated with capitalist Western society. For example, Garbarino and Hershberger (1981) assert that child maltreatment, most notably neglect, can be viewed in the context of the market-driven social order of contemporary life that creates a “collective evil” of institutional insensitivity and greed (Garbarino & Hershberger, 1981, p. 212). Garbarino and Hershberger’s 1981 article presented a radical analysis of contemporary society’s complicity in the phenomenon of child maltreatment, arguing that the security of the privileged rests on the acceptance that there will always be some people who are outside of the circle of privilege. These socially excluded families are at a higher risk for maltreatment due to the disinterest of society at large in ameliorating this inequality. In the case of neglected children, Smith and Fong (2004) note that not only are they neglected by caregivers who do not meet their basic needs, but also neglected by a society at large that turns a blind eye to their deprived condition.

Various writers have also stressed the contribution of dominant Western cultural beliefs that elevate the individual over the collective, leaving individual parents solely responsible for child rearing (Garbarino & Collins, 1999). Without a safety net of extended family and community to
assist in many cases, children are more vulnerable to maltreatment when individual caregivers are struggling to cope. In studying other cultures where a sense of collective community responsibility for children exists, scholars contend that the risk of maltreatment is diminished (Korbin, 1980). Korbin proposes that dominant Western child rearing practices represent the extreme on a cross-cultural continuum with respect to the context in which children are reared:

Children are raised more often in isolated, nuclear (or now single-parent) households. Mothers are more often isolated in their role as the exclusive caretaker. Other adults such as grandmothers or more experienced kinswomen, are less often regular participants in childrearing...Childrearing has moved towards the exclusive domain of biological parents rather than the larger community (p. 10).

As evidence for the influence of cultural norms on abuse and neglect, Korbin notes that as cultures traditionally characterized as more collectively oriented, such as New Zealand’s Maori population, experience breakdown of traditional support networks and begin to be influenced by a more Western style of child rearing, rates of child abuse and neglect are on the rise.

Critics of an environmental deficit model of maltreatment observe that environmental factors such as poverty are not a sufficient cause of neglect; for example, it is widely noted that the majority of poor families do not neglect their children (McSherry, 2004). The same criticism has been articulated with regard to any social stressor identified by the model; families living in the same toxic or socially impoverished neighbourhood, living under the same cultural norms and broad social policies may have very different outcomes with respect to child maltreatment.

Debate has also emerged regarding the direction of the relationships ascribed within the environmental deficits model. For example, while Pelton (1978) argues that harsh environmental conditions cause parental stress and impair parenting abilities, other writers have challenged this assertion. As noted previously, Crittenden (1999) questions the relationship between poverty and maltreatment, suggesting that certain parental characteristics may in fact determine both low income
and maltreatment. Seagull (as cited in Smith & Fong, 2004) contends that social isolation in families labelled neglectful is better framed as a parental deficit rather than a community problem; it is the parents’ behaviour that causes neighbours and community to distance themselves and thus social isolation is a result of parental inadequacies rather than a symptom of the neighbourhood (p. 77). Finally, many scholars have concluded that neither focus on entirely individual characteristics of parents nor broad characteristics of their environments adequately explains the phenomenon of child maltreatment (Belsky, 1993).

**Ecological/Transactional Models**

By the late 1970s, theorists in the field of child maltreatment began looking for an overarching framework that could integrate the seemingly divergent models previously put forward to explain the abuse and neglect of children. While much of the theory generation that had gone before pitted parental and environmental deficit models against each other, in 1980, Belsky sought to combine the best of each model into one coherent framework, noting that “much of the theoretical conflict that has characterized the study of child maltreatment (and has possibly even obstructed progress) is more apparent than real” (p. 320).

Based on the work of Uri Bronfenbrenner (1979), Belsky’s ecological model proposes that child maltreatment occurs as a result of the interaction of several nested systems that impact child development—the micro-, exo- and macro-systems. Belsky (1980) notes that the micro-system encompasses the child’s immediate household; the exo-system is made up of forces at work in the larger social systems in which the family is embedded; and the macro-system incorporates the over-riding cultural beliefs and values that impact the other two systems. In order to account for the individual differences that parents bring with them to the caregiving context in which their children develop (the micro-system), Belsky adds a fourth element, borrowed from the work of Tinbergen (as cited in Belsky, 1980): the notion of a parent’s own ontogenetic development as a critical force in determining how a particular parent develops a repertoire of abusive behaviours.
In 1993, Belsky revisited this model, calling it a developmental-ecological analysis; however, both iterations of the model share certain fundamental principles. First and foremost, the models contend that there are no necessary or sufficient causes of child maltreatment; multiple pathways exist to this phenomenon. Instead, maltreatment is thought to occur through a complex interaction of variables at several levels. For example, a parent who experienced poor parenting as a child, caring for an infant with a difficult temperament, exposed to social stressors such as poverty, living in a culture where child care is the sole responsibility of individual parents, may resort to child care practices that are abusive or neglectful. The model emphasizes “the potentially causative role” that each level of factors plays in child maltreatment while explicitly recognizing “their interaction in the etiology of child abuse and neglect” (Belsky, 1993, p. 330).

Scholars have added to the complexity of the original iteration of the ecological model and have attempted to map out how the combination of factors at multiple levels exert their influence. Most notably, Cicchetti and Lynch (1993), in what they term the ecological transactional developmental model of child maltreatment, added explicit reference to potentiating (risk) and compensatory (resilience) factors that exist at all levels of the environment and exert influence on the individual as well as the surrounding ecology. Their work also expands on the original ecological model by incorporating a focus on children’s developmental outcomes. Potentiating factors increase the likelihood of poor developmental outcomes, while compensatory factors reduce this risk. A temporal and propinquity dimension are layered on top of these concepts, with potentiating and compensatory factors being either transient or enduring and proximal or distal. Lynch and Cicchetti (1998) note that it is the overall balance of potentiating versus compensatory factors found within a child’s ecological context and the relative nearness and endurance of these factors that will influence a child’s developmental competence. Used to explain the phenomenon of child maltreatment, the model hypothesizes that community-level factors such as violence, social isolation, community impoverishment, and population turnover act as enduring potentiating factors that increase the risk for child maltreatment and spousal conflict in the microsystem (Lynch & Cicchetti, 1998).
In their 1998 study to test this model, Lynch and Cicchetti studied a sample of maltreated and non-maltreatment children from low income households. They found that children living in violent neighbourhoods were more likely to have been physically abused and to have experienced more severe forms of neglect than those living in low-violence neighbourhoods. Additionally, the severity of neglect combined with the experience of community violence predicted higher internalizing disorders, reports of traumatic stress, depressive symptomatology, and lower self-esteem for children. The authors interpreted these results as confirming certain tenets of the model: the interaction of potentiating, proximal experiences in the microsystem (maltreatment), combined with potentiating proximal characteristics of the ecosystem (community violence) predicted children’s developmental functioning.

Ecological-transactional models of child maltreatment built on the strengths of previous models and attempt to combine previous thought into a cohesive and comprehensive model. The model’s strength lies in its inclusion of micro through macro factors as opposed to the either/or approach of previous models. The model incorporates a broad range of smaller theories and empirical findings but it does not explicate the specific processes that lead to abuse and neglect and indeed, contends that there are multiple pathways to maltreatment. Critics have noted that explanations for why the various system levels are ecologically nested and how each affects another are not well developed—issues limiting its testability (Scannapieco & Connell-Carrick, 2005b). Further, its breadth may also be regarded as one of its limitations: with so many factors to take into account, this may have the effect of diffusing the relative importance of any one factor.

**Definitions of Poverty and Poverty Paradigms**

Drake and Rank (2009) note that poverty is an environmental stressor that has a known association with multiple negative outcomes in several domains, including health, mental health and educational achievement. While the detrimental impact of poverty on both children and adults has been well-established, scholars continue to debate the best definition and operationalization of this construct.
While some measures focus solely on available income (for example, the Low Income Cut-off Measure, or LICO), in line with a definition of poverty focusing on the level of income obtained by individual households, other measures incorporate the importance of a composite of characteristics such as occupational status and prestige, educational levels, access to services, overall well-being, and the ability to function and participate in society (Maxwell, 1999).

**Absolute Poverty versus Relative Poverty**

The work of the British sociologist Peter Townsend was instrumental in introducing the concepts of absolute versus relative poverty. The term absolute poverty is used to refer to a measure of poverty based on the ability to purchase a fixed minimum basket of goods and services (UNICEF, 2000). By contrast, the concept of relative poverty rests on the premise that poverty affects people not only through straightforward economic deprivation but also through “poverty of opportunity and expectation, of cultural and educational resources, of housing and neighbourhoods, of parental care and time, of local services and communities’ resources (UNICEF, 2010).” In the relative deprivation theory of poverty, Townsend notes that:

…individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the type of diet, participation in the activities, and have the living conditions and the amenities which are customary, or at least widely encouraged or approved in the societies to which they belong. Their resources are so seriously below those commanded by the average family that they are in effect excluded from the ordinary living patterns, customs, and activities (Townsend, 1979).

Scholars argue that the relative definition of poverty is most appropriate, particularly when thinking about child poverty in rich nations, as it takes into account the complex interaction between the economic and social dimensions of disadvantage (UNICEF, 2000).
Poverty Theory

Theories of the relationship between poverty and neglect are informed by discourse and theory about poverty. It is assumed that the extent to which child welfare professionals might consider mobilizing services that address families’ economic and material hardship alongside individually based rehabilitative treatment, is influenced by the working models they hold about why some families are poor.

There are striking similarities between the major theories regarding the etiology of child neglect and theories that seek to explain poverty. Although multiple classification systems exist for poverty theory, major theories of poverty can be organized according to the following three broad paradigms.

1. **Individual Pathology**—theories that hold individuals responsible for their impoverishment due to personal deficits such as laziness, immorality, and low intelligence (Hernstein & Murray, 1994; Kerbo, 1996). There is a related sub-theory developed by the anthropologist Oscar Lewis that proposes a culture of poverty—one that values the skills associated with “working the system” rather than gaining employment—that is transmitted from one generation of poor people to the next (Lewis, 1966; Rafter, 1998).

2. **Structural Inequality**—theory that explains poverty as a by-product of the society in which it occurs. For example, class-based explanations situate poverty in the context of a capitalist, free-market economy and the need to maintain an army of surplus (unemployed) labourers to keep wages low (Rank, Hong-Sik, & Hirschl, 2003). Explanations rooted in inequality note that discrimination based on race, class, gender, and other differences provides inequitable opportunities and perpetuates disadvantage (Bradshaw, 2006);

3. **Cumulative and Cyclical Interdependencies**—theory that positions poverty as caused by cumulative interaction of factors at an individual, community, and societal level, creating and recreating a spiral of disadvantage for the poor (Bradshaw, 2006). This theory proposes that
community and individual well-being are closely linked, with communities that are thriving (i.e.,
good education and employment opportunities) leading to increased well-being for individuals
compared to communities with limited opportunities. The theory incorporates an explanation for
the intergenerational nature of poverty, noting that

…the cycle of poverty means that people who lack ample income fail to invest in their
children's education. Their children do not learn as well in poor quality schools, they fall
further behind when they seek employment, and they are vulnerable to illness and poor
medical care. (Bradshaw, 2006, p. 20)

How child welfare workers conceptualize the role of poverty in child neglect is impacted by
whichever of these discourses is privileged when thinking about why clients are poor.

**Theoretical Framework for the Dissertation**

The ecological model provides a helpful framework for understanding child neglect, and provides
the theoretical basis for this dissertation. In particular, the ecological model moves thinking beyond
the question of “is it psychopathology or is it poverty” (Giovannoni, 1982) to a position that says it
could be either, or the interaction of both. Although a great deal of discussion has focused on which
of these two approaches—personality or poverty—should drive thinking about the causes of and
intervention in cases of neglect, Chambers and Potter (2009) note the importance of moving beyond
this debate “to an understanding that these two sets of risk factors are inextricably linked for a subset
of families” (p. 25). Ecological theory has guided the selection of variables in the current research
and, through its inclusion of micro through macro factors, provides the theoretical rationale for
examining in depth the role of poverty in cases of neglect. The definition of neglect proposed by
Dubowitz et al. (2003), that neglect occurs whenever children’s needs go unmet regardless of cause,
is consistent with the ecological approach of the research. The focus on children’s needs irrespective
of cause can be placed within a framework of children’s rights as rights-based definitions “push the
boundaries to encompass social and environmental harm because from a child’s perspectives these can be indistinguishable” (Reading et al., 2009, p. 333).

**Poverty: Micro- or Macro-System?**

As Spencer and Baldwin (2005) state: “societies, through social, economic, and educational policies, can be supportive or neglectful of children, providing an environment in which the capacity of families to care for their children is either strengthened or undermined” (p. 26). Although issues related to poverty, a central concern of this study, are measured at the family (micro) level, it is the explicit premise of this research that family poverty is, in part, a reflection of the extent to which Canada, through its elected federal and provincial governments, prioritizes social and economic policies that ameliorate poverty and income inequality. With a child poverty rate of over 15% nation-wide — a rate which is over 40% for children living in lone female-led households and Aboriginal children living off-reserve—Canada has made a “policy choice” (Reading et al., 2009, p. 334) demonstrating an acceptance of child poverty, often concentrated among certain marginalized groups, in an otherwise rich nation.

**The Need for a Social Justice Orientation**

Despite widespread support for an ecological model of child neglect in the literature (Garbarino & Collins, 1999) and in social work education more generally (Farley, Smith, Boyle, & Ronnau, 2002), scholars have noted that, in practice, there is a tendency for social workers to individualize and pathologize social problems (Saleeby, 2001). This is well illustrated by the following warning about the pitfalls of applying an ecological model to the problem of child maltreatment:

> The challenge when working with individual families from an ecological perspective is to maintain a clear focus on the individual. It is possible to lose sight of individual accountability for behaviour when environmental and systemic factors are incorporated

21 Calculated using the international low-income measure after tax.
into the analysis. Yet when children are abused, there is always an identified perpetrator who is responsible for the harm that results. (Sparks, 2001, p. 2)

Keddell’s (2011) account of social workers is slightly more generous, but nonetheless underscores the tendency towards an individualized approach to the problem of child maltreatment. In her qualitative study of child welfare decision-making, she asked the 19 workers in her sample to identify the “causes of [their] clients’ problems” (p. 1260). She notes that while workers took pains to avoid blaming clients and constructed them in a sympathetic light, most mentioned individual psychological issues, creating a psychological discourse that ignored macro-level factors such as poverty, gender issues, or discrimination. Keddell states that this was “despite the fact that in 17 out of 19 [cases] the clients were single women parenting with very limited material supports” (p. 1261).

Several writers have attempted to understand the field’s struggle to consistently and enthusiastically take up an approach that moves away from a singular focus on individual parents. Specht and Courtney (1995) argue that social workers represent “unfaithful angels”, many of whom have abandoned the social justice roots of social work in favour of individual-based interventions such as psychotherapy, associated with the more accepted and prestigious disciplines of psychology and psychiatry. Similarly, Swift (1995b) notes that social work’s values (the redress of social inequity) are at odds with its knowledge base, borrowed from diverse disciplines including sociology, psychology, medicine, and law, with varying levels of commitment to social-structural issues. Speaking specifically of child welfare, Lessard (2002) highlights the influence of the dominant ideologies that shape social policy, noting that classic liberal and neo-liberal values of contemporary society, including individualism and self-reliance have framed the intervention of the State into family life as negative. Thus the child welfare system is positioned as being responsible for addressing failed or deviant parents rather than providing support for families in need (Sandau-Beckler, Salcido, Beckler, Mannes, & Beck, 2002), an orientation that puts it at odds with an approach to neglect that moves beyond individual problems.
The current research is premised on the notion that although the ecological model provides a helpful context for understanding and intervening in cases of child neglect, it must be embedded within a framework of social justice. This focus will act to shore up the ecological model’s inclusion of the micro through macro levels, and ensure that questions of social inequality remain in the foreground, even when looking at factors at the micro level. A structural or social justice analysis requires an understanding of how demographic characteristics such as gender, race and socio-economic status are not simply individual factors but have implications for how people are treated and perceived by society and the opportunities available to them (Inhorn & Whittle, 2001). Without a clear commitment to these issues, an ecological theory of neglect becomes diluted and runs the risk of becoming just another way of reinforcing the focus on individual parents and children, as those variables most proximal to individuals are hypothesized to have the strongest effects and have been the overwhelming focus of research on neglect (Stith et al., 2009) and of child welfare intervention.

The use of a social justice framework has been applied in other fields, such as health and education, in which scholars have noted the importance of social location (i.e., race, class, gender, ability, etc.) in determining outcomes (Cochran-Smith, 2008; Link & Phelan, 1995; Wilkinson, 1996). In particular, Link and Phelan elegantly note the need to focus not only on health risks (e.g., smoking, poor diet, high cholesterol, limited exercise), but also the imperative to understand what places people at “risk of risk” (p. 80) such as poverty and lack of access to health services. This approach is particularly applicable to the child welfare context in which risk is considered a “first order construct…one within which all other constructs become organised and processed” (Keddell, 2011, p. 1254). Without attention to the underlying reasons for the unequal distribution of child neglect risk factors across society, social workers cannot take the opportunity to locate these issues within clients’ shared histories of oppression and/or discrimination, which further conceals the possibility of societal change as an avenue for intervention. Lack of understanding of the context which places clients at risk of risk increases the likelihood that people’s problems are viewed as the
consequence of individual deficits and that by default, an individual approach is the only one used to understand and address clients’ concerns.

Using health as an example, scholars explicitly note that a social justice approach to health not only acknowledges that social inequality produces health inequality, but that an important solution to this inequality lies in the creation of policies that reduce social and economic inequity (Wade & Cairney, 2006). To this end, many authors note that a social justice approach to social problems represents both a way of seeing and acting. In other words, while most research is designed to document rather than to alter inequities (Boutain, 2005), Cochran-Smith states that a social justice approach to any research involves “deliberately claiming the role of advocate and activist” (Cochran-Smith, 2002, p. 18). It mandates that research (and the uses to which it is put) actively seeks to promote the strengthening of people, communities, and economic change. The use of a social justice lens for the problem of child neglect is consistent with a children’s rights perspective, which stipulates that children’s rights of “provision and participation are as important as rights of protection” (Reading et al., 2009, p. 332) and acknowledges that violation of these rights can be as a result of neglect and/or exploitation by individuals, institutions, or society.
Chapter 4: Review of the Research Literature

This chapter presents a review of the research literature examining the ecological correlates of child neglect, including those at the child, caregiver, household, community, and societal levels. Particular attention is paid to the literature that explores the contribution of both poverty and individual clinical concerns such as mental health and addictions. As one objective of this dissertation is to understand the relative contribution of poverty to three specific case dispositions—substantiation, ongoing services, and child placement—literature related to decision-making in child welfare is also reviewed. Further, as this dissertation explores whether cases of neglect can be classified using subtypes based on different constellations of clinical and poverty-related need, previous studies that have empirically classified cases of neglect are also considered. The chapter concludes with a discussion of the limitations of previous research and suggestions for future study.

Ecological Correlates of Neglect

This section of the chapter will examine the research exploring the correlates of neglect at multiple levels, including characteristics of individual caregivers and children, households, neighbourhoods and communities, and the broader socio-political environment in which children and families are embedded. While this section attempts to highlight a broad cross-section of variables studied in the research literature, it is not exhaustive. Some variables are given more attention than others due to the scope of the research and the strength of the association (e.g., caregiver substance abuse and mental health problems) or as a result of their centrality to the study’s objectives (e.g., poverty).

Caregiver Correlates

By far the most extensive body of literature regarding the correlates of neglect focuses on individual caregiver problems or characteristics, particularly those of mothers. Studies have found a myriad of caregiver risk factors in families where neglect is a concern, including: mental health problems (Carter
& Myers, 2007; Schumacher, Smith Slep, & Heyman, 2001); substance abuse; Dore, 1998; Curtis & McCullough, 1995); criminal activity (Christofferson, 2000); limited educational achievement (Nelson, Saunders, & Lansman, 1993); single parent status (Jones & McCurdy, 1992; Zuravin & Grief, 1989); young maternal age (Sidebothom & Golding, 2001); and a history of maltreatment as a child (Newcombe & Locke, 2001). Studies vary in methods, in particular how samples are selected and which control groups, if any, are used; however, most studies draw their data from child protection caseloads, a limitation that will be discussed further in this section.

Caregiver Age

Young maternal age is theorized to influence the risk of child neglect through several possible pathways. For example, young mothers are often single, poor, and poorly educated, making young parenthood associated with several other known risk factors for maltreatment. Research suggests that young mothers possess less knowledge of children and their developmental needs compared to older mothers (Osofsky, Hann, & Peebles, 1993). For women who become mothers in their teens, many are still attending to the developmental tasks of adolescence, which may contribute to difficulties in taking on the complex role and tasks associated with motherhood (Noria, 2005).

In their 1999 study, Lee and Goerge (1999) studied the relationship between child maltreatment (including physical and sexual abuse and neglect), early child bearing, and poverty using data collected through the Illinois Integrated Database of Children and Family Services along with Illinois birth certificate records. They found that both maternal age and poverty contributed individually to the chances that a child would be maltreated (evidenced by a substantiated report to child protection services); however, they note that when young maternal age was combined with poverty, the chances of maltreatment increased substantially compared to cases where only one or the other of these risk factors was present. Similar effects were found for both neglect and abuse. The interaction between poverty and young maternal age was also supported by Drake and Pandey (1996). Their study of the community correlates of maltreatment noted that in poor areas, children born to mothers 17 years or
younger were 17 times more likely to be the subject of a substantiated neglect investigation compared to children born to mothers 22 years or older.

**Caregiver Sex**

Research examining the contribution of caregiver gender to the risk of neglect is complicated by the fact that mothers are usually the primary (and sometimes, only) caregivers for children; thus it is not surprising that women are identified as perpetrators of neglect at a significantly higher rate than men. Palacio-Quintin and Ethier (1993) note that even though fathers are not usually the primary caregivers, they have both a direct and indirect influence on the care provided to children through their support of mothers emotionally and financially— influences that are often overlooked and unmeasured in the neglect literature. Notable exceptions are studies by Dubowitz, Dufour, and their colleagues (Dubowitz, 2006; Dubowitz, Black, Kerr, Starr, & Harrington, 2000; Dufour, Lavergne, Larrivee, & Trocmé, 2007), which look specifically at the contribution of fathers to the neglect context.

Dubowitz et al. (2000) found that the presence of a father or father figure decreased the likelihood of neglect when the relationship with the mother had endured for a longer period of time, when fathers were less involved in household chores and caregiving, and when their sense of parental self-efficacy was higher. The finding that less involved fathers decreased the risk of neglect was counter-intuitive and led the authors to hypothesize that the lesser assistance provided by these fathers in the home may have been associated with increased involvement in paid work, bringing valuable economic resources to the household and thereby reducing the risk of neglect.

The almost exclusive focus of child welfare services on mothers has been critiqued by several authors (D’Cruz, 2002; Dubowitz, 2006; Strega et al., 2008; Swift, 1995a), with many writers noting
both the positive contribution of fathers and father figures in the care of children and the simultaneous need to hold some men accountable for their absence as a form of neglect (Walmsley, no date).

**Caregiver Substance Abuse**

Smith and Fong (2005) note the high prevalence of caregiver substance abuse among parents involved in child welfare services. American studies have placed the proportion of child welfare clients who abuse substances as anywhere between 50% and 80% (Austin & Osterling, 2006). Its particular relationship with neglect is multi-faceted. For example, Kearney, Murphy, and Rosenbaum (1994) note that substance abuse by caregivers places children at risk for neglect through impaired decision-making and inattention due to drug or alcohol use and also as a result of the drain on family financial resources. Dore (1998) also theorizes that substance abuse affects parenting through the creation of a child rearing context characterized by caregivers’ limited social supports from healthy relationships; for example she notes that many substance abusing caregivers associate with other users and for mothers who abuse drugs or alcohol, there is an increased likelihood that their partners will also be addicts. While much of the literature regarding substance use and child maltreatment focuses on mothers, Smith and Fong (2004) contend that fathers are equally likely to abuse substances and contribute to a neglectful family environment. This is corroborated by the findings of Dufour et al. (2007) which noted no significant differences between rates of alcohol abuse and drug/solvent abuse for mothers and fathers/father figures in families labelled as neglectful.

There is evidence in the literature for the higher incidence of substance use among neglectful families compared to non-neglecting controls. Carter and Myers (2007) analysed data from 431 open child protection cases with allegations of physical neglect (defined as failure to provide food, clothing, shelter, and/or hygiene), drawn from the National Study of Protective, Preventive, and Reunification Services Delivered to Children and their Families, a nationally representative American study. When controlling for poverty-related variables, these authors found that families were more than twice as likely to be substantiated for physical neglect when the primary caregiver
struggled with substance abuse issues. Although the gender breakdown of primary caregivers is not provided in this study, it can be inferred that the majority of the caregivers studied were female.

In their prospective study, Chaffin, Kelleher, and Hollenberg (1996) used data from Waves I and II of the National Institute for Mental Health's Epidemiological Catchment Area survey. Focusing on the 7,103 parents (both male and female) who did not report any abusive or neglectful parenting at Wave I, researchers followed these caregivers for one year to determine the risk factors associated with new reports of maltreatment at Wave II. Findings indicated that substance abuse was a strong predictor of neglect, with parents who abused substances over three times more likely to neglect their children than parents who did not abuse substances (Chaffin, Kelleher, & Hollenberg, 1996). Although a strength of this study was the use of a non-child welfare sample (i.e., it was not limited to cases reported to child welfare authorities), a potential concern is the fact that the measure of neglectful caregiving relied on parental self-endorsement of four items, including leaving young children alone for extended periods of time, providing inadequate food or care, and having a health care professional suggest that a child was neglected, potentially biasing responses due to social desirability.

Parental substance abuse not only differentiates neglectful families from non-neglectful families; in some studies it is also a stronger indicator of neglect compared to other forms of maltreatment. For example, in their Canadian study comparing neglectful families to those in which another form of maltreatment (i.e., physical, sexual, or emotional abuse) was predominant, Mayer, Lavergne, Tourigny, and Wright (2007) found that neglectful families were more than three times as likely to have a parent for whom substance abuse was an issue. This marker (substance abuse by either parent) was second only to young child age in distinguishing neglected children from abused children in their sample. Similarly, using provincially representative data from the 2003 Ontario Incidence Study of Reported Child Abuse and Neglect (OIS-2003), researchers found that cases substantiated for primary neglect22 were significantly more likely to have a caregiver suffering from

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22 Primary neglect cases are those in which neglect was the predominant form of maltreatment substantiated, as assessed by the investigating case worker. Cases of primary neglect may also have other maltreatment concerns.
an alcohol or drug/solvent problem than cases in which another form of maltreatment was the primary substantiated concern (Schumaker, Fallon, & Trocmé, 2011).

**Caregiver Mental Health Problems**

Caregiver mental health problems have also been well-documented in cases of child neglect. It has been proposed that mental health issues may act to compromise caregiving in a number of ways, including affecting caregivers’ abilities to receive and understand cues from children about their needs, and their ability and motivation to respond appropriately to these needs (Leschied, Chiodo, Whitehead, & Hurley, 2002). As mothers are most often the sole or primary caregivers for young children and even more so in child welfare samples (Wolfe, 1999), the vast majority of research on mental health and neglect of young children has focused on mothers. Maternal mental health problems in particular have been cited as a risk factor for neglect due to the barrier they may present to mother-infant attachment. Observational studies of depressed mothers have identified impairments in their interactions with their babies, characterized by fewer vocalizations and child-centred exchanges and less mobility of expression (Foreman, 1998).

Several studies of maternal mental health and neglect have focused on the personality disorders of mothers considered neglectful. Polansky et al.’s (1981) research of poor white mothers in the Appalachian Mountains describes them as “infantile or narcissistic,” characterized by a high level of impulsivity and an inability to consider the needs of others. These findings are similar to those of Friedrich, Tyler, and Clark (1985), who compared the personality characteristics of low-income abusive, neglectful, and control-group mothers. These writers concluded that of the three groups, neglectful mothers were the most “pathological.” Compared specifically to the abusive mothers, they note that neglectful mothers were “more dysfunctional…, less socialized, more angry, more impulsive…” (p. 453). Although personalities of mothers have been excessively scrutinized, there is only a small body of literature that examines the influence of paternal personality disorders on neglect. Sharma (2008) notes that paternal anti-social personalities increased the risk of neglect,
whereas results from Stewart, Mezzich, and Day’s (2006) study found that paternal psychopathology was not a significant correlate of neglect of 10- to 12-year-olds.

Many studies do not specify the nature of the mental health problems faced by the parents of neglected children, collapsing all issues into one general category (e.g., Mayer et al., 2007; Schumaker et al., 2011). Those studies that focus on a single mental health issue have most frequently targeted maternal depression, possibly due to the fact that depression is more common among mothers in child welfare samples than other cognitive or affective disorders such as bipolar disorder or schizophrenia (Wolfe, 1999). Psychiatric research has often concluded that depressed mothers are “more likely to be hostile, rejecting, and indifferent toward their children and to be neglectful especially with respect to feeding and supervision” (Gaudin, 1993). One study by Zuravin and Grief (1989) compared 281 non-maltreating mothers to 237 mothers with a history of maltreating their children, all of whom were receiving Aid to Families with Dependent Children (AFDC) benefits. Results indicated a significant relationship between maternal depression and neglect. In more recent research, Khol and Kogotho (2011) studied a sample of 1,536 mothers and their children aged three to 10 years referred to child welfare services using National Survey of Child and Adolescent Well-Being data (a nationally representative American dataset). The association between maternal depression and specific parenting practices (emotional maltreatment, neglect, and harsh parenting) was studied over a 36-month follow-up period after the initial child protection investigation. Findings indicated that depression remained high across time periods and was significantly associated with both emotionally maltreating and neglectful parenting.

Caregiver mental health problems have also been suggested as a predictor of neglect cases compared to cases of other maltreatment. Carter and Myers’ (2007) study comparing substantiated and unsubstantiated neglect referrals found that substantiated cases of neglect were almost twice as likely to have a primary caregiver suffering from a mental health problem. Comparing neglected children to children for whom another form of maltreatment was predominant, Mayer et al. (2007) found in bivariate analyses that neglected children were almost twice as likely to have a caregiver
with mental health problems, although mental health problems were strongly associated with other parental personal issues (e.g., history of maltreatment, substance abuse) and as a result, was not retained as a variable in their multivariate analysis. In their Ontario study, Schumaker et al. (2011) found no significant differences in the proportion of families with caregiver mental health problems among cases of primary neglect (29% of families) compared to cases where another form of maltreatment was the primary substantiated issue (28% of families).

**Caregiver History of Maltreatment**

The intergenerational theory of maltreatment has been widely accepted by the field. Based on both attachment and social learning theory, scholars posit that poor parenting, either through abuse or neglect, deprives children of necessary security in relationships, leaves critical needs unmet, or simply supplies inappropriate parenting models that lead to repeated poor parenting when these children become parents themselves. Looking at the issue of maltreatment broadly, Gil (1971) estimated that 7% of parents who experienced maltreatment as children would grow up to become perpetrators themselves. Hunter and Kilstrom (1979) conducted an experimentally controlled prospective study following mothers of 282 premature babies for 12 months. They noted that of the 49 mothers who had initially disclosed a childhood history of maltreatment, nine (18%) had been reported to child welfare authorities for maltreatment at the end of the follow-up year, compared to just one of the 233 who did not identify being maltreated as a child. Summarizing three prospective studies, Kaufman and Zigler (1987) identify the rate of intergenerational transfer as approximately 30%. Studies of intergenerational transmission rates differ in their samples and design, with prospective studies generally reporting much lower rates of intergenerational transfer of maltreatment compared to retrospective studies.

Newcomb and Locke (2001) note that the notion of intergenerational transmission of child maltreatment, while popular in theory, has been plagued with controversy. In part, this is due to the methodological limitations of previous studies that have used predominantly CAS
samples, dichotomous measures of maltreatment, and have failed to distinguish between different maltreatment typologies, both as predictors and outcomes (Newcomb & Locke, 2001). In their 2001 study, these writers addressed previously identified methodological limitations through the use of a community sample of 383 parents, measuring both history of maltreatment (through the Child Trauma Questionnaire) and current parenting practices (using the Parental Acceptance and Rejection Questionnaire) with reliable and valid continuous measures. The authors employed structural equation modeling to understand the general effect of child maltreatment history on broad parenting outcomes; they also looked specifically at history of neglect compared to history of physical or sexual abuse on parenting practices. They concluded that for mothers, a family history of neglect was strongly associated with current poor parenting, which was in turn associated with rejecting and neglecting tendencies and a lack of warmth. With fathers, a history of sexual abuse had a direct relationship with parenting characterized as rejecting and was indirectly associated with neglect and a lack of warmth. This study did not produce a transmission rate as do many other studies, with the authors instead focusing on “a relatively neglected area of research” including the pathways between childhood history of maltreatment and subsequent parenting style (p. 1223).

**Caregiver Cognitive Impairment**

Adults with intellectual disabilities are a relatively uncommon phenomenon, estimated at approximately 1% of the population, and yet an estimated 10% of families in Canada investigated by child welfare services have at least one caregiver identified as cognitively impaired (McConnell, Feldman, Aunos, & Prasad, 2011). Similar overrepresentation has been noted in England and Australia (McConnell, Llewellyn, & Ferranato, 2003). The pathway through which intellectual disability influences caregiving are not clearly articulated, although one study noted that mothers with intellectual disabilities were found to have significantly higher levels of parenting stress compared to a normative sample, along with lower levels of social supports; in this study, mothers’
satisfaction with their support was significantly correlated with positive parent-child interactions (Feldman, Varghese, Ramsay, & Rajska, 2002).

Although several studies have documented that parental cognitive impairment is associated with parenting deficiencies that often result in child protection referrals, a large body of research suggests it is most closely associated with neglect and adverse developmental outcomes rather than abuse (Feldman, Leger, & Walton-Allen, 1997). For example, in their study of 12 cases before a Children's Court Clinic in Australia, all of which involved a mother with an identified intellectual disability, Glaun and Brown (1999) found that neglect rather than abuse was more often the alleged form of maltreatment. However, several studies note that factors such as IQ alone do not account for the majority of variance in parenting difficulties; many studies of parents with intellectual disabilities stress the interaction between cognitive impairment, social isolation, poverty, and stigmatization, among other social factors, which creates a cumulative risk context for poor parenting.

**Child Level Correlates**

The study of child factors that might contribute to maltreatment outcomes is controversial, with some writers concerned about blaming the child victim for his/her own maltreatment. However, research into these factors often stresses of the reciprocal nature of parent-child interaction, with certain child characteristics leading to increased caregiving demands, making some children more difficult to care for than others.

**Child Age**

Several studies have indicated that younger children are more likely to experience maltreatment (particularly physical abuse and neglect) than older children (Powers & Eckenrode, 1988; U.S. Department of Health and Human Services, 2005). In the case of neglect, younger children generally require more care and are more dependent on adults for basic necessities, making them particularly vulnerable to poor outcomes when parents are unable to meet their needs. Sedlak and Broadhurst
(1996) note that children older than six are more likely to be harmed by emotional neglect. Carter and Myers (2007) cite recent data from the U.S. Department of Health and Human Services that indicate that children under the age of three have an increased chance of neglect. This is supported by analysis of 2006 NCANDS data that illustrates that infants (children under one year of age) have an incidence rate for neglect of just over 12 per 1,000, higher than any other single year age category and more than double the rate for the next highest category, one-year-olds (Wulczyn, 2009). The same data demonstrate that the rate of neglect for infants is nearly 12 times greater than the rate of physical abuse and that the age disparities for physical abuse were nowhere near as pronounced as for neglect, making age a significant factor in the likelihood of neglect, but not abuse (Wulczyn, 2009).

**Child Sex**

While several studies have looked at the effect of child sex as a risk factor for different forms of abuse (e.g., sexual abuse, physical abuse) only a few studies have examined the relationship between child sex and neglect (see for example Bolger & Patterson, 2001; DiLalla & Crittenden, 1990) and they found no association. Lending credence to this, a recent meta-analysis of the literature points to an insignificant effect size for this relationship (Stith et al., 2009). However, studies not included in this meta-analysis conducted on non-North American samples have revealed some interesting findings. For example, the International Centre for Research on Women analysed a sample of 50,136 never-married women in rural India. The study looked at differential health outcomes for boys versus girls, including the rate of severe stunting (defined as a World Health Organization standard of height-for-age that is an indicator of sustained nutritional neglect) and level of immunization. Results indicated that by age five, 6% more girls than boys are severely stunted and 13% more girls are unvaccinated. Findings also showed that the risk of neglect is significantly increased for girls who live in families with two or more older sisters. The authors conclude that due to the widespread gender preference for boys in Indian culture, girls are far more likely to suffer neglect if they are the last in a series of daughters, than if they are born into families who already have sons (Pande &
Malhotra, 2006). Results of this study suggest an interaction between gender and culture (i.e., girls are at greater risk of neglect in cultures where males are the preferred gender for children).

**Child Behaviour/Temperament**

Horwath (2007) notes that children who are difficult to parent due to temperament or behaviour may be more likely to experience neglect. Several studies have noted a link between children’s externalizing behaviours (e.g., aggression, hyperactivity, oppositional behaviours) and neglect. For example, Bousha and Twentyman (1984) observed three groups of mothers and children in their homes: mothers with a history of abusive parenting; mothers with a history of neglectful parenting; and mothers with no known history of maltreatment of children. The authors noted high levels of aggressive behaviours among both the maltreated groups compared to controls. However, given that this study collected data on child behaviours following known maltreatment, it is not clear whether children’s behaviours were a risk factor or an outcome of abuse and/or neglect. Similarly, de Paul and Arruaberrena (1995) studied abused, neglected, and non-maltreated children in Spain. Using the Teacher’s Report Form from the Child Behaviours Checklist, they found that neglected children scored higher than both their abused counterparts and non-maltreated controls on the externalizing scale. Again, findings are difficult to interpret given that behaviour was not measured prior to the experience of maltreatment. In their 2002 study, Dubowitz, Papas, Black, and Starr studied outcomes in a group of 136 high-risk urban preschoolers and their primary caregivers using a prospective, longitudinal design. They found that mother’s report of a difficult child temperament was a predictor of emotional but not other forms of neglect.

**Child Health/Special Needs**

Children’s health status and the presence of special needs have been cited as a possible contributing factors to neglect, perhaps due to increased attention required by these children (Wulczyn, 2009) and the fact that their needs may overwhelm parents without adequate resources (Horwath, 2007).
In a 2004 study, researchers examined both maternal socio-demographic and infant perinatal risk factors for maltreatment in a sample of 189,055 children born in Florida in 1996. Findings noted that low birth weight infants had a relative risk rating for maltreatment that was two times the population average (Wu et al., 2004). Expanding on theories of parental investment, Mann (1992) explored the relationship between high risk infants (those with “adverse” congenital, pre-natal, or perinatal conditions) and the risk of neglect. She posited that infants who are medically fragile are at increased risk of neglect due to selective parental investment processes that pressure mothers to invest more in the most viable offspring.

Sullivan and Knutson (2000) studied 40,211 children enrolled in the public and Catholic school systems in Omaha, Nebraska—3,262 of whom were enrolled in a special educational program due to an educationally relevant diagnosed disability (e.g., autism, speech/language disorder, mental retardation, behavioural disorder, mental health problem). Although the rate of maltreatment was approximately 11% in the sample as a whole, the authors noted that the rate was 3.4 times higher for children with disabilities than for non-disabled peers. Additionally, their study noted that while neglect was the most common category of maltreatment experienced by these children, they were more likely than their non-disabled counterparts to experience multiple forms of maltreatment across numerous episodes (Sullivan & Knutson, 2000).

**Households/Families**

**Family Income**

Research has demonstrated a strong relationship between poverty and neglect, compared to both non-neglected and maltreated controls. In 1979, Wolock and Horowitz studied a sample of mothers in receipt of Aid to Families with Dependent Children in New Jersey, 380 of whom were known to the public child welfare agency (predominantly for reasons of neglect) and 144 of whom had no history of child welfare involvement. Results indicated that while both groups experienced a
high level of poverty, the maltreating group lived in the most materially deprived circumstances, making neglect most prevalent among the “poorest of the poor” (p. 175). Using data from the third National Incidence Study of Child Abuse and Neglect, Sedlack and Broadhurst (1996) compared the incidence of neglect in families with an income of at least $30,000 to those with an income below $15,000. Children in the lower income households had odds four times higher for experiencing abuse and odds more than 12 times higher for experiencing neglect than those in higher earning households; thus while poverty can be said to be a strong correlate of both abuse and neglect, it is more closely associated with neglect (Sedlack & Broadhurst, 1996).

As noted in Chapter 3 (Analysis of Theoretical Perspectives), some scholars have proposed that the relationship between low income and neglect found in child welfare samples is confounded through a series of class-related biases in labelling and reporting neglect. Although a review of the relevant literature conducted by Drake and Zuravin (1998) revealed no evidence for a pervasive class-related bias in labelling and reporting maltreatment, concern about this issue persists. In a recent (2009) study, Jonson-Reid, Drake, and Khol further examined whether overrepresentation of poor families on child welfare caseloads was as a result of bias or need. Using data from multiple sources, including child welfare administrative data, hospitals, mental health services, and courts, researchers followed three groups of children and families from initial report to child welfare authorities (occurring between 1993 and 1994) through to mid-2006 in a large Midwestern U.S. city. Groups consisted of poor (AFDC recipient) families referred to child welfare, non-poor (non AFDC recipient) families referred to child welfare, and poor families not referred to child welfare.

Researchers hypothesized that if a substantial poverty bias was at play, they would find a higher rate of parental concerns and poorer child outcomes over the longer term in non-poor families, as the threshold for non-poor families to enter child welfare should be higher. They further hypothesized that the severity of reported maltreatment for non-poor families should be higher for the same reasons. Finally, researchers proposed that if substantial class bias exists, then children in poor reported families should have only small, if any, differences in outcomes from poor non-
reported families. Findings did not support any of these hypotheses, with data suggesting that poor children presented with higher levels of caregiver risk factors and reports of more serious maltreatment concerns compared to their non-poor referred counterparts. Poor children also had higher rates of recurrence of maltreatment (64%) compared to non-poor children (33%). Further, results indicated that there were significant differences in longer term outcomes between the poor reported children compared to the poor non-reported children, with reported children having twice the risk or greater for a series of caregiver mental health and child-related outcomes, such as involvement in criminal activity, mental health services, injuries (both accidental and non-accidental), and teen pregnancy. Researchers concluded that the data “uniformly argue against the presence of large amounts of [class-based] bias” (p. 426) and in fact suggest that poor families must display higher levels of need before child welfare authorities become involved.

**Family Structure**

Several studies have examined the relationship of family structure to child neglect, with most concluding that single, female-led households are more at-risk than other family configurations (Martin & Walters, 1982). Using data from the 2003 Ontario Incidence Study, Schumaker et al. (2011) noted that a higher proportion of families where neglect was the predominant concern were single female led (46%) compared to those where another form of maltreatment was predominant (36%). Similarly, Mayer et al. (2007) noted a higher percentage of lone parent families in cases of neglect (44.5%), compared to cases of other maltreatment (32.7%). Lone parent status, particularly single female-led households, which comprise the vast majority of single parent households in child welfare samples (Trocmé et al., 2005), may be a proxy measure for poverty given the relationship between single mothers and low income in Canada (Hunter, 2010).
Number of Children

Some studies have noted that the number of siblings living in the home is a risk factor for neglect, with larger sibling groups posing greater risk (Martin & Walters, 1982; Sedlack & Broadhurst, 1996; Zuravin, 1988). Data from the 2003 cycle of the Ontario Incidence Study of Reported Abuse and Neglect (OIS-2003) also demonstrate that a significantly higher number of children in cases of primary neglect are living in households with four or more children (21%) compared to children in cases where another form of maltreatment in the predominant reason for substantiation (13%) (Schumaker et al., 2011). These findings are similar to Mayer et al. (2007) who found that for substantiated investigations of Quebec families, the relationship between family size and neglect was linear: the greater the number of children in the household, the more likely a child was to have experienced neglect as opposed to another form of maltreatment.

Presence of Domestic Violence

Domestic violence has often been cited as a factor in cases of child neglect. Shepard and Raschick (1999) surveyed child protection workers to understand how they assessed and intervened in cases of domestic violence. Using a sample of 95 child protection cases opened in 1996 in South St. Louis County (United States), workers identified that of the cases involving child neglect, 35% also involved concerns regarding domestic violence. Using a much larger sample, Antle et al. (2007) analysed all cases investigated for child neglect in 1999 in a single county in Kentucky, United States. They found a rate of co-morbidity between domestic violence and child neglect of 29%. Further, findings from this study noted a significant correlation between the level of severity of neglect and the presence of domestic violence, with more severe cases of neglect more likely to co-occur with domestic violence. A recent longitudinal study conducted in the United States followed 2,544 families who were part of a preventative program for at-risk families. Findings from this study indicated that after a five-year period, substantiated neglect was twice as likely in families where domestic violence was also present (McGuigan & Pratt, 2001).
Family Cultural Heritage: Aboriginal Families

Data from the First Nations component of the CIS-2008 (Kiskisik Awasiak: Remember the Children, Understanding the Overrepresentation of First Nations Children in the Child Welfare System) indicate that Aboriginal children have a significantly increased likelihood of neglect compared to their non-Aboriginal counterparts. The incidence of substantiated neglect among Aboriginal children is eight times higher: 27.7 per 1,000 compared to a rate of 3.5 per 1,000 for non-Aboriginals (Sinha et al., 2011). This overrepresentation was apparent in the data collected through the CIS-2003 as well, which indicated a rate of neglect for Aboriginal children of over 17 per 1,000 compared to 3.5 per 1,000 for their non-Aboriginal peers (Trocmé et al., 2006).

Research that has attempted to understand this heightened risk of neglect for Aboriginal children has identified three factors that drive the overrepresentation of Aboriginal children in cases of neglect: poverty; inadequate housing; and substance misuse (Trocmé, Knoke, & Blackstock, 2004; Trocmé et al., 2006). Several authors have argued that Aboriginal overrepresentation for neglect is associated with environmental and structural risks that should be addressed through culturally based child welfare interventions that target these risks, along with support for Aboriginally driven socio-economic development (Blackstock, 2003). Aboriginal status of the family may also act as a proxy indicator for factors better situated at the broad socio-political-cultural level, including issues of racism, discrimination, and colonialism.

Neighbourhoods/Communities

Daro and Dodge (2009) note that over the last 10 years, a growing body of research has focused on measuring and describing the ways in which neighbourhoods influence children’s developmental outcomes and support caregivers in their parenting role. A recent summary of this research concluded that neighbourhoods are indeed influential, both directly through the provision and quality of schools, parks, and other primary supports and indirectly, through the shaping of parental attitudes and behaviors and their impact on a parent’s self-esteem.
Garbarino (1976) and Garbarino and Crouter (1978) identified several community level correlates of maltreatment. In particular, they noted the association between neglect and the percentage of families in the community with the following characteristics: low income; female-led households; parents have not graduated from high school; and frequent moves. In their 1980 study (described in more detail in Chapter 3), Garbarino and Sherman concluded that the strength of the human ecology of the neighbourhood was an important determining factor of maltreatment rates in two otherwise similar communities, based on socio-economic status. The community with higher maltreatment rates was less socially integrated and inhabitants reported more stressful daily life events and less positive experience with neighbours (Garbarino & Sherman, 1980).

In later research, Garbarino and Kostelny (1992) examined 77 communities in the Chicago area and identified four communities for study: two with lower than expected and two with higher than expected rates of maltreatment based on the socio-demographics of the neighbourhoods. Using data from 1980, 1982, and 1986, the authors noted that two neighbourhoods with similar maltreatment rates in 1980 had very different trajectories over time. By 1986, the North neighbourhood had become high-risk, with a maltreatment rate of 21.8 per 1,000 children, while the West neighbourhood had dropped to low-risk status, with a rate of 10.9. To understand these differences, the authors interviewed seven community leaders in each neighbourhood about issues related to social environment, characteristics of the neighbourhood, and morale. Results of these interviews supported earlier hypotheses that the high-risk community showed signs of community impoverishment (low morale, limited services available, limited knowledge about services, and poor support network of formal and informal social supports) while the low-risk neighbourhood showed strong levels of social integration, characterized by the perceived strength of supportive networks and positive attitudes about the neighbourhood as “poor but not hopeless” (p. 461). The authors concluded by stating that “child maltreatment is a symptom of not just individual or family trouble, but neighbourhood or community trouble as well. It is a social as well as a psychological indicator” (p. 463).
In more recent work, Zolotor and Runyan (2006) examined the association between social capital (measured using a 22 question survey tapping into the constructs of respondents’ sense of collective efficacy, neighborhood cohesion, and psychological sense of community) and child neglect. Their sample included 1,435 mothers in North and South Carolina. Findings indicated that with each one unit increase in the social capital index, there was a 30% reduction in the risk of neglect.

**Social/Political/Economic/Cultural Environment**

Limited research has been conducted regarding the contribution of the broader social, political, economic, and cultural environments to child maltreatment in general and neglect in particular. Research that does address these issues often looks at variables similar to those identified in the previous sections, such as poverty, unemployment, and availability of supportive services; however, the focus on these factors is less as characteristics of a particular individual or community, but rather on the policies that convey a nation’s commitment to and/or priority placed on these issues.

In highlighting the complicity of society at large in rates of child neglect, Spencer and Baldwin (2005) claim that “the powerful association of child neglect with poverty and low income suggests that rich societies with high levels of child poverty associated with their economic and social policies are increasing the probability of child neglect within families” (p. 31). Comparison of maltreatment rates between countries is difficult for several reasons, including the lack of epidemiological data, different definitions of maltreatment and methods used to collect this data where they do exist, and the very different policies in place across nations that guide child welfare eligibility and intervention (Gilbert et al., 2011). However, there is general support for the notion that maltreatment rates are lower in countries such as Sweden than in the United States (Gelles & Edfeldt, 1986), attributable to Sweden’s adoption of a “collectivist orientation that puts children’s welfare at the centre of social policy formulation” (Durrant, 1996, p. 25). Particular enablers of lowered maltreatment rates in Sweden include the ban on corporal punishment (introduced through legislation in 1979), which
was accompanied by a widespread public education campaign aimed at changing societal attitudes (Durrant, 1996). Further, there is some suggestion that countries that employ a family welfare approach to child maltreatment (i.e., Northern Europe and New Zealand), which has a stronger focus on family support and prevention, have lower rates of maltreatment than countries in which a residual, protection-driven model dominates (Gilbert et al., 2011).

Given the strong correlation of poverty with cases of neglect, research regarding broad societal attitudes towards poverty and their relationship to social policy has a particular relevance in understanding macro level influences on child neglect. Reading et al. (2009) note that in the 1980s, most Western countries adopted increasingly free-market economies with distinct repercussions in terms of widening the gap between the rich and the poor. These authors contend that while some countries, most notably in Scandinavia, took measures to protect children from the effects of these developments (for example, through the implementation of adequate parental leave programs and child care provisions that encourage ongoing participation in the labour market, particularly for women), others did not. They conclude by arguing that “a more radical interpretation is that child poverty is a policy choice harmful to children” rather than an accidental or unpreventable by-product of the current economic climate (Reading et al., 2009, p. 334).

Phipps (2001) studied people’s beliefs about poverty in the United States, Canada, and Norway using data from the World Values Survey. In particular, she examined what people perceived to be the reasons for poverty and their level of concern about income inequality. Respondents from Canada were more than twice as likely as Norwegian respondents to identify that people live in need “because of laziness and lack of willpower” (p. 78); respondents from the United States were more than three times more likely to select this response that those from Norway. Additionally, Norwegians were significantly more likely to express concern about income inequality than were Canadians or Americans. The conclusions of Phipps’ research support the notion that how a society attributes responsibility for issues of poverty has direct bearing on the social policies in place to address it (or vice versa), with Canada and the United States representing “liberal” nations concerned that “too
generous transfers” will lead people to take advantage of income support programs by “working less for pay and ‘enjoying’ more time jobless” (Phipps, 2000, p. 82). Further, in examining attitudes in conjunction with poverty rates, she notes that whatever the direction of causality, the country that expressed the most concern about income inequality (Norway) is the country that has been the most effective at redistributing income and addressing poverty. Further research is needed to understand the impact of these findings, if any, on rates of child neglect.

**Outcomes of Neglect**

According to McSherry (2004), child neglect may receive less attention compared to the more “emotionally charged” problem of child abuse due to the underestimation of its impact on children. While many studies have identified the short- and long-term outcomes for maltreated children generally, comparatively fewer have separated out abuse from neglect and focused on consequences for the latter. As noted in Chapter 2, one of the first longitudinal studies to document the outcomes for neglected children as separate from abused and non-maltreated children was the Minnesota Longitudinal Study of Parents and Children. Beginning in 1977, this study recruited 267 first time mothers in their third trimester of pregnancy deemed to be at high risk for parenting problems (due to poverty, youth, low education, and lack of social supports), and regularly assessed these mothers and their children using multiple measures and methods for more than three decades. Initial data from the study was used to classify mothers’ caregiving styles into one of five primary groups: non-maltreating; physically abusive; hostile/verbally abusive; psychologically unavailable; or neglectful. Testing and observation of the mother-child dyads occurred at birth, 3, 6, and 12 months, and every 6 months until age 2.5 years; longer term assessments have taken place at various intervals throughout childhood, adolescence, and into adulthood.

Early findings from this study (see for example Egeland & Sroufe, 1981a; Egeland & Sroufe, 1981b; Egeland et al., 1983; Erickson & Egeland, 1996) noted extremely high rates of anxious-insecure and in particular, anxious-avoidant attachment at the 18-month assessment among children
whose mothers were identified as either psychologically unavailable (i.e., emotionally neglectful) or (physically) neglectful, both compared to otherwise maltreated and non-maltreated children in the sample. Observation of these children at 42 months in a pre-school setting and in interactions with their mothers during a problem-solving task characterized the children of psychologically unavailable mothers as angry and non-compliant, and the neglected children as distractible, impulsive, and inflexible. Both groups were described as lacking creativity and as highly dependent on teachers for help, support, and nurturance in the preschool setting, along with continued avoidance of the mother. Neglected children in particular were described as lacking in self-esteem and agency, with researchers stating starkly: “This is an unhappy group of children, presenting the least positive and most negative affect of all [study] groups” (Egeland et al., 1983, p. 469).

Other research has documented the outcomes of neglected children compared to abused children or to non-maltreated controls. Several studies note the difficulties of neglected children in social, emotional, and behavioural development including a tendency towards social withdrawal from both peers and caregivers (Crittenden, 1992), limited peer acceptance (Egeland et al., 1983), difficulties recognizing and regulating emotions and high rates of internalizing problems compared to both abused children and non-maltreated peers (Erikson & Egeland, 1996). Studies also suggest that neglected children present with high rates of non-compliance and aggression, although these behaviours may not be as pronounced for neglected children compared to their physically abused counterparts (Erickson & Egeland, 1996; Manly et al., 1994). Longitudinal research conducted by Widom and her colleagues followed a group of neglected and abused children identified between 1967 and 1971; data from this study have suggested several long-term negative outcomes for neglected children including an increased risk for delinquency and incarceration (Kazemian, Spatz Widom, & Farrington, 2011), health problems such as poor vision, oral health, and above-normal hemoglobin (Widom, Czaja, Bentley, & Johnson, 2012), difficulties in adult romantic relationships and parenting (Coleman & Widom, 2004), along with poor educational achievement and adult economic well-being (Currie & Widom, 2010).
Child Welfare Decision Making

Baumann, Kern, and Fluke (1997) describe what they referred to as the “decision-making ecology” of child welfare services. In brief, they argue that decision-making in child welfare is influenced by a complex set of interacting factors including the characteristics of the case, the individual decision-maker (i.e., child welfare workers), the child welfare organization, and other external factors such as laws and policies. The premise of this model is that decisions are prone to human error and that to understand decisions, one must understand their context (Baumann, Dalgleish, Fluke, & Kern, 2011) and the factors in this context that affect error. This model has been empirically tested and has been used to understand issues of disproportionality in child welfare, along with both the substantiation and placement decisions.

An alternate theory, Drake’s (1996) harm-evidence model, proposes that substantiation is based on two factors: harm to the child (or risk of harm) and evidence that maltreatment has occurred. In this model, Drake argues that while the purpose of substantiation is to verify actual events of maltreatment, the unsubstantiated label should not be taken to mean that maltreatment has definitely not occurred, that the family requires no services, or that the case was erroneously reported. He argues for the heterogeneity of unsubstantiated cases, noting that many may show evidence of either harm (but evidence is not clear that this is due to maltreatment) and/or service need. Elaborating on Drake’s original model, Khol, Jonson-Reid, and Drake (2009) make a distinction between the factors that should influence the substantiation decision (harm/risk and evidence) compared to those that should influence decisions around the provision of ongoing child welfare services, with risk and need, regardless of substantiation, the most pertinent factors in making this decision.

Several studies have confirmed the primacy of harm and risk of harm in making decisions in child welfare. However, these studies have also identified a series of variables that, in principle, should be extraneous to decisions around verifying maltreatment, the provision of services, and
child placement. These include case-level factors such as race/ethnicity of the child/caregiver, source of referral, sex of the alleged perpetrator, cooperation level of caregivers, and poverty-related issues such as poor housing and unemployment, controlling for variables related to harm and risk. Further, some studies have suggested that worker and organizational level factors (e.g., level of education, tenure in child welfare, size, and rural versus urban location) may also influence decision-making above and beyond evidence of harm and risk.

**Substantiation**

There have been multiple studies conducted on factors that influence the decision to substantiate maltreatment, although not all analyses have differentiated predictors of substantiation by type of maltreatment. Generally, studies have supported Drake’s harm/evidence model, with severity of maltreatment (i.e., evidence of harm) along with risk explaining a significant amount of the variance in the substantiation outcome (English, Marshall, Brummel, Novicky, & Coghlan, 1998; Scannapieco & Connell-Carrick, 2005a; Winefield & Bradley, 1992). For example, Trocmé et al. (2009) found that for neglect investigations, the odds of substantiation increased significantly in cases where there was evidence of physical harm (OR = 8.51), emotional harm (OR = 4.07), and/or three or more primary caregiver risk factors were present (OR = 3.6). However, in this study, several variables that might be considered extraneous to the substantiation decision were also significant predictors including the source of referral (with police referrals increasing the odds of substantiation more than four-fold), the presence of one or more housing risks (making the odds of substantiation more than half again as high for one risk and almost four times as high when two or more housing risks were present), and caregivers whose ethno-racial status was identified as “other minority” (increasing the odds of substantiation by over one-third). Given that these variables reached significance in a model that controlled for evidence of harm and child and caregiver clinical risk factors, it is possible that these factors represent sources of potential bias in the decision to substantiate maltreatment.
In addition to factors that support harm and evidence of risk, child age has been noted as a significant determinant in the substantiation of neglect. For example, Eckenrode and colleagues (1988) found that for cases of neglect, the decision to substantiate was related to age of the child and source of report, with younger children and those reported by professional sources more likely to be substantiated. Trocmé, Knoke, Fallon, and MacLaurin (2009) noted that the odds of substantiation increased in cases of neglect when reports were from the police, there was evidence of physical or emotional harm, there were multiple caregiver functioning concerns, one or more housing risks, and the child was younger.

Studies have also found a host of specific caregiver risk factors that predict substantiation in neglectful families, including mental health (Schumacher et al., 2001), substance abuse (Carter & Myers, 2007; Dunn et al., 2002), criminal activity (Christofferson, 2000), poor educational achievement (Nelson et al., 1993), single parent status (Jones & McCurdy, 1992; Zuravin & Grief, 1989), young maternal age (Sidebothom & Golding, 2001), and a history of maltreatment as a child (Newcombe & Locke, 2001).

Few studies have examined the unique contribution of poverty to the decision to substantiate neglect. Although Scannapieco and Connell-Carrick (2005a) found a significant bivariate relationship between income and the substantiation of neglect, subsequent multivariate analysis in their study combined substantiated neglect and physical abuse into one dependent variable. While income no longer remained a significant predictor of abuse and neglect combined, it is not possible to determine whether this would have been the case had they run a separate analysis predicting neglect only. In their 1999 study, Lee and Goerge found that neighbourhood poverty rates were significant predictors of substantiated reports of neglect, with children in neighbourhoods where the child poverty rate was 40% or higher over six times more likely to be substantiated for neglect compared to those who lived in neighbourhoods with a less than 10% child poverty rate (Lee & Goerge, 1999).
Studies of substantiation and general maltreatment have had mixed results for the role of poverty in these decisions; while English and her colleagues (1998) found no relationship between income and the decision to substantiate, Detlaff (2011) found that families from the lowest income group (those with incomes under $10,150) had a likelihood of substantiation that was almost double that of the highest income group (those with incomes above $40,550).

**Ongoing Protection Services**

There has been limited research examining predictors of ongoing service provision in child welfare. Early research examining the decision to provide ongoing child welfare services has noted that substantiation is often an important predictor, although studies by both Stevens (1998) and DePanfilis and Zuravin, (2001) note that many cases that are substantiated are not recommended for ongoing services and thus the two dispositions should not be viewed as synonymous. In their 2001 study, Zuravin and DePanfilis note that substantiated cases of neglect were 20% less likely to be opened for ongoing services, making type of maltreatment (abuse versus neglect) a significant predictor of ongoing service.

In their 2006 study looking at the influence of poverty on case dispositions in investigated cases of physical abuse, Moraes, Durrant, Brownridge, and Reid found that low parental education, living in public housing, and unsafe housing were significant predictors of ongoing service provision. However, this study did not control for caregiver clinical concerns that may have been correlates of these poverty-related factors and may have accounted for some of the variance in outcome. Further, as the authors studied only physical abuse that occurred within the context of punishment (i.e., discipline), the extent to which these findings might apply to other forms of maltreatment or even other physical abuse contexts is unclear.

In more recent research, Jud, Trocmé and Fallon (2012) used multi-level analysis to examine the factors that contributed to the decision to provide ongoing services or service referrals in the CIS-2008 data. While the majority of cases received some type of service, variables having the
most impact on services were those associated with child, caregiver and household need (i.e., child and caregiver clinical concerns and poverty-related need) rather than substantiation status per se. Further, cases of neglect in this study had odds of service that were more than double those of cases where neglect was not a concern \( (OR = 2.83) \). Poverty related need (i.e., frequent moves and financial concerns) were also significantly associated with service provision, with financial issues in particular more than quadrupling the odds of services.

**Placement**

The decision to place a child in out-of-home care is one of the most critical to understand, given the level of intrusiveness into the family and the potential impact on children who are removed from their homes. The role of poverty and poverty-related need in this decision is particularly important to assess because if it can be demonstrated that, all else being equal, poverty plays a significant role in the placement of children, this calls for other interventions (e.g., admission prevention funding to meet material needs) that might be used in lieu of the more intrusive placement of a child (O’Brien, 2005).

Several writers have suggested that poverty is a significant predictor of child placement even after controlling for other relevant factors (Lindsey, 1994; Page, 1987; Ross & Katz, 1983). In a 1986 study conducted by Katz and his colleagues, researchers studied hospital records of 185 children referred to a trauma team at Boston Children’s Hospital. The sample included children who were living at home with their parents at the time of admission to hospital and where there was either a physical injury sustained by the child or suspicion of neglect. Log linear analysis was conducted using several predictor variables to predict one of three outcomes: child returned home, no services; child returned home with services; and child discharged from hospital to a foster care or institutional setting. Results suggested that children from poor families (those who were Medicaid eligible) were more likely to be discharged to foster care when there was physical injury to the child but less likely to be placed in cases of neglect. The authors concluded that in cases of physical injury, the poor families in their sample were more likely to be labeled abusive, whereas physical injury sustained by
a child from an affluent family tended to be termed accidental (Katz, Hampton, Newberger, Bowles, & Snyder, 1986, p. 261). Further, the finding that more affluent families were more likely to have a child placed compared to poorer families in cases of suspected neglect led researchers to conclude that “a negative evaluation is made of families who appear to neglect their children despite adequate financial resources” (p. 261).

Using a nationally representative sample of 9,507 cases known to child welfare in 1978, Lindsey (1991) used logistic regression to understand the relative influence of several theoretically-based variables on the decision to place a child in out-of-home care. Lindsey’s model included factors related to the reason for placement (e.g., child behavioural problems, caregiver concerns such as mental health, incarceration), reason for services (e.g., abuse, neglect, environmental problems). Income inadequacy was measured through employment status (i.e., part-time, full-time, no employment) and source of income (e.g., from employment, through government programs, through friends, family, or alimony). Results of the multivariate analyses revealed that stability of income was the single best predictor of placement; the odds of placement for children whose families’ primary source of income was through family, friends, or alimony were 121 times those of children whose caregivers earned income through paid labour (termed “self-support”). Limitations of this study were that Lindsey ran four different models, one for each broad factor (reason for placement/ reasons for service, source of referral, employment status, and employment source) rather than one model controlling for all factors. Thus results indicating the significantly higher odds of placement for children whose caregiver’s income was derived from family, friends, and alimony did not control for all other factors (i.e., reason for service, caregiver functioning, etc.) and no model takes into account maltreatment severity.

In a more recent (2006) study, Barth, Wildfire, and Green examined the interplay between poverty and several other case characteristics in the decision to place a child. Results indicated that while the poorest families in their study (those who struggled to purchase basic necessities) were most likely to have children placed, the effect of poverty differed by geographical location
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(urban versus rural), with poverty a significant predictor of placement in urban settings. Specific
to cases of neglect, Walsh (2010) found that placement was more likely in families that were poor,
controlling for other relevant factors such as caregiver substance abuse, mental health problems,
child age, gender, co-occurring maltreatment, family structure, urban versus rural, and the presence
of domestic violence. Substance abuse emerged as the most significant predictor of placement in
this study.

Studies of placement have also identified several other factors as predictors, including severity
of maltreatment (Runyan et al., 1982), age of the child (Wulczyn et al., 2005; Horwitz, Hurlberg,
Cohen, Lang & Landsverk, 2011), child behaviour problems (Barth, Lloyd, Green, James, Leslie &
Landsverk, 2007), inadequate housing (Courtney et al., 2004; Chau, Fitzpatrick, Hulchanski, Leslie
& Schatia, 2009), caregiver substance abuse (Barth et al., 2004; Tittle, Harris & Poertner, 2000), and
type of maltreatment, with neglect found to be the maltreatment typology most likely to result in
placement in several studies (Schumaker, Fallon & Trocmé, 2011; Chiodo, Leschied, Whitehead &
Hurley, 2003; Trocmé et al., in press).

Empirical Classification of Neglect Contexts

As reviewed in Chapter 3, several theories have been developed that outline profiles of families in
which neglect is a concern. For example, Crittenden proposes three subtypes of neglect based on
family characteristics, including disorganized, emotionally neglecting, and depressed neglect, each
of which is characterized by different deficits of parental cognitive processing. Wilson and Horner
(2005) also propose several subtypes of families, noting differences between families characterized
by the following: (1) pervasive poverty, (2) poverty coupled with depression, (3) demoralization,
(4) substance abuse and anti-social characteristics, (5) substance abuse as self-destruction,
and (6) intergenerational transmission of abject poverty coupled with social isolation. These
classifications are based on clinical experience and may resonate quite strongly with practitioners,
who will certainly see their clients in some these descriptions. In order to validate clinically based
findings such as these, a limited number of studies have attempted to use data to empirically classify cases of neglect into subtypes.

A literature search found only two previous studies using statistical analysis to identify subgroups of neglecting families (Wilson, Kuebli, & Hughes, 2005; Chambers & Potter, 2009). Wilson, Kuebli and Hughes (2005) used an archival dataset first collected by Gaudin and Dubowitz in 1993 to examine family functioning in neglectful families. The dataset includes demographic and family functioning data on a nonprobability sample of 102 families (recruited from three children’s aid societies) identified as neglectful, and 103 matched controls living in the state of Georgia in 1993. Data were collected using standardized measures, including the Maternal Characteristics Scale developed by Polansky and his colleagues, the Child Wellbeing Scale, which assesses mothers’ abilities in the areas of relatedness, impulse control, confidence, and verbal accessibility. Using cluster analysis, the authors identified five clusters of mothers in the neglecting families: (1) those who were deemed significantly impaired due to low scores in all four areas assessed by the Maternal Characteristics Scale; (2) those identified as positively rated due to high scores across each of the four areas; (3) those assessed as markedly disinhibited due to low scores on the impulsivity scale but high scores in the other three areas; (4) those mothers rated as low efficacy due to their low scores on the confidence scale; and (5) mothers labelled as transitional due to generally high scores across all four areas of interest, although scores were lower than the positively rated group. The authors discuss implications for intervention with each group. Limitations of the study include its non-probability sampling technique, its reliance on old data, and its focus on mothers only.

In 2009, Chambers and Potter conducted a cluster analysis of 160 cases of substantiated primary neglect in El Paso County, Colorado between November 2002 and July 2004. The objective of the study was to explore whether coherent clusters of family needs (including parental, child, and family poverty needs) could be derived. Results of the analysis supported three clusters of cases including: (1) low needs cases, characterized by a low level of need across economic and personal domains; (2) a substance abuse group, characterized by high levels of substance abuse problems and transportation
issues, moderate levels of employment and housing needs, and low levels of child special education; and (3) economic/domestic violence/mental health, characterized by high levels of poverty-related needs, with a high percentage of caregivers experiencing mental health problems and domestic violence. This third cluster represented the highest level of risk based on risk assessment scores and was also the group with the highest rate of child placement. Chambers and Potter concluded that for this subset of families, serious economic and personal problems are inextricably linked and urged the field to move beyond the need to see neglect as caused by one or the other.

**Limitations of Previous Research**

Before drawing unequivocal conclusions from the research literature, it is important to examine several methodological issues pertaining to the available studies. The sampling methods, study designs, analytic strategies, and measures employed all have implications for the strength of the reported findings.

First and foremost, definitions of neglect differ across studies, making comparisons between studies difficult. Further, some authors explicitly state that they deal with a particular subtype of neglect, for example physical neglect, although even two studies purporting to address this subtype defined it differently and included different subsets of cases. For example, Carter and Myers (2007) defined physical neglect as a failure of caregivers to provide adequate food, clothing, shelter, and hygiene. Dubowitz and colleagues (2002) incorporated measures of overcrowding, household furnishings, household sanitation, organization of the household, and provision of appropriate play materials into their criteria for physical neglect.

Second, the vast majority of studies cited used cases drawn from child protection services samples, which often represent the most severe cases of neglect (Dubowitz, Papas, Black, & Starr, 2002), and which may be subject to biases in reporting and substantiation that might account for the overrepresentation of poor, minority children referred to child welfare agencies (Hampton & Newberger, 1985). Additionally, surveys of sentinels suggest that many cases of neglect are never
referred to child protection services at all (Sedlack et al., 2010). Finally, the substantiation of neglect by child protection agencies is fraught with difficulty and influenced by a variety of factors (English et al., 2005). As a result, the extent to which child welfare samples represent instances of neglect across the general child population is unknown.

A third methodological concern relates to difficulties with control groups. Many studies failed to control for co-occurring maltreatment (Clemmons, Walsh, DiLillo, & Messman-Moore, 2007; Kaplan et al., 1999; Manly et al., 1994), despite the fact that neglect is often found in conjunction with other forms of maltreatment. Conclusions of these studies become difficult to interpret as it is unclear whether risk factors are associated with neglect, another form of maltreatment, or the experience of co-occurring maltreatment. A few studies did not utilize control groups at all (for example, Dufour et al., 2007), making it impossible to determine whether risk factors in cases where children are not neglected are equally prevalent in families where neglect has not taken place.

Similar concerns present with respect to the use of maltreatment as the dependent variable. Several studies (for example, Wu et al., 2004) failed to differentiate between maltreatment outcomes, making it impossible to determine the extent to which risk factors are present for neglect as opposed to abuse. Many studies that purported to assess factors for both abuse and neglect cited results that relate to abuse only (for example, Crosse, Kaye, & Ratnofsky, n.d.). While abuse and neglect share many risk factors, such as poverty, mental health, and substance abuse issues, more research is needed that looks at the specific risk factors associated with neglect. Factors associated with abuse have been comparatively better covered.

Very little longitudinal prospective research has been conducted for child neglect. Most studies have used cross-sectional designs, collecting correlational information about risk factors at the time that the neglect was identified, making causality difficult, if not impossible to determine. This is particularly problematic in studies that look at the contribution of child behaviour and developmental status to the etiology of neglect. Without prospective, longitudinal designs, it cannot be determined if difficult child behaviours, temperament or developmental problems are
an antecedent or an outcome of neglectful caregiving (or both). To a lesser extent, cross-sectional studies also raise the question of whether certain caregiver risk factors (e.g., depression) are causes or consequences of a substantiated report of maltreatment.

Many studies cited are descriptive in nature and identify the point prevalence of various factors in cases of neglect compared to abuse or non-maltreated controls, (e.g., the proportion of neglect cases characterized by single female-led households). Without the use of multivariate analyses that control for factors like poverty, it is difficult to determine the unique or direct effect of such variables. Further, in studies that identified a higher proportion of particular variables in cases of neglect (e.g., domestic violence), many did not examine the reasons why these group differences were found.

Much of the research on child neglect has treated it as though it were a homogeneous phenomenon or has collapsed neglect into a “general neglect” category (Dubowitz et al., 2004) in spite of compelling evidence that suggests that neglect manifests itself in several subtypes (e.g., failure to supervise, inadequate hygiene, inadequate nurturing/affection, failure to provide medical care, etc.), each with its own potentially unique etiology and impact on children (Dubowitz et al., 2005).

In addition to methodological issues that need to be addressed through future research, there also exists a paucity of research into etiological factors at the community and most particularly, the broader socio-cultural environmental level. This may be due in part to the very real difficulties inherent in collecting macro-level data (Lynch & Cicchetti, 1998). However, without additional research at this level, intervention at the macro level remains unlikely and the current trend of researching and treating individual parental deficits will remain unchallenged and unchanged. More research at this level is needed to support an agenda of social change.

Finally, neglect has been constructed as a form of maltreatment for which mothers are almost exclusively responsible (Swift, 1995b) and there has been comparatively limited attention to the role of fathers in this particularly harmful maltreatment typology (Dufour, Lavergne, Larrivee, & Trocmé, 2007; Dubowitz, 2006). Notable exceptions are studies by Dubowitz (2004) and Dufour et al. (2007), which looked specifically at the issue of neglect within the context of both mothers and fathers.
Chapter 5: Research Design and Methods

The research reviewed in the previous chapter identifies the multiple variables that are correlated with neglect. In particular, research suggests that families labelled *neglectful* are characterized by extreme poverty—the “poorest of the poor.” Previous studies have explored the nature of the relationship between poverty and child abuse and neglect as a broad category, assessing the extent to which it may be an artefact of class-based biases of reporters (e.g., Hampton & Newberger, 1985; Jonson-Reid et al., 2009) and/or child welfare workers (e.g., Moraes et al., 2006), or whether it is mediated by the close association between poverty and a host of individual concerns for the caregivers in these families, such as alcohol and drug abuse and mental health problems (e.g., Carter & Myers, 2007). As the previous chapter also shows, several studies have focused on these individual problems of caregivers in neglectful families, documenting numerous correlates of neglect. Most studies have been done using American data and few have controlled for or systematically documented the poverty-related concerns of these families, despite noting the strong correlation between poverty and neglect. Most have treated neglect as a unified construct and many have classified cases based on the nature of the neglectful act (i.e., physical neglect, supervisory neglect) rather than on the constellation of needs experienced by the afflicted families.

The current research builds on these previous efforts to understand the relationship between poverty and maltreatment generally, focusing specifically on child neglect. It is comprised of four primary objectives:

1) To identify the nature and frequency of both clinical (i.e., caregiver and child functioning concerns such as addictions and mental health problems) and poverty-related concerns in both substantiated and unsubstantiated child neglect investigations;

2) Based on the needs identified, to assess the extent to which service referrals made for investigated cases of neglect (both substantiated and unsubstantiated) reflect an individually-based, structurally-driven, or combined approach to families' problems;
3) To examine possible confounds in the relationship between poverty and child neglect introduced by either reporting or decision-making poverty-related biases by:

(a) comparing the rate of substantiation for poor versus less-poor families investigated for reasons of neglect; and

(b) exploring the contribution of poverty-related variables to worker decision-making regarding (i) substantiation, (ii) ongoing service provision, and (iii) child placement, controlling for the relevant clinical concerns of the case;

4) To explore whether there are subgroups of substantiated neglect cases characterized by different levels and/or combinations of poverty-related and clinical needs.

Specific methods for each objective are outlined in more detail following a description of the CIS-2008 data and data collection methods.

**CIS-2008 Dataset**

This study is a secondary data analysis of the 2008 Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2008). The CIS-2008 was the third in a series of incidence studies of reported child abuse and neglect in Canada; previous cycles were conducted in 2003 and 1998. The primary objective of the CIS studies was to produce national estimates of the incidence of child maltreatment in Canada.

Using a multi-stage sampling design, the CIS-2008 first identified a representative sample of 112 child welfare service areas from a total of 411 in Canada. Data were collected directly from the investigating worker in each of the selected study sites for a three-month case selection period (in most cases, from October 1 through December 31, 2008). The three-page data collection instrument (see Appendix B, Child Maltreatment Assessment Form) was designed to capture standardized information about child maltreatment investigations that workers would normally gather during the course of an investigation, such as: type of abuse/neglect investigated; level of substantiation; evidence
of physical and/or emotional harm to the child; child functioning concerns; caregiver risk factors; source of income; housing issues; and short-term service dispositions of the case. Data for up to two caregivers for each child and for up to three types of maltreatment per investigation were collected.

Maltreatment typologies used for classification included: physical abuse; sexual abuse; neglect; emotional maltreatment; and exposure to interpersonal violence. Subsumed under these typologies were 32 forms of maltreatment. The following nine forms of neglect were documented by the CIS-2008: failure to supervise, physical harm; failure to supervise, sexual harm; permitting criminal behavior; physical neglect; medical neglect; failure to provide psychiatric/psychological treatment; abandonment; educational neglect; and inadequate nurturing and affection.23 The resulting dataset consists of over 400 variables, with information on 15,980 child maltreatment investigations conducted for children under the age of 16 years.

Although the CIS-2008 provides national estimates using annualization and regionalization weights, the strength of the conclusions are constrained by the margin of error of the derived estimates. As the purpose of the current research was not to extrapolate national estimates, the unweighted data were thought to be most appropriate and were used for all analyses. Unweighted data nonetheless comprise a nationally (Canadian) representative sample.

### Study Samples

Of the 15,980 child investigations for children under 16 years, 5,279 involved neglect as either the primary or secondary24 reason for investigation. Two thousand, seven hundred and fifty-seven (2,757) were investigations of neglect only (investigated neglect only or INO), i.e., workers had no concerns about any other type of maltreatment during the course of the investigation; 2,522 were investigations of both neglect and at least one other type of maltreatment (investigated neglect and

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23 Although the CIS-2008 classifies inadequate nurturing and affection as a form of emotional maltreatment, these cases may also be considered emotional neglect and can be classified as an act of omission, an important definitional distinction between abuse (an act of commission) and neglect.

24 Secondary can mean either the second or third reasons for investigation as the data collection form allowed workers to document up to three forms of investigated maltreatment.
other maltreatment or INOM), i.e., neglect was investigated concurrently with at least one other form of maltreatment such as physical abuse, sexual abuse, emotional maltreatment, or exposure to intimate partner violence. Of the INO sample, 1,193 were substantiated and the remaining 1,564 were unsubstantiated (either unfounded or suspected).

Of the INOM sample, 1,518 were substantiated with 728 investigations involving substantiated neglect only and 636 investigations substantiated for neglect and at least one other type of maltreatment. A further 154 investigations resulted in substantiation of other maltreatment but not neglect. One thousand and four (1,004) investigations were fully unsubstantiated—neither neglect nor another form of maltreatment was verified at the end of the investigation.

The current research required the use of two different samples, due to the nature of the research questions. For Objectives 1, 2, and 3, where there was a need to document both substantiated and unsubstantiated cases or where substantiation was the outcome variable, a sample was required that included both substantiated investigations and an appropriate comparison group of unsubstantiated cases. For Objective 4, in which the different constellations of needs among confirmed neglect cases was examined, a sample of investigations substantiated for neglect only was required. These two samples are described in more detail below.

**Sample A: Substantiated and Unsubstantiated Neglect Sample**

This sample was derived from two distinct subgroups of investigated cases: (1) cases where neglect was the only reason for investigation (investigated neglect only or INO); and (2) cases where neglect was investigated concurrently with at least one other type of maltreatment, i.e., physical abuse, sexual abuse, emotional maltreatment, exposure to intimate partner violence (investigated neglect and other maltreatment or INOM). Investigations from the INO group that were substantiated ($N = 1,193$) were combined with investigations from the INOM group that were substantiated for neglect only ($N = 728$), for a total of 1,921 substantiated neglect only cases. These two subgroups are highlighted in dark grey in Figure 1 on page 125. These inclusion criteria meant that the 636 cases
from the INOM stream that were substantiated for neglect and another form of maltreatment were excluded from the analysis. The rationale for this was that the research questions focused on exploring the relationship between poverty-related need, clinical concerns, and neglect. Including substantiated cases of co-occurring neglect (i.e., neglect and another form of maltreatment) makes it difficult to understand if findings are attributable to the neglect context, another form of maltreatment, or the experience of co-occurring maltreatment.

To form the control group, unsubstantiated cases from the INO group \( N = 1,564 \) were combined with cases that were unsubstantiated for both neglect and other maltreatment from the INOM group \( N = 1,004 \), for a total of 2,568 unsubstantiated cases. These two subgroups are highlighted in light grey in Figure 1. The rationale for including only the fully unsubstantiated cases from the INOM stream (i.e., those substantiated for neither neglect nor another form of maltreatment) in the comparison group was that conceptually, they most closely resembled the unsubstantiated cases from the INO stream—no form of maltreatment was substantiated. This decision resulted in the 154 cases from the INOM stream that were unsubstantiated for neglect but substantiated for another form of maltreatment being excluded from the analysis.

Based on these inclusion criteria, the final number of cases in the substantiated-unsubstantiated neglect sample was 4,489. Figure 1, on page 125 shows the detail of the sample.

**Sample B: Substantiated Neglect Only Sample**

Substantiated cases of neglect only were required for analyses exploring the utility of classifying cases of neglect into subtypes based on levels and constellations of personal and economic needs. The rationale for using substantiated cases for the cluster analyses was that these analyses were intended to explore the existence of subtypes among confirmed cases of neglect. A body of literature has explored the consistency and meaning of substantiation decisions (e.g., Drake & Jonson-Reid, 2000; Khol, Jonson-Reid, & Drake, 2009; Slep & Heyman, 2006), with some studies concluding that substantiation is not necessarily a reliable measure of whether maltreatment has actually
taken place (Drake & Jonson-Reid, 2000; Hussey et al., 2005; Slep & Heyman, 2006). However, substantiation status in the CIS-2008 dataset provides an index of the worker’s level of confidence that maltreatment has occurred and is the best measure available of true positives.

The substantiated neglect only sample (see Figure 1 on page 125) consisted of the 1,921 cases of substantiated neglect only, 1,193 from the investigated neglect only stream (highlighted in dark grey in Figure 1), and 728 from the investigated neglect and other maltreatment stream (also highlighted in dark grey in Figure 1). Excluded from the analysis were the 636 cases of substantiated neglect and other maltreatment. The rationale for excluding these cases was that the research is focused on the relationship between poverty and neglect; as previously articulated, using cases of co-occurring maltreatment would make it difficult to attribute findings definitively to the neglect context.

As the structure of the CIS-2008 dataset is hierarchical, with children nested within families, thought was given to how to manage the intra-cluster correlation inherent in the data when considering the sampling design. To address this issue, some analyses of the CIS data have elected to randomly select one child per family from each investigated household in recognition of the fact that children in the same family usually share the same caregiver(s) and household characteristics and thus do not contribute entirely independent observations. In the study sample, the mean number of children investigated per family was 2.2 across more than 2,000 families. There is debate in the literature about whether clusters of this size pose a threat to independence of observation, with some writers noting that when the number of participants in each cluster is small (as in the current study), the effect of the clustering on the standard error is less pronounced (Williams, 2000). Further, limiting the sample to one child per family affects the statistical power due to the reduced sample size, in particular for less frequent events such as child placement. The dataset also contains multiple observations by the same workers. Although the contribution of worker characteristics was unmeasured in the current study, each worker conducted, on average 8.5 investigations, possibly posing a threat to the independence of observations. Previous research using CIS data has assessed
the threat to independence posed by worker clusters as minor due to the dissimilarity across workers and the relatively small size of the clusters (Fallon, 2005).

**Data Analysis: Descriptive Analyses**

The first two objectives of the research were descriptive in nature: (1) to identify the type and frequency of both clinical (i.e., caregiver and child functioning) and poverty-related concerns in both substantiated and unsubstantiated child neglect investigations; and (2) based on the needs identified, to assess the extent to which service referrals made for investigated cases of neglect (both substantiated and unsubstantiated) reflect a clinically-driven, concrete/material support-driven, or combined (both clinical and concrete services) approach to families’ problems.

**Description of Child, Caregiver, and Poverty-Related Needs**

To address Objective 1, descriptive statistics including frequencies and percentages were used to document a series of poverty-related and personal concerns for caregivers residing with the child (measured at the household level) and children investigated for reasons of neglect ($N = 4,489$). The frequency and percentage were documented separately for unsubstantiated ($N = 2,568$) and substantiated cases ($N = 1,921$); as the purpose of this phase of the research was purely descriptive, no tests of statistical significance were run comparing substantiated and unsubstantiated cases. As the data are cross-sectional, not longitudinal, they represent a description of the presenting needs of children at the time of investigation; whether these needs were antecedents or consequences of suspected maltreatment cannot be determined.

Child level concerns for each investigated child in both substantiated and unsubstantiated cases were documented by age category, using the categories developed through the CIS-2008 dataset: under 3 years; 4–7 years; 8–11 years; and 12–15 years. This approach was informed by previous analyses of child welfare data that suggest the importance of a bio-ecological life-course perspective which supports age differentiated analyses of child welfare data (Wulczyn, Barth, Yuan,
Figure 1. Substantiated and unsubstantiated neglect samples
Jones-Hardman, & Landsverk, 2005). Stratifying by age allowed for a better understanding of the different presenting concerns for each age group, something that may be masked when assessing the sample as a whole. As there are age-related patterns within the data, this analytical approach provides information for how interventions might be tailored to developmental stage. A further benefit to stratifying the data by child age was that it addressed the concern that many of the child functioning issues collected through the CIS-2008 are more likely to be experienced by older versus younger children. For example, very young children are unlikely to suffer from drug or alcohol problems, to demonstrate frequent running from home/placement, or to have involvement with authorities under the *Youth Criminal Justice Act*. Thus, stratification controls for the effect of age on the likelihood of specific child-related concerns.
Table 2
Child, Caregiver, and Poverty-Related Concerns Included in the Descriptive Analyses

<table>
<thead>
<tr>
<th>Identified needs</th>
<th>Measurement Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child needs</td>
<td></td>
</tr>
<tr>
<td>Depression/anxiety/withdrawal</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Self-harming behaviour</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>ADD/ADHD*</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Attachment issues</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Aggression</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Running (multiple incidents)</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Inappropriate sexual behaviour</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>YCJA** involvement</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Intellect./develop. disability</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Failure to meet dev. milestones</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Academic difficulties</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Fetal alcohol syndrome/effect</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Positive toxicology at birth</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Physical disability</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Drug/solvent abuse</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Other functioning issue</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Caregiver needs (household level)</td>
<td></td>
</tr>
<tr>
<td>Few social supports</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Mental health</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Drugs/solvents</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Victim of domestic violence</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>History of foster care as child</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Physical health</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Perpetrator of domestic violence</td>
<td>Dichotomous (noted/not noted)</td>
</tr>
<tr>
<td>Poverty-related needs</td>
<td></td>
</tr>
<tr>
<td>Household source of income</td>
<td>Categorical (full-time; part-time/seasonal; benefits; unknown; none)</td>
</tr>
<tr>
<td>Type of housing</td>
<td>Categorical (own home; rental; public housing; Band housing; hotel/shelter; other; unknown)</td>
</tr>
<tr>
<td>Home overcrowded</td>
<td>Dichotomous (yes/no)</td>
</tr>
<tr>
<td>Number of moves in last 12 mos.</td>
<td>Ordinal (none; one; 2–3; 4 or more)</td>
</tr>
<tr>
<td>Presence of household hazards</td>
<td>Dichotomous (yes/no)</td>
</tr>
<tr>
<td>Family reg. runs out of $</td>
<td>Categorical (yes; no; unknown)</td>
</tr>
</tbody>
</table>
Table 2
Child, Caregiver, and Poverty-Related Concerns Included in the Descriptive Analyses

<table>
<thead>
<tr>
<th>Identified needs</th>
<th>Measurement Level</th>
</tr>
</thead>
</table>

Note: A full description/definition of each item in this table is provided in the CIS-2008 Guidebook (Appendix A)

* Attention deficit hyperactivity disorder
** Youth Criminal Justice Act

**Nature of the Child Welfare Response to Neglect Investigations**

The second objective of the research was exploratory in nature and was intended to assess the extent to which the child welfare response to families referred for neglect is characterized by a focus on treating parents’ or children’s clinical (individual) problems, supporting families’ material, economic, and/or social needs or a combination of both. Both substantiated and unsubstantiated cases of neglect were included in the analysis (N = 4,489) although documented separately. This part of the research built on the results of the descriptive analyses documenting the nature of presenting needs in both substantiated and unsubstantiated cases.

**Categorization of Presenting Needs**

Although understanding the predominant approach to service for cases of neglect was the objective of this stage of the research and in particular, assessing the extent to which those cases involving poverty-related concerns were provided with referrals for material/concrete services, it was recognized that referrals should complement the presenting concerns of the investigation. In other words, for cases where both poverty-related and clinical/individual concerns were identified, the preferred referral response would be one that addressed both the family’s treatment/individual and material/concrete needs. Thus a variable was derived that categorized cases according to the constellation of presenting needs. If a case had any of the nine caregiver functioning concerns identified in Table 2 and/or any of the 18 child concerns noted in Table 2, it was classified as having clinical needs. If a case had either identified income concerns and/or housing concerns (defined in Table 3), it was classified as having poverty-related needs. If a case had neither clinical nor poverty-
related concerns, it was classified as no identified needs. A variable was then derived to categorize cases according to the constellation of presenting needs: no identified needs (0); only poverty needs (1); only clinical needs (2); and both poverty and clinical needs (3).

Table 3 (below) shows the details of how this variable was derived:

Table 3

<table>
<thead>
<tr>
<th>Presenting needs category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No identified needs</td>
<td>No identified clinical needs (none of the caregiver or child needs outlined in Table 2 were identified)</td>
</tr>
<tr>
<td>Only poverty related needs identified</td>
<td>At least one income and/or housing need identified. Cases identified as having income needs are those in which (the) caregiver(s) do not have a full-time source of income, i.e., household income comes from part-time/seasonal employment; social assistance/other benefits; no source of income; unknown source. Cases identified as having “housing concerns” are those in which one or more of the following is present: family lives in public housing; hotel/shelter, other housing type or unknown housing; there is at least one household hazard present, i.e., exposed wires, broken glass, drug paraphernalia, accessible weapons, etc.; the family has moved two or more times in the last 12 months; the home is assessed as being “overcrowded.”</td>
</tr>
<tr>
<td>Only clinical needs</td>
<td>One or more of the child and/or caregiver concerns identified in Table 2 is noted.</td>
</tr>
<tr>
<td>Both poverty-related and clinical needs</td>
<td>At least one income and/or housing need is identified and at least one clinical need is identified.</td>
</tr>
</tbody>
</table>

Description of Service Referral Variables

The CIS-2008 collected information about up to 15 types of service referrals made for any family member, along with an “other” referral category. Referral categories included: parent support group; in-home family counseling; other family or parent counseling; drug or alcohol counseling; welfare or social assistance; food bank; shelter services; domestic violence services; psychiatric or psychological services; special education placement; recreational services; victim support program; medical or dental services; child or day care; cultural services; and other. When “other” was selected, workers were asked to identify the type of service referral made. The way in which data were collected through the CIS means that some referral data (e.g., drug or alcohol counseling,
psychological/psychiatric services) do not distinguish between referrals made on behalf of a child versus a caregiver. Of the 4,489 cases included in the analysis (substantiated-unsubstantiated neglect sample) approximately 400 noted a service referral identified as “other.” For these cases, the text provided by workers regarding the nature of this referral was analysed to assess whether the referral type fit into one of the existing categories on the data collection form. In many cases, “other” referrals fit into existing categories. For a further group of cases, “other” referrals were categorized into one of six new referral categories: (1) financial assistance; (2) housing services; (3) employment services; (4) assistance with transportation; (5) connection to church/spiritual group; (6) other concrete services (e.g., Christmas fund; winter coat program, etc.). After these reclassifications, 262 cases with “other” referrals indicated remained classified as other.

Once recoding was complete, all 22 service referral types were collapsed into four categories, outlined in Table 4 (below):

Table 4
Service Referrals by Category

<table>
<thead>
<tr>
<th>Category of referral</th>
<th>Referral types included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting/family support</td>
<td>Parent support group; in-home family counselling; other parent or family counselling.</td>
</tr>
<tr>
<td>Clinical/treatment</td>
<td>Drug or alcohol counselling; psychiatric/psychological services; domestic violence services; victim support services; special education services.</td>
</tr>
<tr>
<td>Material support</td>
<td>Welfare or social assistance; food bank; shelter services; housing services; employment services; child or day care; financial assistance; assistance with transportation; medical/dental services; other concrete services.</td>
</tr>
<tr>
<td>Social/recreational support</td>
<td>Recreational services; cultural services; church/spiritual connection.</td>
</tr>
<tr>
<td>Other service referral</td>
<td>Other service referral</td>
</tr>
</tbody>
</table>

Once referrals were coded by category, frequencies were run. Initial categories were then collapsed into the following two categories: rehabilitative referrals and concrete referrals, adapted from definitions provided by Pelton (2008), described in Table 5 (page 131).
Table 5
Referral Categories by Response Approach

<table>
<thead>
<tr>
<th>Response approach</th>
<th>Definition\textsuperscript{a}</th>
<th>Referral categories included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitative</td>
<td>Services intended to change the person or family in some way (e.g., psycho-educational, therapeutic, or treatment-oriented)</td>
<td>Parenting/family support; clinical/treatment</td>
</tr>
<tr>
<td>Concrete support</td>
<td>Services intended to change or modify people's situation or environment.</td>
<td>Material/concrete; social/recreational support</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Definitions adapted from Pelton (2008)

If a worker made any rehabilitative referrals on behalf of the child, caregiver, or family, a variable entitled any rehabilitative referrals was coded as 1. If no referrals of a rehabilitative nature were made, this variable was coded as 0. If a worker made any concrete service referrals on behalf of the child, caregiver, or family, any concrete referrals was coded as 1. If no concrete referrals were provided this variable was coded as 0.

A variable was then derived that best characterized the overall approach to service referrals for each investigation, consisting of the following categories: no referrals made (coded as 0); only rehabilitative referrals (coded as 1); only concrete referrals (coded as 2); and both rehabilitative and concrete referrals (coded as 3).

Cross tabulations were then run to assess the fit between the nature of the identified needs of the case (i.e., clinical, poverty-related, both clinical and poverty-related) and the service referral approach (i.e., rehabilitative only, concrete only, both rehabilitative and concrete). For example, cross tabs examined the extent to which cases presenting with both poverty-related and clinical needs were provided with service referrals consisting of both rehabilitative and concrete support services. An important caveat of these analyses is that they document service referrals only; whether the child, caregiver or family actually received services cannot be ascertained through the available data.
Data Analysis: Multivariate Analyses

The third and fourth objectives of the research required the use of multivariate statistics and were as follows:

3) To examine possible confounds in the relationship between poverty and child neglect introduced by either reporting or decision-making poverty-related biases by:

(a) comparing the rate of substantiation for poor versus less-poor families investigated for reasons of neglect; and

(b) exploring the contribution of poverty-related variables to worker decision-making regarding (i) substantiation; (ii) ongoing service provision; and (iii) child placement, controlling for the relevant clinical concerns of the case.

4) To explore whether there are subgroups of substantiated neglect cases characterized by different levels and/or combinations of poverty-related and clinical needs.

Exploration of Confounds Between Poverty and Neglect

As discussed in Chapter 3, the theoretical literature proposes that several possible biases (e.g., visibility bias, labeling bias, and reporting bias) occurring at distinct decision points may explain the relationship between poverty and child neglect found in child welfare samples. Further, child welfare decision-making models (discussed in Chapter 4) note that poverty may come to bear in decision-making in a way that affects a worker’s threshold for when to close a case versus providing ongoing services and/or when to place a child in out-of-home care, even when controlling for risk levels (Rivaux et al., 2008). These potential biases and the decision-point with which they are associated are illustrated in Figure 2 (page 135). As illustrated by Figure 2, the CIS-2008 data do not allow for an exploration of each of the potential confounds between poverty and neglect; for example, the existence of the visibility bias or the labelling bias cannot be assessed. Further, the CIS-2008 data do not include all cases reported to child welfare services, only those screened in for
An Exploration of the Relationship Between Poverty and Child Neglect in Canadian Child Welfare

investigation, making assessment of a potential screening bias impossible. As a result, the extent to which screening “corrects” for a possible reporting bias (i.e., “trivial” cases or those reported for poverty alone are screened out and not investigated) cannot be determined. Those potential confounds that can be explored using the CIS-2008 data are the subject of Objective 3, and are denoted in Figure 2 using the black arrows.

**Objective 3a: Reporting Bias**

Objective 3a explored whether or not there is a poverty-related bias in reporting to child welfare authorities that might explain the high proportion of poor families substantiated for neglect in the CIS dataset. In other words, it addressed the notion that neglect may be a classless phenomenon, but one in which poor families are significantly more likely to be reported, making the relationship between poverty and neglect in child welfare samples an artefact of this reporting bias. The hypothesis was that if substantial class-related reporting bias explains why so many poor families relative to non-poor families are known to child welfare for reasons of neglect, the proportion of false positives (i.e., families investigated but not substantiated) should be higher among poor families than for less poor families, as poor families would be more likely to have been reported for less serious concerns (i.e., for reasons of poverty alone or for relatively minor concerns). Conversely, the associated hypothesis was that if the threshold for less poor families is higher (i.e., reports for these families are more likely to be made due to more serious and/or less ambiguous situations), these reports would be more likely to be substantiated due to the higher level of harm and/or evidence. Cases investigated for neglect only (\(N = 2,757\)) were used for this analysis, as the focus was to understand whether poverty influences reporters’ decisions about reporting neglect to child welfare authorities. Using reports of neglect and another form of maltreatment would make it difficult to assess the extent to which reporters’ decisions about neglect versus another form of maltreatment were influenced by poverty.

To categorize investigations according to poverty level in the absence of income data, an ordinal, three-level poverty variable was developed, based on a methodology employed for a previous analysis.
of the 2003 Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2003) dataset (see Knoke, 2007). This composite variable reflects disadvantage from two sources: (1) housing concerns and (2) low income. A household was considered to have housing concerns if one or more of the following characteristics were present: (1) the family accommodation was noted as either hotel/shelter, public housing, or other housing; (2) there was at least one household hazard noted; (3) the family had moved two or more times in the previous year; and/or (4) the home was assessed as overcrowded. A household was considered to have low income if the primary source of income was not full-time employment. A composite variable was then developed with the following three categories: (1) full-time employment and no housing concerns, (2) no full-time employment or at least one housing concern, and (3) no full-time employment and at least one housing concern.

The composite variable was validated by examining the subset of investigated neglect only cases with data regarding whether the household regularly ran out of money for basic necessities (see Table 6, page 136). Of the 2,169 cases with available data for the variable “household regularly runs out of money for basic necessities,” (number of cases with missing or unknown data was 588 or 21%), 743 (34%) had neither income nor housing concerns; 872 (40%) had either housing or income concerns; and 554 (26%) had both housing and income concerns. The proportion of those assessed as regularly running out of money for basic necessities was 4% \( (n = 30) \) of the group with neither concerns; 15% \( (n = 131) \) of the group identified as having either housing or income concerns; and 37% \( (n = 203) \) of the group identified as having both housing and income needs. As these proportions followed the logic of the derived variable (i.e., cases with both income and housing concerns had the highest proportion of households endorsed as regularly running out of money, while cases with neither housing nor income concerns had the lowest rate), the composite poverty variable was thought to have adequate validity.
Figure 2. Potential confounds by decision-point in the relationship between poverty and child neglect
Table 6
Level of Poverty-Related Needs by “Household Regularly Runs Out of Money for Basic Necessities,” Investigated Neglect Only, N = 2,169

<table>
<thead>
<tr>
<th>Poverty level</th>
<th>No</th>
<th>%</th>
<th>Yes</th>
<th>%</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No poverty-related concerns</td>
<td>713</td>
<td>96</td>
<td>30</td>
<td>4</td>
<td>743</td>
<td>100</td>
</tr>
<tr>
<td>One poverty-related concern</td>
<td>731</td>
<td>84</td>
<td>141</td>
<td>16</td>
<td>872</td>
<td>100</td>
</tr>
<tr>
<td>Two poverty-related concerns</td>
<td>351</td>
<td>63</td>
<td>203</td>
<td>37</td>
<td>554</td>
<td>100</td>
</tr>
</tbody>
</table>

a 588 cases had a response of “unknown” for household regularly runs out of money for basic necessities

Once groups were established according to relative level of poverty-related needs (low, moderate, or high), chi-square analyses were used to assess whether there were statistically significant differences in the substantiation rates between the groups. Chi-square analysis is a bivariate method used to determine whether the observed frequencies are statistically significantly different from the expected frequencies. Chi-square is an appropriate technique for dichotomous and categorical data.

**Objective 3b: Assessing Potential Poverty-Related Bias in Substantiation, Ongoing Service Provision, and Placement Decisions**

Objective 3b was concerned with examining whether or not reporting bias explains the high proportion of poor families involved with child welfare for reasons of neglect through an examination of substantiation rates. However, analyses conducted did not examine the extent to which poverty influences cases decisions controlling for other relevant concerns. Further, once a case has been screened-in, decisions are made by investigating child welfare workers, who may themselves be influenced by a family’s poverty-related status when determining if neglect has occurred. To address this, the second set of analyses conducted through this stage of the research examined whether worker decision-making is influenced by poverty-related concerns after controlling for the clinical concerns of the case. The hypothesis for these analyses was that if workers’ decisions related to substantiation, ongoing service provision, and child placement are directly influenced by
poverty, poverty-related variables such as housing concerns and low/unstable income should have a significant, unique contribution to case decision-making after controlling for evidence of harm and child and caregiver risk factors.

The statistical technique used to examine this hypothesis was logistic regression. Logistic regression is suited to analyses that examine dichotomous or binary outcomes with two mutually exclusive levels and permits the use of both continuous and categorical predictor variables (LaValley, 2008). Further, logistic regression does not assume that the relationship between the predictor and outcome variables is linear, an assumption which is usually violated when the outcome of interest is dichotomous and has been assigned an arbitrary value of 0 or 1, making it more likely to be sigmoidal (S-shaped) (Grace-Martin, 2009). Logistic regression was also suitable as it can compare different models and estimate the relative contribution of a large number of independent variables.

Predictor variables were selected based on their theoretical and empirical relationship to the outcome variables of interest. In addition to this, consideration was given to parsimony, as increasing the number of predictors in the model increases the degrees of freedom and affects the power of the model, an issue of particular relevance for models predicting lower frequency outcomes such as placement.

**Description and Selection of Predictor Variables**

As reviewed in Chapter 4, the case disposition literature indicates that the decision to substantiate maltreatment, provide ongoing services, and place a child in out-of-home care is influenced by key clinical variables (child and caregiver functioning) along with characteristics of the case and the severity of maltreatment. Further, other factors such as child age and Aboriginal status, caregiver age and gender, and level of cooperation with the intervention have been demonstrated to influence case dispositions as well. In combination, variables were selected to represent an ecological model of child neglect and to control for other known factors that influence decision-making in child welfare in order to understand the relative contribution of poverty-related needs in determining
case dispositions following investigation. A brief description of each of the variables used in the analyses follows below.

Child Level Variables

Child Age and Sex

Child age refers to the age of the child at the time of the investigation. It is a continuous variable. Child sex identifies the child as either male (0) or female (1).

Aboriginal Status

Workers were asked to identify each investigated child using one of six possible categories: not Aboriginal; First Nations Status; First Nations, non-Status; Metis; Inuit; and other [Aboriginal]. This variable was recoded into a dichotomous variable: non-Aboriginal child (0); and Aboriginal child (1).

Child Functioning Concerns

The CIS-2008 data collection instrument identified 18 child functioning concerns: depression/anxiety/withdrawal; suicidal thoughts; self-harming behaviour; ADD/ADHD; attachment issues; aggression; running (multiple incidents); inappropriate sexual behaviour; Youth Criminal Justice Act involvement; intellectual/developmental disability; failure to meet developmental milestones; academic difficulties; FAS/FAE; positive toxicology at birth; physical disability; alcohol abuse; drug/solvent abuse; other child functioning concern. Each concern is defined in detail in the CIS-2008 Guidebook (Appendix A). Workers were asked to indicate whether each concern was: confirmed, meaning it was disclosed to the worker or documented in the file through a medical/professional diagnosis; suspected, meaning it was not confirmed but the worker suspected the item as an issue for the child; no, meaning the worker was sure this was not an issue for the child; or unknown, meaning the worker did not know if this was an issue for the child. Each of these variables was initially recoded into a dichotomous variable: noted, including both confirmed and suspected; and
not noted, including no or unknown. Once this was done, cases were then categorized into four clusters, based on face validity (i.e., functioning concerns that appeared to be related to common broad domains of child well-being). These clusters included the following:

- **physical/cognitive/developmental**, consisting of one or more noted concerns related to physical disability; intellectual/developmental disability; failure to meet developmental milestones; academic difficulties; positive toxicology at birth; FAS/FAE; or ADD/ADHD;

- **mental/emotional**, consisting of one or more concerns related to depression/anxiety/withdrawal, suicidal thoughts, self-harming behaviours; or attachment issues;

- **behavioural concerns**, consisting of one or more concerns related to aggression; running (multiple incidents); Youth Criminal Justice Act (YCJA) involvement; alcohol abuse; drug/solvent abuse; inappropriate sexual behaviour; and

- **other concerns**, representing cases where workers endorsed the “other” functioning concern category on the CIS-2008 data collection instrument.

Limitations of this method of coding include the notion that children with more than one concern in each domain are considered the same as a child with only one concern; further, each concern is given equal weight, regardless of the relative severity of the presenting issue.

**Caregiver Characteristics**

**Age of the Youngest Caregiver**

The CIS-2008 data collection instrument collected information about age of up to two caregivers (primary and secondary) using eight categories: under 16; 16–18 years; 19–21 years; 22–30 years; 31–40 years; 41–50 years; 51–60 years; and over 60 years. A variable was derived that identified the age category of the youngest (of up to two) identified caregivers. Preliminary analyses revealed that the proportion of the sample for which the youngest caregiver fell into the youngest or oldest categories was small: only two cases (.04%) in the sample had a youngest caregiver younger than 16
years; 1.2% of cases \( (n = 62) \) had a youngest caregiver between the ages of 16 and 18 years; and 4.7% of cases \( (n = 241) \) had a youngest caregiver between the ages of 19 and 21 years. Older “youngest caregivers” were also uncommon, with 2.5% \( (n = 127) \) of cases having a youngest caregiver between the age of 51 and 60 years and 0.5% \( (n = 24) \) having a youngest caregiver over 60 years. To reduce the degrees of freedom in the multivariate model and provide sufficient cell size for analyses, the age categories for the youngest caregiver were collapsed into: under 22 years \( (0) \); 22–30 years \( (1) \); 31–40 years \( (2) \); and over 40 years \( (3) \).

**Caregiver Functioning Concerns**

The data collection instrument collected information about nine possible caregiver risk factors. These included: alcohol abuse; drug/solvent abuse; cognitive impairment; mental health issues; physical health issues; few social supports; victim of domestic violence; perpetrator of domestic violence; and history of foster care as a child. Like the child functioning concerns, workers could respond to these items with one of four options: confirmed; suspected; no; or unknown. A derived variable collapsed these responses into noted (confirmed or suspected) or not noted (no or unknown). If at least one caregiver residing in the family home had a particular functioning concern noted, this was considered a caregiver concern for the household.

Using household level concerns also has some inherent limitations. Cases in which both the primary and secondary caregivers present with a particular concern are given the same weight as cases in which only one caregiver presents with the problem. Further, the same weight is given to the presence of the concern, whether it is the primary or the secondary caregiver who is noted to have the problem, an approach that could be challenged based on the assumption that the functioning of the primary caregiver likely has more impact on whether or not children’s needs are met. The rationale for identifying caregiver concerns at the household level was that previous research has focused almost exclusively on the functioning deficits of mothers, and mothers (or females) are the primary caregivers in 88% of the investigated neglect sample. The current research was informed by an
ecological perspective, which necessitates the examination of all factors in the child’s environment, including the often unmeasured contribution of fathers (male caregivers). Further, the social justice orientation of the research dictates that an understanding of and response to child neglect should not perpetuate the feminization of this problem (Daniel & Taylor, 2006).

**Primary Caregiver Cooperation with the Intervention**

The CIS data collection instrument collected information about the response of the primary caregiver to the intervention. Workers were able to indicate whether the caregiver was: cooperative; uncooperative; or not contacted.

**Household Characteristics**

**Family Structure**

The CIS-2008 data collection form asked workers to indicate up to two caregivers living in the home and the nature of the relationship to the investigated child. These responses were collapsed into the following categories: lone female; lone male; two-parent biological; two-parent blended (biological parent and other caregiver); and other family structure.

**Number of Children in the Family**

Workers were asked to identify the number of children living in the family home. The total number of children in the household in the study sample ranged from one to nine.

**Maltreatment Characteristics**

**Mother/Stepmother as Alleged Perpetrator**

The CIS-data collection form asked workers to identify the alleged perpetrator of the maltreatment and more than one perpetrator could be identified. A variable was derived to indicate whether the mother/stepmother was identified as an alleged perpetrator. For cases where either the biological
mother or the stepmother was the alleged perpetrator, a code of 1 was assigned. For cases where mothers/stepmothers were not alleged as perpetrators, a code of 0 was assigned.

**Source of Referral**

The CIS-2008 notes whether the source(s) of referral include any professionals (e.g., teachers, police, hospital personnel, etc.) versus non-professionals (e.g., family, friend, neighbour, etc.). Cases for which there was at least one professional source of referral were coded 1; cases in which only non-professionals were the referral sources were assigned a value of 0.

**History of Previous Openings**

Workers were asked to indicate the number of previous openings (if any) at the family level for each investigated child. Responses were collapsed into a dichotomous variable, with 1 representing one or more previous openings and 0 indicating no previous child welfare openings.

**Presence of Physical Harm**

Workers were asked to note whether any physical harm (i.e., bruises, burns/scalds, broken bones, head trauma, or fatality) was noted for each substantiated investigation. A variable was derived that indicated whether physical harm was present with 0 representing no physical harm and 1 indicating at least one form of physical harm.

**Presence of Emotional Harm**

Workers were requested to indicate whether emotional harm to the investigated child was evident (yes or no).
Poverty-Related Variables

Source of Income

The data collection form asked workers to indicate the primary source of income for the household of each investigated child. Response options included: full-time employment; part-time/seasonal employment; unemployment/other benefits; no source of income; unknown source.

Housing

The households of investigated children were categorized into one of seven situations: own home; public housing; rental; band housing; hotel/shelter; other; and unknown.

Unsafe Housing

Workers were asked to identify hazards present in the home, including: accessible weapons; drugs; drug production/trafficking in the home; chemicals/solvents used in the home; other home injury hazards; and other home health hazards. A variable was derived collapsing these variables into a dichotomous response: at least one household hazard, yes (1) or no (0).

Overcrowded Housing

Workers were able to indicate whether the home, in their estimation, was overcrowded. Responses included: yes, no, and unknown.

Number of Family Moves in the Last 12 Months

The number of family moves in the last 12 months was indicated as one of the following: none; one move; two or more moves; unknown.

Family Regularly Runs out of Money for Basic Necessities

Workers were asked to indicate for each investigated child whether the family regularly runs out of money for necessities. Responses included: yes; no; and unknown.
Table 7 (below) provides an overview of the theoretical and/or empirical support for the selected variables.

<table>
<thead>
<tr>
<th>Predictor variables</th>
<th>Theoretical assumptions</th>
<th>Support in the literature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child-level variables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child age</td>
<td>Younger children pose greater caregiving demands due to their increased dependency and requirements for care. Neglect that occurs during infancy or toddlerhood leads to more serious impairments in cognitive, emotional, and social development than that which occurs later in childhood. Young children known to child welfare are more likely to be referred for neglect compared to other maltreatment typologies.</td>
<td>Hildyard &amp; Wolfe, 2002; Wulczyn, 2009</td>
</tr>
<tr>
<td>Child functioning (physical, cognitive, emotional, and behavioural)</td>
<td>Poor child health, externalizing or internalizing difficulties, and/or difficult temperament lead to increased caregiving demands, making neglect more likely. Some theoretical work has suggested that the link between medically fragile infants and neglect is due to selective parental investment in the most viable offspring.</td>
<td>Dubowitz, Papas, Black, &amp; Starr, 2002; Sullivan &amp; Knutson, 2000; Mann, 1992</td>
</tr>
<tr>
<td>Aboriginal status</td>
<td>Aboriginal children are more likely to grow up in poverty, a circumstance strongly associated with neglect. They often live in communities with few supportive or culturally appropriate services, increasing the likelihood of placement.</td>
<td>Blackstock, 2004; Blackstock, 2003; MacLaurin, Trocmé, Fallon, Blackstock et al., 2008; Trocmé, Fallon, MacLaurin et al., 2005; MacLaurin, Fallon, Knobe et al., 2006; Fluke, Chabot, Fallon, MacLaurin, &amp; Blackstock, 2010.</td>
</tr>
<tr>
<td><strong>Caregiver-level variables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver age</td>
<td>Caregivers who become parents at a very young age often lack the knowledge and skills required to adequately parent. Young age at first birth is associated with an increased risk of neglect.</td>
<td>Carter &amp; Myers, 2007; Sidebothom &amp; Golding, 2001; Lee &amp; Goerg, 1999</td>
</tr>
<tr>
<td>Caregiver functioning</td>
<td>Caregivers whose functioning is compromised due to issues such as alcohol or drugs, and/or mental health problems often have limited personal and financial resources to meet the needs of their children. Caregivers who abuse substances are often socially isolated, with limited support networks to help them personally and/or with parenting.</td>
<td>Carter &amp; Myers, 2007; Schumacher, Slep &amp; Heyman, 2011; Newcombe &amp; Locke, 2001; Chaffin, Kelleher &amp; Hollenberg, 1996; Polansky et al., 1981, Dore, 1996</td>
</tr>
</tbody>
</table>

*continued on following page*
Table 7  
**Theoretical/Empirical Importance of Predictor Variables**

<table>
<thead>
<tr>
<th>Predictor variables</th>
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<th>Support in the literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver cooperation</td>
<td>Caregivers with poor interpersonal skills or who do not accept responsibility may be perceived more negatively. Readiness to change theory proposes that acknowledgement of responsibility may predict engagement with helping services.</td>
<td>Radke-Yarrow &amp; Brown, 1993; Littell &amp; Girvin, 2005</td>
</tr>
<tr>
<td>Household-level variables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family composition</td>
<td>Single female-led households are significantly overrepresented in cases of neglect. Research suggests this could be due to difficulties finding enough time for all household tasks related to care and stimulation of children along with paid work, being unable to supervise children due to work, and the increased likelihood of poverty for single female-led households.</td>
<td>Jones &amp; McCurdy, 1992; Zuravin &amp; Grief, 1989; Martin &amp; Walters, 1982; DePanfilis, 2006</td>
</tr>
<tr>
<td>Number of children</td>
<td>A greater number of children in the household results in increased caregiver demand, and increased strain on family resources.</td>
<td>Martin &amp; Walters, 1982; Sedlack &amp; Broadhurst, 1996; Zuravin, 1988</td>
</tr>
<tr>
<td>Case and maltreatment variables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perpetrator sex</td>
<td>Mother are more likely than fathers to be identified as perpetrators in cases of neglect, partially due to the fact that neglect is commonly conceptualized as omissions in care and mothers are more likely to be the primary (or sole) caregivers. Other theory stresses that neglect has been constructed as “failed motherhood” making neglect a purposefully gendered construction in which mothers’ lapses in care are considered “deviant” whereas fathers’ lapses are more likely to be framed as accidental or due to lack of knowledge.</td>
<td>U.S. Department of Health and Social Services, 2005; Swift, 1995</td>
</tr>
<tr>
<td>Source of referral</td>
<td>Professional referrals for neglect are more likely to result in substantiation.</td>
<td>Trocmé, Knoke, MacLaurin &amp; Fallon, 2009</td>
</tr>
<tr>
<td>Previous openings</td>
<td>Previous history of child welfare involvement is a measure of chronicity.</td>
<td></td>
</tr>
<tr>
<td>Physical harm</td>
<td>The presence of physical harm is an indication of maltreatment severity. Although physical harm in neglected children is rare, when it does occur it is more likely to be serious (i.e., require medical treatment). Evidence of harm is thought to be a primary driver in determining “actual maltreatment.”</td>
<td>Drake, 1996</td>
</tr>
<tr>
<td>Emotional harm</td>
<td>The presence of emotional harm is an indication of maltreatment severity. Evidence of harm is thought to be a primary driver in determining actual maltreatment.</td>
<td>Drake, 1996</td>
</tr>
</tbody>
</table>

*continued on following page*
Table 7  
*Theoretical/Empirical Importance of Predictor Variables*

<table>
<thead>
<tr>
<th>Predictor variables</th>
<th>Theoretical assumptions</th>
<th>Support in the literature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Poverty related needs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income concerns</td>
<td>There is strong theoretical and empirical support for the relationship between poverty and neglect. Different theories emphasize the direct relationship (i.e., poverty prevents parents from providing materially for their children) and the indirect relationship (i.e., mediated by the strong association between poverty and poor caregiver functioning and/or the sense of hopelessness and helplessness experienced by poor caregivers).</td>
<td>Pelton 1979; 1994; Wolock &amp; Horowitz, 1979; 1984</td>
</tr>
<tr>
<td>Housing concerns</td>
<td>The same caregiver behaviours (i.e., lack of supervision) have different consequences in an unsafe housing context compared to a safe one. Families who have inadequate housing and/or who move frequently are more likely to be poor.</td>
<td>Courtney et al., 2004; Chau, Fitzpatrick, Hulchanski et al., 2009; Ross &amp; Roberts, 2000.</td>
</tr>
</tbody>
</table>

To decrease the degrees of freedom in the model and ensure adequate power, several strategies were used. First, the CIS-2008 dataset includes information about nine caregiver functioning concerns, all of which have theoretical and empirical support in the literature as ecological correlates of neglect. However, four caregiver concerns emerge in the literature as particularly strong predictors of neglect: alcohol problems; drug abuse; mental health problems; and few social supports. While other caregiver variables collected by the study are also associated with neglect (i.e., caregiver cognitive impairment, physical health problems, history of foster care as a child, and the presence of either caregiver victims or perpetrators of domestic violence in the home), they were not included in the model as they were considered to have a weaker association with neglect. Consideration was given to alternate approaches to caregiver functioning variables. For example, previous analyses of CIS data have clustered caregiver functioning variables into categories based on statistical procedures or used a count of the number of caregiver functioning concerns present for each case; for example, one, two, three, four, or more concerns. A limitation of these approaches for the current study is the inability to individually control for important correlates of...
analyses cannot specifically control for alcohol, drugs, and/or mental health concerns, variables which previous research has shown to be strong predictors of both substantiation and placement.

In the first stage of each regression analysis, frequencies were calculated to determine the extent of missing data. Cases with missing data were excluded from the analysis. This approach resulted in a total sample of 4,352 for the regression analysis predicting substantiation; 137 investigations (3% of the original sample) were excluded from the analysis. The sample was reduced to 4,210 for the regression predicting ongoing services due to missing data. The total sample for the analysis predicting child welfare placement was 1,768 child investigations. Comparison of the excluded data to the remainder of the sample suggested that excluded cases did not differ significantly from included cases on the outcome variables of interest.

Bivariate analyses (chi-squares for categorical variables, independent samples t tests for continuous variables) were conducted to identify predictor variables with a significant relationship to the outcome variables of interest. Despite the large number of bivariate analyses conducted, significance levels for all analyses were set at $p < .05$, as the research was considered exploratory and inclusiveness was important. Only variables with a statistically significant relationship to the outcome variables were included in the multivariate models. The final number of predictor variables was 16 for the logistic regression predicting substantiation, 19 for the logistic regression predicting ongoing service provision, and 15 for the logistic regression predicting child welfare placement.

Models were developed by entering predictor variables in theoretically relevant blocks (child, caregiver, household, case, and maltreatment and two variables measuring poverty-related needs of income and housing adequacy) to examine the change in the predictive ability of the model when poverty-related variables were entered. To facilitate this, clinical and case characteristic variables were entered into the model first as control variables, followed by the inclusion of the poverty-related variables. Given the association between poverty and several of the other predictor variables (e.g., alcohol and drug use, single female-led households, Aboriginal status) the model was run with the
poverty-related variables entered last to understand the unique contribution of poverty-related need to the case dispositions while controlling for other clinical concerns and case characteristics. This provided a conservative estimate of the extent to which decisions about case dispositions are affected by families’ poverty-related needs per se rather than characteristics often associated with poverty.

Cut points were adjusted to reflect the rate of case dispositions in the samples. The cut point for the model predicting substantiation was .43. For the model predicting ongoing service provision the cut point was .31; the cut point was .19 for the model predicting child placement.

**Dependent Variables**

Three case dispositions (substantiation status, the decision to keep a case open for ongoing services, and formal child welfare placement) were the dependent variables for this stage of the research. A description of these dispositions follows below:

**Substantiation**

Workers were asked to indicate the substantiation level for each child investigation at the conclusion of the CIS-2008 data collection instrument. Workers could choose from three levels, including: substantiated; suspected; and unfounded. Cases categorized as substantiated were those where the balance of evidence indicated that abuse or neglect had occurred. Cases noted as suspected were those where there was insufficient evidence to substantiate, although the worker was unable to rule out maltreatment. Finally, those cases categorized as unfounded were those where the evidence indicated that maltreatment had not occurred. For the current study, cases noted as substantiated were counted as substantiated. Cases where maltreatment was either suspected or unfounded were recoded as unsubstantiated, resulting in a dichotomous substantiation variable: substantiated (1); and unsubstantiated (0). Previous analysis of CIS-2003 data (see Trocmé, Knoke, Fallon, & MacLaurin, 2009) has suggested that substantiated and suspected cases differ along important dimensions and have a different trajectory through the front-end of the system; further, this analysis indicated that
approximately 40% of suspected cases could not be distinguished from unfounded investigations, although there was also some overlap between suspected and substantiated cases. The decision to collapse suspected and unfounded cases into one category to form a binary substantiation variable represents a conservative approach to the determination of maltreatment.

*Ongoing Services*

The CIS-2008 data collection form asked workers to indicate whether the case would remain open for ongoing services. Response options included yes and no and the variable was coded 0 (not open for ongoing services) or 1 (open for ongoing services).

*Child Welfare Placement*

The CIS-2008 data collection form asked workers to indicate the most appropriate child placement decision for each investigation. Options included: no placement required; placement considered; informal placement (i.e., kinship services); foster placement; group home placement; or residential secure treatment. This variable was recoded into a dichotomous variable, with 0 representing cases where no formal out-of-home placement occurred (no placement required, child placement considered, and informal placements) and 1 representing situations where the child was placed in a formal child welfare out-of-home placement (foster care, group home, or residential/secure treatment).

*Power*

To ensure that the analyses had adequate power, a power analysis following the methods recommended by Peduzzi, Concato, Kemper, Holford, and Feinstein (1996) was conducted for each of the regression analyses. These writers recommend that in a logistic regression, the sample size \((N)\) should be equal to 10 times the number of predictors in the model \((k)\) divided by the lowest frequency outcome of the dependent variable \((p)\), or \(N = 10k/p\). All three models had adequate sample size based on this formula.
Cluster Analyses

The fourth objective of the research was to explore whether there are subgroups of substantiated neglect cases characterized by different levels and/or combinations of poverty-related and clinical need. A particular objective of this part of the research was to assess whether there exists a subgroup of substantiated neglect cases characterized by high poverty-related need and low levels individually based risk factors (i.e., clinical need); in other words, cases called “neglect” by the child welfare system that are predominantly poverty.

The analytical approach to address this objective was cluster analysis, a method of empirically classifying or categorizing cases into groups in which members are simultaneously similar to each other and different from members of other groups (clusters). While there are three primary methods of cluster analysis (K-means, hierarchical, and two-step), only one of these methods (two-step) was appropriate for use with the CIS-2008 data, as it allows for the inclusion of both continuous and categorical data and can accommodate large sample sizes (Norusis, 2011). Two-step was also appropriate for the current research as the desired number of clusters was not known in advance, a requirement of the K-means method, but one which is optional for two-step cluster analyses.

The distance measure used (the measure that determines how the similarity between cases will be calculated) for datasets with both continuous and categorical variables is the log-likelihood criterion, which is a probability-based measure (Brandt, 2005). It produces the best results under the following circumstances: when variables are independent of one another; continuous variables are normally distributed; and categorical variables have a multinomial distribution (Norusis, 2011). Although this is often not the case in practice, the procedure in SPSS is robust enough that violations of the assumptions of independence and distribution are not considered serious (Brandt, 2005).

Selection of Clustering Variables

The selection of variables in cluster analysis cannot be determined through any statistical technique, but is important as it reflects the researcher’s assumptions about the relevance of the variables and
the purpose of the analysis (Everitt, Landau, & Leese, 2001). Variables can be selected based on either inductive (highly inclusive) or deductive (theory-driven) methods. Punj and Stewart (1983) support a deductive approach to variable selection, as including available but irrelevant variables may impact the validity of the clusters. Given that the primary purpose of this stage of the research was to determine whether cases of neglect can be grouped according to combinations and levels of poverty-related and individual child and caregiver clinical needs, only those variables that related to individual child/caregiver functioning and the level of poverty-related need were included in the cluster analysis.

Eight variables were included to partition the data into clusters. The following seven variables were identical to those included in the regression analyses, described earlier in the chapter:

- Any child physical/cognitive/developmental concerns
- Any child mental/emotional concerns
- Any child behavioural concerns
- Caregiver alcohol problems noted (household level)
- Caregiver drug/solvent problems noted (household level)
- Caregiver mental health concerns noted (household level)
- Caregiver few social supports (household level)

The last variable included in the analysis was the composite poverty variable described in the methods for objective 3a (pages 133–134). This variable was an ordinal measure of poverty-related needs that included three levels: no identified income or housing-related concerns; either income or housing concerns identified (but not both); and both income and housing concerns identified.

Running the Analyses and Assessing the Stability and Validity of the Cluster Solution

In total, three cluster analyses were run. To generate the first cluster solution, the full sample of substantiated neglect-only cases was used ($N = 1,921$). Cases were randomly sequenced using the
random number generator in MS Excel to address concerns that cluster analysis is influenced by the ordering of the cases in the dataset (Norusis, 2011). Validation of this initial “full sample” solution was then explored through a split half analysis. The dataset was randomly split into two groups: a “test” sample, \( N = 960 \); and a “cross-validation” sample, \( N = 961 \). A two-step cluster analysis was run on the test sample. The number of clusters in the cluster solution was then imposed on the cross-validation sample through the two-step procedure. Cluster solutions from these two halves were compared to each other and to the full sample solution to assess the stability of the clusters in terms of number and profile (Brandt, 2005).

Cluster analysis is exploratory in nature and has some inherent limitations. Different methods can yield differences in the number and membership of the clusters (Mezzich & Solomon, 1980). There are few guidelines and no statistical tests to assist in selecting the best solution and an assessment of its heuristic utility may be the best way of deciding between different solutions. Clusters may not be stable across analyses and assessing both the clinical usefulness of the clusters and their stability is important.

Jain and Dubes (1988, p. 188) note that “the validation of clustering structures is the most difficult and frustrating part of cluster analysis.” They suggest several techniques beyond the split half analyses and randomization of the data employed above. For example, these authors suggest that the use of an external index (i.e., data not used in the clustering) can be used to assess the extent to which cluster labels match externally supplied class labels. Limitations with this method include the notion that reproducing previous results may not be the intention of exploratory research. Further, Mooi and Sarstedt (2011) suggest that validating the cluster solution can be done through an assessment of criterion validity. This entails using variables that have a theoretically-based relationship to the clustering variables but were not included in the analysis. For example, case outcomes related to ongoing service provision and child placement should be related, in theory, to different levels of clinical and poverty-related need as these constitute both potential risks for recurrence of maltreatment and needs that should (or could) be addressed through
service. Chi-square analyses were run comparing the clusters within each solution on these two outcome variables to see if they differed significantly across clusters; if these outcomes variables are statistically significantly (and clinically significantly) different, there is greater confidence that the clusters represent distinct groups (i.e., non-random structure within the data).

**Describing the Clusters**

Once the cluster solutions were assessed for acceptable validity and stability, other descriptive data and case characteristics were used to describe differences in the cluster membership of the full sample solution. These variables included: child age and Aboriginal status; caregiver victim or perpetrator of domestic violence; the presence of physical or emotional harm to the child; prior child welfare history; and the form of substantiated neglect.
Chapter 6: Results, Descriptive Analyses

Results: Objective 1

Summary of Research Methods, Objective 1

The first objective of the research was to document the nature and frequency of caregiver and child clinical concerns, as well as poverty-related needs in substantiated and unsubstantiated child neglect investigations. Cross tabulations were run for all caregiver functioning variables collected through the CIS-2008 (outlined in Table 2 of the dissertation, page 127) by substantiation status. Child functioning concerns were also documented for substantiated and unsubstantiated cases, stratified by age at the time of investigation. Finally, cross tabulations were run for each poverty-related need (outlined in Table 2) collected through the CIS-2008 by substantiation status. As the objective of this stage of the research was to document the presenting concerns for both substantiated and unsubstantiated neglect investigations, no tests of statistical significance were run to determine relationships among caregiver, child, and poverty-related needs and substantiation status. Once descriptive statistics were run, a new variable was derived that best described the nature of the presenting concern(s) of each case, comprised of the following four categories: (1) no identified needs, (2) only poverty-related needs, (3) only clinical needs (either child and/or caregiver), and (4) both poverty and clinical needs. These categories supported the second objective of the research, which assessed the service referral response to both substantiated and unsubstantiated neglect investigations by the nature of presenting needs.

25 Significance at the bivariate level between substantiation status and caregiver, child, and poverty-related concerns is assessed through Objective 3b of the research and reported in the Results section for Objective 3b, beginning on page 180.
Results: Caregiver Clinical Concerns

Table 8
Caregiver Clinical Concerns (Household Level), by Substantiation Status, N = 4,489

<table>
<thead>
<tr>
<th>Caregiver concern</th>
<th>Unsubstantiated (N = 2,568)</th>
<th>Substantiated (N = 1,921)</th>
<th>Total (N = 4,489)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Few social supports</td>
<td>789</td>
<td>31</td>
<td>967</td>
</tr>
<tr>
<td>Alcohol</td>
<td>520</td>
<td>20</td>
<td>718</td>
</tr>
<tr>
<td>Mental health</td>
<td>502</td>
<td>20</td>
<td>652</td>
</tr>
<tr>
<td>Drug/solvents</td>
<td>484</td>
<td>19</td>
<td>636</td>
</tr>
<tr>
<td>Victim of domestic violence</td>
<td>478</td>
<td>19</td>
<td>458</td>
</tr>
<tr>
<td>Physical health</td>
<td>241</td>
<td>9</td>
<td>273</td>
</tr>
<tr>
<td>History of foster care as child</td>
<td>212</td>
<td>8</td>
<td>252</td>
</tr>
<tr>
<td>Perpetrator of domestic violence</td>
<td>237</td>
<td>9</td>
<td>225</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>172</td>
<td>7</td>
<td>228</td>
</tr>
<tr>
<td>At least one functioning concern</td>
<td>1,604</td>
<td>62</td>
<td>1,572</td>
</tr>
</tbody>
</table>

Table 8 shows the frequency and percentage of nine caregiver clinical concerns for both substantiated and unsubstantiated neglect investigations. Caregiver concerns are documented at the household level (i.e., if either the primary or where applicable the secondary caregiver residing in the household had a particular issue noted, it was considered present for the household). Table 8 presents these concerns in descending order based on their frequency in the sample as a whole (N = 4,489).

Overall, 39% of children in the sample live in households where at least one caregiver is identified as having few social supports (50% for substantiated and 31% for unsubstantiated investigations). Approximately one-quarter of investigated children live in households where at least one caregiver suffers from alcohol problems (28%), mental health problems (26%), or drug/solvent abuse (25%). Although no statistical tests were run, the frequency of these issues appears higher in substantiated compared to unsubstantiated cases (see Table 8 for details). One-fifth (21%) of investigated children live in households where at least one caregiver is identified as a victim of domestic violence. Eleven
per cent of children investigated live in households where at least one caregiver has physical health concerns (14% in substantiated and 9% in unsubstantiated investigations) and 10% of investigated children live with a primary and/or secondary caregiver with a history of foster care as a child (13% of substantiated cases and 8% of unsubstantiated cases). Overall, 10% of investigated children live with at least one caregiver who is a perpetrator of domestic violence (12% and 9% of substantiated and unsubstantiated investigations, respectively) and 9% of child investigations involve a primary and/or secondary caregiver who has a noted cognitive impairment (12% and 7% of substantiated and unsubstantiated investigations, respectively).

As illustrated by Table 8, the majority of substantiated cases (82%) involve children living in households where at least one caregiver concern is present; almost two thirds (62%) of unsubstantiated cases also involve caregivers with at least one clinical concern.

**Results: Child Functioning Concerns**

**Substantiated Investigations**

Frequencies and percentages of noted child functioning concerns were documented separately for substantiated and unsubstantiated cases and stratified by age of the child at the time of investigation. Table 9 presents these concerns in descending order for the sample as a whole (N = 4,489).
<table>
<thead>
<tr>
<th>Child concern</th>
<th>0–3 years (N = 557)</th>
<th>4–7 years (N = 482)</th>
<th>8–11 years (N = 434)</th>
<th>12–15 years (N = 448)</th>
<th>Total (N = 1,921)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Academic difficulties</td>
<td>12</td>
<td>2</td>
<td>132</td>
<td>27</td>
<td>180</td>
</tr>
<tr>
<td>Depression/anxiety/withdrawal</td>
<td>8</td>
<td>1</td>
<td>50</td>
<td>10</td>
<td>104</td>
</tr>
<tr>
<td>Attachment issues</td>
<td>56</td>
<td>10</td>
<td>77</td>
<td>16</td>
<td>78</td>
</tr>
<tr>
<td>Aggression</td>
<td>17</td>
<td>3</td>
<td>57</td>
<td>12</td>
<td>69</td>
</tr>
<tr>
<td>Intellectual/developmental disability</td>
<td>42</td>
<td>8</td>
<td>73</td>
<td>15</td>
<td>79</td>
</tr>
<tr>
<td>Failure to meet developmental milestones</td>
<td>78</td>
<td>14</td>
<td>77</td>
<td>16</td>
<td>51</td>
</tr>
<tr>
<td>ADD/ADHD</td>
<td>15</td>
<td>3</td>
<td>68</td>
<td>14</td>
<td>72</td>
</tr>
<tr>
<td>FASD</td>
<td>39</td>
<td>7</td>
<td>31</td>
<td>6</td>
<td>33</td>
</tr>
<tr>
<td>Self-harming behaviour</td>
<td>3</td>
<td>1</td>
<td>19</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td>Running (multiple incidents)</td>
<td>1</td>
<td>0</td>
<td>12</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Drug/solvent abuse</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Inappropriate sexual behaviour</td>
<td>4</td>
<td>1</td>
<td>16</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Other functioning issue</td>
<td>18</td>
<td>3</td>
<td>16</td>
<td>3</td>
<td>31</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>YCJA involvement</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Positive toxicology at birth</td>
<td>29</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Physical disability</td>
<td>12</td>
<td>2</td>
<td>12</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>At least 1 functioning concern</td>
<td>169</td>
<td>30</td>
<td>232</td>
<td>48</td>
<td>265</td>
</tr>
</tbody>
</table>

Children 0–3 Years: Substantiated

As shown in Table 9, 30% of investigated infants and toddlers (N = 557) for whom neglect was substantiated presented with at least one functioning concern, the lowest frequency across all age
groups. The profile of these children differs from that of the sample overall. The most frequently identified concerns for children in this age group were: failure to meet developmental milestones (14%), attachment issues (10%), intellectual/developmental disability (8%), and FAS/FAE (7%). Although the frequency is very low across all age groups, infants and toddlers had the highest rate of noted positive toxicology at birth, at 5% of this subsample.

**Children 4–7 Years: Substantiated**

Almost half (48%) of early school-aged children (those aged 4–7 years, \( N = 482 \)) who were the subject of a substantiated investigation presented with at least one functioning concern. The predominant concern for these children was academic difficulties, with over one-quarter (27%) of children aged 4–7 years noted as struggling in school. Sixteen per cent of children in this age group were also identified as having attachment issues and/or failing to meet developmental milestones, and 15% were noted as having an intellectual/developmental disability. ADD/ADHD was a noted problem for 14% of these children, aggression was identified as an issue for 12%, and depression/anxiety/withdrawal was a concern for 10% of children aged 4–7. Similar to their younger counterparts, 6% of children in these age groups were identified with FAS/FAE.

**Children 8–11 Years: Substantiated**

Sixty-one per cent of children aged 8–11 years who were the subject of a substantiated neglect investigation (\( N = 434 \)) had at least one noted functioning concern. A similar profile of needs is evident for these later elementary school-aged children, although the frequency of noted concerns may be higher than for their early elementary school counterparts. For example, well over one-third of children aged 8–11 (41%) were identified as having academic difficulties and almost one-quarter (24%) were identified as either depressed or anxious/withdrawn. Eighteen per cent of these children were assessed as having attachment issues and/or an intellectual/developmental disability. Seventeen per cent were noted as having ADD/ADHD and fully 16% of late elementary school-aged children
were noted as having aggressive behaviour and/or attachment issues. Twelve per cent were assessed as failing to meet developmental milestones. Unlike younger children, whose behavioural and/or emotional concerns were negligible, a small minority (7%) of latency aged children in substantiated neglect investigations presented with concerns related to self-harm. Further, 8% were identified with FAS/FAE.

**Youth 12–15 Years: Substantiated**

Adolescents aged 12–15 who were the subject of a substantiated neglect investigation ($N = 448$) presented with the highest frequency of concerns among children in substantiated cases. Overall, more than three-quarters (79%) of children in this age group had at least one functioning concern noted. The most commonly identified concerns were similar to both early and later elementary school-aged children, however the point prevalence of these concerns among this subsample was considerably higher. For example, academic difficulties were noted for adolescents at the highest rate compared to any other age category—53% of teenagers were noted as struggling in school. The rate of depression/anxiety/withdrawal was also highest among teenagers, at 42% of this subsample. Over one-third (34%) of adolescents in substantiated neglect investigations were assessed as aggressive and over one-quarter (29%) were considered to have attachment issues. Almost one-quarter of teenagers (22%) were noted as having an intellectual/developmental disability and/or engaging in drug/solvent use (23%); approximately one-fifth of teenagers had a diagnosis of ADD/ADHD (19%), engaged in self-harming behaviour (18%), drug/solvent use (21%), or frequent running behaviour (21%). Emotional and behavioural concerns were most common in this age group compared to any other age category, with 17% engaged in problematic use of alcohol, 16% of youth in substantiated neglect cases were noted to have suicidal thoughts; and 14% had involvement under the *Youth Criminal Justice Act* (YCJA). Similar to their younger counterparts, 7% of adolescents were noted to have FAS/FAE.
Unsubstantiated Investigations

Functioning concerns for children in unsubstantiated neglect investigations were documented separately from children for whom neglect was substantiated. Table 10 (below) shows the functioning concerns by age category for children who were the subject of unsubstantiated neglect investigations in descending order for the sample overall \( (N = 2,568) \).

Table 10

*Child Functioning Concerns by Child Age, Unsubstantiated Neglect, N = 2,568*

<table>
<thead>
<tr>
<th>Child concern</th>
<th>0–3 years ( (N = 708) )</th>
<th>4–7 years ( (N = 641) )</th>
<th>8–11 years ( (N = 638) )</th>
<th>12–15 years ( (N = 581) )</th>
<th>Total ( (N = 2,568) )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic difficulties</td>
<td>9</td>
<td>106</td>
<td>164</td>
<td>222</td>
<td>501</td>
</tr>
<tr>
<td>Depression/anxiety/withdrawal</td>
<td>1</td>
<td>38</td>
<td>81</td>
<td>159</td>
<td>279</td>
</tr>
<tr>
<td>Aggression</td>
<td>8</td>
<td>56</td>
<td>84</td>
<td>118</td>
<td>266</td>
</tr>
<tr>
<td>Intellect./develop. disability</td>
<td>30</td>
<td>64</td>
<td>74</td>
<td>79</td>
<td>247</td>
</tr>
<tr>
<td>ADD/ADHD</td>
<td>7</td>
<td>54</td>
<td>72</td>
<td>83</td>
<td>216</td>
</tr>
<tr>
<td>Attachment issues</td>
<td>18</td>
<td>35</td>
<td>53</td>
<td>72</td>
<td>178</td>
</tr>
<tr>
<td>Failure to meet developmental milestones</td>
<td>50</td>
<td>45</td>
<td>40</td>
<td>37</td>
<td>172</td>
</tr>
<tr>
<td>Running (multiple incidents)</td>
<td>0</td>
<td>3</td>
<td>17</td>
<td>81</td>
<td>101</td>
</tr>
<tr>
<td>Self-harming behaviour</td>
<td>2</td>
<td>11</td>
<td>30</td>
<td>55</td>
<td>98</td>
</tr>
<tr>
<td>Drug/solvent abuse</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>91</td>
<td>96</td>
</tr>
<tr>
<td>Inappropriate sexual behaviour</td>
<td>2</td>
<td>25</td>
<td>16</td>
<td>45</td>
<td>88</td>
</tr>
<tr>
<td>Other functioning issue</td>
<td>16</td>
<td>25</td>
<td>21</td>
<td>26</td>
<td>88</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>64</td>
<td>67</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>0</td>
<td>5</td>
<td>11</td>
<td>50</td>
<td>66</td>
</tr>
<tr>
<td>YCJA involvement</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>51</td>
<td>51</td>
</tr>
<tr>
<td>Physical disability</td>
<td>8</td>
<td>11</td>
<td>12</td>
<td>15</td>
<td>46</td>
</tr>
<tr>
<td>Fetal alcohol syndrome/effect</td>
<td>4</td>
<td>10</td>
<td>11</td>
<td>19</td>
<td>44</td>
</tr>
<tr>
<td>Positive toxicology at birth</td>
<td>17</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>At least 1 functioning concern</td>
<td>103</td>
<td>209</td>
<td>259</td>
<td>350</td>
<td>921</td>
</tr>
</tbody>
</table>
Children 0–3 Years: Unsubstantiated

Similar to the youngest children in substantiated investigations, infants and toddlers who were the subject of unsubstantiated neglect investigations had very low rates, overall, of all functioning concerns. Of the 708 children in this subsample, 15% had at least one functioning concern. The most commonly noted concerns included failure to meet developmental milestones (7%), intellectual/developmental disability (4%), and attachment issues (3% of children aged 0–3 years).

Children 4–7 Years: Unsubstantiated

One-third of early elementary school-aged children aged 4–7 years (N = 641) in unsubstantiated neglect investigations were identified as having at least one functioning concern. Similar to their substantiated counterparts, these children were most likely to present with concerns of a developmental or academic nature, but with less frequency than children in substantiated neglect investigations. Predominant concerns for children in unsubstantiated investigations in this age group include academic difficulties (17%), intellectual/developmental disability (10%), aggressive behaviour (9%), ADD/ADHD (8%), failure to meet developmental milestones (7%), and depression/anxiety/withdrawal (6%). Attachment issues were noted for 5% of children in this subsample.

Children 8–11 Years: Unsubstantiated

Forty-one per cent of latency aged children (8–11 years, N = 638) who were the subject of an unsubstantiated neglect investigation had at least one functioning concern. Twenty-six per cent of these children had academic difficulties noted and like their substantiated same-aged peers, this was the most commonly noted functioning concern for these children. Aggressive behaviour and depression/anxiety/withdrawal were also noted for this age group, with concerns noted for 13% of 8–11 year olds in unsubstantiated neglect investigations. Twelve per cent of latency aged children had intellectual/developmental disabilities noted and 11% had a diagnosis of ADD/ADHD. Eight per cent were considered to have attachment issues.
Youth 12–15 Years: Unsubstantiated

Sixty per cent of adolescents who were the subject of an unsubstantiated neglect investigation (N = 581) presented with at least one functioning concern, the highest frequency across all age groups of unsubstantiated cases. These young people, similar to same aged peers in substantiated cases of neglect, were most commonly noted to experience academic difficulties (38%), depression/anxiety/withdrawal (27%), or to display aggressive behaviour (20%), although the proportion of children in this age group with these problem is lower in unsubstantiated cases. Sixteen per cent were engaged in drug/solvent use, and 14% had a diagnosis of ADD/ADHD and/or were noted to have intellectual/developmental disabilities. Attachment issues were a noted concern for 12%, while 11% had concerns with respect to alcohol abuse. Similar to children in substantiated cases, adolescents in unsubstantiated neglect investigations showed the highest rate of emotional and/or behavioural concerns compared to their younger peers. Although the frequencies are lower than for teenagers who were the subject of a substantiated investigation, just under 10% of this subsample was identified as having suicidal thoughts, self-harming behaviour, or involvement under the Youth Criminal Justice Act. Eight per cent engaged in inappropriate sexual behaviour.

Results: Poverty-Related Concerns

Poverty-related concerns collected by the CIS-2008 data collection instrument consist of variables representing disadvantage in either source and/or adequacy of income or housing. These indicators, while not a continuous measure of poverty such as income, provide an index of socio-economic stress are associated with low income in previous research (Ross & Roberts, 2000).

Source and Adequacy of Income

As shown in Table 11 (page 164), the majority of children in both substantiated and unsubstantiated investigations live in households where the primary source of income is not from full-time employment. Of the 1,921 children who were the subjects of substantiated investigations, 35% lived
in households where at least one caregiver was employed full-time; this rate was slightly higher for children in unsubstantiated investigations, at 45%. For children in substantiated investigations, the most common source of income was unemployment/other benefits (45%). Benefits were the second most common source of income for the households of children in unsubstantiated cases at 36% of this subsample. The remaining children in both substantiated and unsubstantiated investigations lived in households deriving income through part-time/seasonal work (11% and 12% respectively) or through unknown (7% and 6% respectively) or no source (2% and 1% of the subsamples, respectively). In one-quarter of substantiated child investigations, workers indicated that the household regularly runs out of money for basic necessities; 12% of unsubstantiated child investigations were so assessed. The response to this question was noted as unknown for 21% of the sample overall (22% of substantiated and 21% of unsubstantiated investigations, respectively).

**Housing Type and Environment**

The vast majority (79%) of children investigated for neglect, whether substantiated or not, do not live in a home owned by their caregivers. The rate of home ownership is lower in substantiated cases (17%) compared to unsubstantiated cases (23%). Approximately half of investigated children (51%) live in rental accommodations, with an additional 15% living in public housing and 5% living in (First Nations) band housing (5%). A slightly higher proportion of children in substantiated investigations live in one of these two housing types (21% combined) compared to unsubstantiated cases (18% combined). The remaining children live in either a shelter/hotel (1%), a housing type other than those previously mentioned (3%), or in a form of housing unknown to the worker (5%). Almost one-quarter of children who were the subject of a substantiated investigation live in a home where at least one household hazard is present (i.e., access to drugs; weapons; physical hazards, such as broken glass, exposed wires; or other health or safety concerns). The housing environment was deemed hazardous for 7% of children in unsubstantiated investigations. In 13% of substantiated child investigations, the home was assessed as overcrowded; it was so assessed in
Table 11

Poverty-Related Concerns, by Substantiation Status, N = 4,489

<table>
<thead>
<tr>
<th>Poverty concerns</th>
<th>Unsubstantiated (N = 2,568)</th>
<th>Substantiated (N = 1,921)</th>
<th>Total (N = 4,489)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Source and adequacy of income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Household source of income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>1,163</td>
<td>45</td>
<td>678</td>
</tr>
<tr>
<td>Part-time &lt;30 hours/seasonal</td>
<td>303</td>
<td>12</td>
<td>205</td>
</tr>
<tr>
<td>Other benefits/unemployment</td>
<td>927</td>
<td>36</td>
<td>865</td>
</tr>
<tr>
<td>Unknown source</td>
<td>154</td>
<td>6</td>
<td>126</td>
</tr>
<tr>
<td>No source of income</td>
<td>21</td>
<td>1</td>
<td>47</td>
</tr>
<tr>
<td>Household regularly runs out of $</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1,743</td>
<td>68</td>
<td>1,021</td>
</tr>
<tr>
<td>Yes</td>
<td>296</td>
<td>12</td>
<td>481</td>
</tr>
<tr>
<td>Unknown</td>
<td>529</td>
<td>21</td>
<td>419</td>
</tr>
<tr>
<td>Type and adequacy of housing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own home</td>
<td>612</td>
<td>24</td>
<td>336</td>
</tr>
<tr>
<td>Rental</td>
<td>1,274</td>
<td>50</td>
<td>1,003</td>
</tr>
<tr>
<td>Public housing</td>
<td>362</td>
<td>14</td>
<td>281</td>
</tr>
<tr>
<td>Band housing</td>
<td>109</td>
<td>4</td>
<td>121</td>
</tr>
<tr>
<td>Hotel/shelter</td>
<td>15</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td>Other</td>
<td>63</td>
<td>2</td>
<td>56</td>
</tr>
<tr>
<td>Unknown</td>
<td>133</td>
<td>5</td>
<td>91</td>
</tr>
<tr>
<td>Home overcrowded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2,236</td>
<td>87</td>
<td>1,577</td>
</tr>
<tr>
<td>Yes</td>
<td>241</td>
<td>9</td>
<td>256</td>
</tr>
<tr>
<td>Unknown</td>
<td>92</td>
<td>4</td>
<td>87</td>
</tr>
<tr>
<td>Number of moves in past year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1,221</td>
<td>48</td>
<td>799</td>
</tr>
<tr>
<td>One</td>
<td>533</td>
<td>21</td>
<td>376</td>
</tr>
<tr>
<td>Two or more</td>
<td>270</td>
<td>11</td>
<td>274</td>
</tr>
<tr>
<td>Unknown</td>
<td>544</td>
<td>21</td>
<td>472</td>
</tr>
<tr>
<td>At least one household hazard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2,405</td>
<td>94</td>
<td>1,458</td>
</tr>
<tr>
<td>Yes</td>
<td>163</td>
<td>6</td>
<td>463</td>
</tr>
</tbody>
</table>
11% of unsubstantiated investigations. Finally, one-fifth (20%) of children investigated for neglect, whether substantiated or not, had moved once in the past 12 months; 14% of children who were the subject of substantiated investigations and 11% of children in unsubstantiated investigations had moved two or more times in the last year at the time of data collection. This information was unknown for 23% of the sample.

**Categorization of Presenting Needs**

Presenting child and caregiver concerns (outlined in Tables 8 through 10) were considered clinical concerns as they point to the need for some type of individual and/or family-based therapeutic intervention. Concerns related to income and housing adequacy (outlined in Table 11) were considered poverty-related needs due to their association with low income. A variable was derived to describe the overall presenting needs for each case, using the following approach: cases where the only presenting needs were clinical in nature were coded as *only clinical needs*; cases where the presenting needs were related only to income source and/or adequacy of housing were coded as *only poverty-related needs*; cases in which both of these types of needs were noted were coded as *both poverty-related and clinical needs*; and cases where workers identified neither clinical nor poverty-related needs were documented as *no identified needs*. Table 12 shows the results of categorizing child investigations according to the nature of the identified needs, by substantiation status.

**Table 12**

*Nature of Identified Needs at Investigation by Substantiation Status, N = 4,489*

<table>
<thead>
<tr>
<th>Identified needs</th>
<th>Unsubstantiated (N = 2,568)</th>
<th>Substantiated (N = 1,921)</th>
<th>Total (N = 4,489)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>No identified needs***</td>
<td>301</td>
<td>12</td>
<td>87</td>
</tr>
<tr>
<td>Only poverty-related needs***</td>
<td>365</td>
<td>14</td>
<td>113</td>
</tr>
<tr>
<td>Only clinical needs***</td>
<td>606</td>
<td>24</td>
<td>333</td>
</tr>
<tr>
<td>Both poverty and clinical***</td>
<td>1,296</td>
<td>50</td>
<td>1,388</td>
</tr>
<tr>
<td>Total</td>
<td>2,568</td>
<td>100</td>
<td>1,921</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001
As Table 12 illustrates, 9% of children investigated for neglect lived in households for which there were no identified needs (no caregiver, child, or poverty-related concerns were identified at the time of the investigation). The proportion was higher for children in unsubstantiated cases (12%) than for substantiated investigations (5%). A further 11% of the children investigated lived in households where only poverty-related (i.e., income and/or housing related) needs were identified; again, this was more likely for children who were the subject of an unsubstantiated compared to a substantiated investigation (14% compared to 6% respectively). Twenty-one percent of investigated children lived in households for which workers noted clinical needs only (24% of children in unsubstantiated and 17% in substantiated investigations). At the conclusion of the majority of investigations (60% overall), workers noted that children’s living situations were marked by both poverty and clinical needs, with 50% of unsubstantiated child investigations so characterized compared to almost three-quarters (72%) of substantiated investigations.

Summary of Objective 1 Results

The first objective of the research was to document the presenting needs of both substantiated and unsubstantiated child neglect investigations. The purpose of this stage of the research was not to look for statistically significant differences between substantiated and unsubstantiated cases (although some comparisons are made to highlight marked differences), but rather to consider all investigations as opportunities to assess family needs that may need to be addressed either through the child welfare system and/or through referrals to other supportive community-based services. Documenting the child, caregiver, and poverty-related needs for both substantiated and unsubstantiated cases provides an indication of the nature and level of service needs for all investigated cases.

Results of this descriptive analysis highlight that almost two-fifths of children investigated for neglect (39%) live with socially isolated caregivers and a sizeable minority live with at least one caregiver struggling with concerns related to alcohol, drugs, and/or mental health. Although limited
social support was identified as a problem for caregivers of half of the substantiated children, it is also an issue for almost one-third of caregivers in unsubstantiated child investigations. Further, while alcohol, mental health, and drug problems (well-known correlates of neglect) are more likely to present in substantiated cases (approximately one-third), these concerns are also present in approximately one-fifth of unsubstantiated cases.

As with caregiver problems, child functioning concerns are more prevalent among the children for whom neglect was substantiated but are also evident for children in unsubstantiated cases. Analysing the data by age category highlights different constellations of need for different ages/developmental stages. Consistent with previous analyses of child welfare data, the youngest children (those aged 0–3 years) who come into contact with child welfare are more likely to present with developmental concerns (i.e., failure to meet developmental milestones) compared to other child functioning issues. Analyses also highlight the high proportion of investigated children (whether substantiated or not) who are struggling academically across all school-aged groups and in particular, the academic difficulties experienced by adolescents who come into contact with the child welfare system. The same pattern is evident for depression/anxiety/withdrawal and aggressive behaviour—concerns experienced by a substantial minority of children aged 8–11 and 12–15, regardless of substantiation status.

Documentation of poverty-related needs reveals that for a sizeable minority of children investigated for neglect, inadequate household income and/or housing may be a factor. Less than half of investigated children (41%) live in households where at least one caregiver has full-time work, a resource that is particularly uncommon for children in substantiated cases (35%). Two-fifths of the sample (40%) live in households where the primary source of income is unemployment/other benefits (i.e., social assistance). Further, in almost one-quarter of substantiated child neglect investigations, workers indicated that the household regularly runs out of money for basic necessities, a finding more common for children in substantiated cases. One-fifth of investigated children live in some form of subsidized housing (either public housing or band housing). Unsafe housing is
a particular concern for children in substantiated cases of neglect, with almost one-quarter living in homes where at least one household hazard is present; this issue affects a comparatively low proportion of children in unsubstantiated cases (7%).

Categorization of presenting needs for cases of investigated neglect demonstrates that only a small minority of investigated children (9%) live in households with no identified needs (neither clinical nor poverty-related). Further, classifying cases according to presenting needs reveals that a similarly small subgroup (11% of all investigated cases) present with noted poverty-related needs alone (i.e., no clinical concerns are noted). This is more prevalent in the unsubstantiated subsample (14%) compared to the substantiated sub-group (6%). While 20% of all neglect investigations in the sample can be classified as having only identified clinical needs, the majority of investigated children (60%) live in households where both clinical and poverty-related needs are present; this is particularly true for substantiated cases (72%) compared to unsubstantiated cases (51%).

Results: Objective 2

Summary of Research Methods, Objective 2

The second objective of the research was to classify and document the nature of the child welfare service response to both substantiated and unsubstantiated cases of investigated neglect. Service referrals made at the conclusion of the investigation for any member of the household were coded into one of five initial categories: parenting/family support, clinical/treatment, material support, social/recreational support, and other service referrals. Frequencies were run for these referral categories for both substantiated and unsubstantiated cases. Cases could have referrals in up to five of these categories. Following this, parenting/family support referrals and clinical/treatment referrals were collapsed into a new category called rehabilitative services and material support referrals and social/recreational support referrals were collapsed into a category entitled concrete services. These new categories were then used to categorize cases based on the overall service response, which
included the following options: no referrals made, only rehabilitative referrals made, only concrete referrals made, and both rehabilitative and concrete referrals made. Cases with only other referrals were coded as other. Cross tabulations were then run using the classification of presenting needs developed through the previous stage of the research (no identified needs, only clinical needs, only poverty-related needs, and both clinical and poverty related needs) to assess the suitability of the service response to the presenting needs of the case.

**Initial Classification of Referrals**

Table 13

<table>
<thead>
<tr>
<th>Type of referral</th>
<th>Unsubstantiated (N = 2,568)</th>
<th>Substantiated (N = 1,921)</th>
<th>Total (N = 4,489)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Parenting/family support***</td>
<td>576</td>
<td>22</td>
<td>769</td>
</tr>
<tr>
<td>Clinical/treatment***</td>
<td>311</td>
<td>12</td>
<td>718</td>
</tr>
<tr>
<td>Material support***</td>
<td>309</td>
<td>12</td>
<td>410</td>
</tr>
<tr>
<td>Social/recreational support</td>
<td>45</td>
<td>2</td>
<td>49</td>
</tr>
<tr>
<td>Other referrals*</td>
<td>139</td>
<td>5</td>
<td>140</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001

As illustrated in Table 13, the most common type of referral made for investigated cases of neglect was to services related to parenting skills training and/or family support. This type of referral was made in two-fifths (40%) of substantiated investigations and in almost one-quarter (22%) of unsubstantiated investigations. Clinical/treatment referrals were similarly common for substantiated cases, with 37% of families receiving a referral to a form of clinical/treatment services (e.g., alcohol or drug counselling, psychiatric/psychological services). This type of referral was less common in unsubstantiated investigations, with 12% of the sample receiving a referral of this nature. Material support referrals (e.g., social assistance, housing services, food bank) were made for just 16% of all investigated cases, with over one-fifth (21%) of substantiated cases and 12%
of unsubstantiated cases receiving a referral for this type of service. Social/recreational support services (e.g., cultural centre, YMCA, Big Brothers) were the least likely to be facilitated, with only 2% of the sample overall receiving a referral of this nature (3% and 2% of substantiated and unsubstantiated cases respectively). Finally, other referrals were made for 7% of substantiated cases and 5% of unsubstantiated investigations.

**Collapsed Referral Categories**

Referral types noted above were collapsed into three groups. Parenting/family support referrals and clinical/treatment referrals were considered rehabilitative: designed to change the person in some way (Pelton, 2008). Material support referrals and social/recreational services were collapsed into a category called concrete services: designed to change the person’s situation or environment (Pelton, 2008). Table 14 shows the frequency of referrals based on these new categories for both substantiated and unsubstantiated cases. Over one-half (57%) of substantiated cases were provided with at least one rehabilitative referral, as were over one-quarter (28%) of unsubstantiated cases. Almost one-quarter (23%) of substantiated investigations resulted in at least one referral to a service designed to meet a concrete need, compared to 13% of unsubstantiated cases. A small percentage of cases were provided with a referral type classified as other (neither rehabilitative nor concrete): 7% of substantiated cases and 5% of unsubstantiated cases.

<table>
<thead>
<tr>
<th>Collapsed referral category</th>
<th>Unsubstantiated (N = 2,568)</th>
<th>Substantiated (N = 1,921)</th>
<th>Total (N = 4,489)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Any rehabilitative referrals***</td>
<td>726</td>
<td>28</td>
<td>1,086</td>
</tr>
<tr>
<td>Any concrete referrals***</td>
<td>335</td>
<td>13</td>
<td>441</td>
</tr>
<tr>
<td>Any other referrals</td>
<td>139</td>
<td>5</td>
<td>140</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001
**Nature of the Service Referral Response**

Using the new categories outlined in Table 14, a new variable was derived that classified the overall referral response to the case. For child investigations that resulted in only rehabilitative referrals, the case was coded as “only rehabilitative referrals.” For those investigations resulting in only concrete referrals, the case was coded as “only concrete referrals.” Cases for which workers made both rehabilitative and concrete referrals were coded as “both rehabilitative and concrete.” If only referrals defined as “other” were made, the case was coded as “other.” Finally, in cases where workers facilitated no referrals to supportive services at the conclusion of the investigation, a classification of “no referrals made” was given. Table 15 shows the frequency of these categories of referral responses by substantiation status.

Table 15

<table>
<thead>
<tr>
<th>Nature of the referral response</th>
<th>Unsubstantiated (N = 2,568)</th>
<th>Substantiated (N = 1,921)</th>
<th>Total (N = 4,489)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>No referrals made***</td>
<td>1,606</td>
<td>63</td>
<td>651</td>
</tr>
<tr>
<td>Only concrete referrals</td>
<td>171</td>
<td>7</td>
<td>131</td>
</tr>
<tr>
<td>Only rehabilitative referrals***</td>
<td>532</td>
<td>21</td>
<td>751</td>
</tr>
<tr>
<td>Both rehabilitative and concrete referrals***</td>
<td>194</td>
<td>8</td>
<td>335</td>
</tr>
<tr>
<td>Only “other” referrals</td>
<td>65</td>
<td>3</td>
<td>53</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001

As illustrated by Table 15, one-half of investigated cases received no service referrals at the conclusion of the investigation although rates differed by substantiation status, with 34% of substantiated investigations receiving no referrals compared to 63% of unsubstantiated cases. The most common service referral response for substantiated cases was rehabilitative only, with 40% of these cases receiving rehabilitative referrals only compared to just over one-fifth (21%) of unsubstantiated cases. A small minority of both subgroups received a service referral response
classified as concrete only (7% of substantiated and 6% of unsubstantiated investigations). Both rehabilitative and concrete referrals were made for an additional 16% of substantiated cases and 7% of unsubstantiated cases. Three per cent of investigated cases received only other referrals.

**Service Referral Response by Identified Needs: Substantiated Investigations**

Analyses were conducted to assess the nature of the child welfare service referral response by the nature of the identified needs. As presented in Table 12, 5% of substantiated cases had no identified needs at the conclusion of the investigations, 6% had only poverty-related needs identified, 17% were assessed as having only clinical needs, and the remaining 72% were noted to have both poverty and clinical needs. Table 16 shows the results of the cross tabulations of nature of the presenting needs by the nature of the child welfare service referral response for substantiated investigations.

<table>
<thead>
<tr>
<th>Nature of child welfare response</th>
<th>No Identified Needs (N = 87)</th>
<th>Only Poverty (N = 113)</th>
<th>Only Clinical (N = 333)</th>
<th>Both Poverty and Clinical (N = 1,388)</th>
<th>Total (N = 1,921)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No referrals made</td>
<td>62</td>
<td>71</td>
<td>83</td>
<td>73</td>
<td>651</td>
</tr>
<tr>
<td>Only concrete referrals made</td>
<td>7</td>
<td>8</td>
<td>10</td>
<td>9</td>
<td>131</td>
</tr>
<tr>
<td>Only rehabilitative referrals made</td>
<td>14</td>
<td>16</td>
<td>11</td>
<td>10</td>
<td>751</td>
</tr>
<tr>
<td>Both rehabilitative and concrete referrals made</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>335</td>
</tr>
<tr>
<td>Only “other” referrals made</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>8</td>
<td>53</td>
</tr>
</tbody>
</table>

Table 16

*Nature of Child Welfare Response by Identified Needs, Substantiated Investigations, N = 1,921*
Service Referral Response: No Identified Needs

Of substantiated cases where no needs were identified (N = 87), the majority (71%) received no referrals at the conclusion of the investigations; 8% received referrals to meet concrete needs only; 16% were provided with service referrals that were rehabilitative only; 1% received referrals to both concrete and rehabilitative services; and for the remaining 3%, workers facilitated other referrals—neither concrete nor rehabilitative (e.g., police, legal services, etc.).

Service Referral Response: Only Poverty-Related Needs

Of the 112 substantiated child investigations in which only poverty-related needs were identified, almost three-quarters (73%) resulted in no referrals. Workers facilitated referrals to concrete services only for 8% of these investigations and to rehabilitative services only for 11% of these cases. A further 8% of cases presenting with only poverty-related needs received referrals to other services only. None of these cases had a referral response characterized by a connection to services of both a concrete and rehabilitative nature.

Service Referral Response: Only Clinical Needs

Of the 333 substantiated investigations for which only clinical needs were identified, 33% received no referrals at the conclusion of the investigation. Five per cent of these cases received referrals to concrete services only. In just under half (45%) of these investigations, workers referred to services that were rehabilitative in nature and in 12% of these investigations, services were arranged that consisted of both concrete and rehabilitative supports. In the remaining 5% of cases, only other referrals were made.

Service Referral Response: Both Poverty and Clinical Needs

Of the 1,388 investigations in which both poverty-related and clinical needs were present, just over one-quarter (28%) received no service referrals at the conclusion of the investigation. In 7% of these
cases, workers made referrals to only concrete services. Forty-two per cent of these cases resulted in referrals to rehabilitative services only and a further 21% received services designed to meet both concrete and rehabilitative needs. Finally, in 2% of cases, workers made referrals to services characterized as other only.

Service Referral Response: Unsubstantiated Investigations

As reviewed in the Results section for Objective 1, workers identified no presenting needs in 12% of unsubstantiated cases; 14% of unsubstantiated cases had only poverty-related needs identified; 23% of unsubstantiated investigations had only clinical needs noted; and in the majority of unsubstantiated cases (51%), workers noted a combination of poverty-related and clinical needs.

Table 17
Nature of Child Welfare Response by Identified Needs, Unsubstantiated Investigations, N = 2,568

<table>
<thead>
<tr>
<th>Nature of child welfare response</th>
<th>No Identified Needs (N = 301)</th>
<th>Only Poverty (N = 365)</th>
<th>Only Clinical (N = 606)</th>
<th>Both Poverty and Clinical (N = 1296)</th>
<th>Total (N = 2,568)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No referrals made</td>
<td>246 82</td>
<td>299 82</td>
<td>343 57</td>
<td>718 55</td>
<td>1,606 63</td>
</tr>
<tr>
<td>Only concrete referrals made</td>
<td>6 2</td>
<td>22 6</td>
<td>38 6</td>
<td>105 8</td>
<td>171 7</td>
</tr>
<tr>
<td>Only rehabilitative referrals made</td>
<td>37 12</td>
<td>28 8</td>
<td>174 29</td>
<td>293 23</td>
<td>532 21</td>
</tr>
<tr>
<td>Both rehabilitative and concrete referrals made</td>
<td>8 3</td>
<td>9 2</td>
<td>30 5</td>
<td>147 11</td>
<td>194 8</td>
</tr>
<tr>
<td>Only “other” referrals made</td>
<td>4 1</td>
<td>7 2</td>
<td>21 3</td>
<td>33 3</td>
<td>65 3</td>
</tr>
</tbody>
</table>

Service Referral Response: No Identified Needs

As illustrated in Table 17, of the 301 unsubstantiated investigations in which no needs were identified, no referrals were made in 82% of these cases. In 12% of these cases, only rehabilitative
referrals were made. Workers facilitated concrete referrals only in 2% of cases with no identified needs and both rehabilitative and concrete referrals for an additional 3%. In 1% of cases, only other referrals were made.

**Service Referral Response: Only Poverty-Related Needs**

Of the 365 cases in which only poverty-related needs were identified, a significant majority (82%) had no referrals made at the conclusion of the investigation. In 8% of cases, workers provided referrals of a rehabilitative nature only and in a further 6% of cases, referrals were to services designed to address concrete needs only. In a small minority of these cases (2%), workers facilitated both rehabilitative and concrete referrals or services categorized as other only.

**Service Referral Response: Only Clinical Needs**

Of the 573 unsubstantiated cases in which only clinical needs were identified, over half (57%) received no referrals to supportive services at the conclusion of the investigation. Twenty-nine per cent received referrals designed to address clinical needs only and in 6% of cases, workers brokered referrals intended to address concrete needs. In 5% of these cases, referrals to both rehabilitative and concrete resources were made and in the final 3% of cases, only referrals defined as other were facilitated.

**Service Referral Response: Both Poverty-Related and Clinical Needs**

Of the 1,259 unsubstantiated cases for which both poverty-related and clinical needs were identified, over half (55%) received no referrals for supportive services at the conclusion of the investigation. Almost one-quarter of these cases (23%) resulted in rehabilitative referrals only and 11% received both concrete and rehabilitative referrals. Eight per cent of cases with both poverty-related and clinical needs received referrals designed to address concrete needs only and the final 3% of these cases received referrals classified as other only.
Summary of Results, Objective 2

The second objective of the research was to understand the nature of the child welfare service referral response to both substantiated and unsubstantiated neglect investigations. Cases were categorized according to the nature of the presenting needs identified through the investigation and by the service response that best characterized the referrals made on behalf of the investigated child and his/her caregivers. Initial analyses classifying service referrals into four categories demonstrated that the most common service referral for all investigations was to parenting/family support counselling, such as parenting skills training, followed by referrals to clinical/treatment services (e.g., drug or alcohol counselling, psychological/psychiatric services). Referrals to address material needs (e.g., social assistance, housing, employment services, medical/dental care) were less common, as were referrals to services designed to provide social support and/or recreational opportunities (e.g., cultural services, church communities, Big Brothers, etc.). Some referrals could not be categorized under any of the aforementioned four categories and remained classified as other, for example, referrals to legal services and/or to the police (for unspecified reasons).

When collapsed into three predominant referral categories, rehabilitative referrals (either clinical/treatment or parenting/family support) remained to most common referral type, with 40% of the sample receiving at least one rehabilitative referral. In 17% of cases, workers facilitated at least one concrete referral and in 6% of cases, at least one other referral was made. Categorization of cases based on the nature of the service referral response revealed that for substantiated cases, the predominant response of workers was to make rehabilitative referrals only (40% of cases) followed by no referrals (34% of cases). In 16% of substantiated cases, both concrete and rehabilitative referrals were made and in 7% of cases, workers facilitated only concrete referrals. Three per cent of substantiated cases received only referrals classified as other. A slightly different pattern emerged for unsubstantiated cases, with these cases most likely to have a response of no referrals (63% of cases), followed by clinical referrals only (21% of investigations). The service referral response to a small
proportion of these cases was characterized by concrete referrals only (6%) or both rehabilitative and concrete referrals (7%). Similar to substantiated cases, 3% of unsubstantiated cases had only other referrals made.

Analysis of the nature of the referral response based on presenting needs of the investigation demonstrated that for substantiated cases, the proportion of cases with at least one referral was highest in those cases with both clinical and poverty-related needs (72%), and lowest in those cases for which no concerns were identified (29%). Workers responded in a predominantly rehabilitative fashion, regardless of the constellation of presenting needs. For example, in those cases where both poverty-related and clinical needs were identified, 42% of families received treatment-oriented referrals only while 21% of families with both poverty and clinical needs were referred to a combination of treatment and concrete services.

In unsubstantiated cases, the presence of clinical needs, either on their own or in combination with poverty-related needs, increased the likelihood of at least one service referral being made.

A detailed analysis of these findings is presented in Chapter 8 (Discussion).
Chapter 7: Results, Multivariate Analyses

Results: Objective 3

Summary of Research Methods: Objective 3a

The third objective of the research was to explore a series of possible confounds in the relationship between poverty and child neglect found in child welfare samples, introduced by either biases in reporting or decision-making following investigation. The first analysis in this stage of the research assessed the extent to which reporting biases may account for the disproportionate number of poor families known to child welfare for reasons of neglect. Child investigations of neglect only \( (N = 2,527) \) were coded according to a composite poverty variable (described in Chapter 5) as either low poverty-related needs, moderate poverty related needs, or high poverty-related needs. Chi-square analyses were run to assess differences in the rate of substantiation between the three groups. The hypothesis was that if substantial reporting biases exist, the rate of substantiation should be statistically significantly lower in poorer families compared to less-poor families, as poor families would be more likely to have been reported for minor concerns (i.e., false positives), whereas less-poor families would represent more serious situations due to the higher threshold for reporting of these families resulting in a high rate of true positives (i.e., children investigated and substantiated for neglect). Cases of investigated neglect only were used for this analysis to assess the extent of poverty-related bias, if any, in cases referred for neglect rather than cases referred for both neglect and another form of maltreatment.
Chi-square analysis, presented in Table 18, revealed that there was a statistically significant relationship between the relative level of poverty-related needs and substantiation rates in investigation of neglect only. However, the relationship was the inverse of that predicted by the hypothesis: in other words, instead of a higher false positive rate (cases investigated but not substantiated) for children living in households with the highest level of poverty-related needs, these children had a statistically significantly higher rate of substantiation compared to those with a lower level of poverty-related need, $\chi^2 (2, N = 2,527) = 70.46, p < .001$. As illustrated by Table 18, the rate of substantiation for children living in the highest need households was 56%; the substantiation rate for children living in households with moderate poverty-related needs was 41%. Children living in households with the lowest level of poverty-related needs also had the lowest substantiation rate at 35%. To ensure that the difference in the substantiation rate between cases with low compared moderate poverty related needs was statistically significant, a post-hoc chi-square test was run, $\chi^2 (2, N = 1,994) = 5.65, p = .017$.

**Summary of Research Methods: Objective 3b**

The next set of analyses conducted to address Objective 3 involved a series of regression analyses, performed to assess the extent to which poverty-related variables influence workers’ decision-making while controlling for other important clinical and maltreatment-related characteristics.
Specifically, these analyses assessed the contribution of poverty-related variables to workers’ decisions to (i) substantiate an investigation, (ii) keep the case open for ongoing protection services; and (iii) place a child in out-of-home care, while controlling for child, caregiver, household, and maltreatment related factors. Regression analyses were conducted using each of these case dispositions as the outcome variable, entering predictor variables into the model in theoretically relevant blocks. The hypothesis for these analyses was that if substantial poverty-related biases exist in the sample, poverty-related variables will have a significant unique contribution to decision-making, even after controlling for the presenting clinical concerns of the case, including the relevant case history and characteristics of the maltreatment.

**Bivariate Results, Substantiation**

The first set of analyses examined the contribution of a series of ecological variables to the decision to substantiate child neglect investigations. The first step of this analysis assessed the bivariate relationships between child, caregiver, case and maltreatment, and poverty-related variables and the decision to substantiate a case. Results of the bivariate analyses are reported below.
**Child-Level Variables**

Table 19

*Child Characteristics by Substantiation Status, N = 4,489*

<table>
<thead>
<tr>
<th>Child characteristics</th>
<th>Unsubstantiated ( N = 2,568 )</th>
<th>Substantiated ( N = 1,921 )</th>
<th>Total ( N = 4,489 )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( M )</td>
<td>( SD )</td>
<td>( M )</td>
</tr>
<tr>
<td>Age of investigated child</td>
<td>7.2</td>
<td>4.6</td>
<td>7.1</td>
</tr>
<tr>
<td>Sex of investigated child</td>
<td>( n )</td>
<td>%</td>
<td>( n )</td>
</tr>
<tr>
<td>Female</td>
<td>1,276</td>
<td>58</td>
<td>913</td>
</tr>
<tr>
<td>Male</td>
<td>1,292</td>
<td>56</td>
<td>1,008</td>
</tr>
<tr>
<td>Aboriginal status***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Aboriginal</td>
<td>1,959</td>
<td>61</td>
<td>1,232</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>609</td>
<td>47</td>
<td>689</td>
</tr>
<tr>
<td>Child Functioning Concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical/cognitive/developmental***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>1,890</td>
<td>62</td>
<td>1,147</td>
</tr>
<tr>
<td>Noted</td>
<td>678</td>
<td>47</td>
<td>774</td>
</tr>
<tr>
<td>Mental/emotional***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>2,164</td>
<td>61</td>
<td>1,365</td>
</tr>
<tr>
<td>Noted</td>
<td>404</td>
<td>42</td>
<td>556</td>
</tr>
<tr>
<td>Behavioural***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>2,192</td>
<td>59</td>
<td>1,520</td>
</tr>
<tr>
<td>Noted</td>
<td>1,399</td>
<td>40</td>
<td>2,124</td>
</tr>
<tr>
<td>“Other” concern</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>2,480</td>
<td>58</td>
<td>1,829</td>
</tr>
<tr>
<td>Noted</td>
<td>88</td>
<td>49</td>
<td>92</td>
</tr>
</tbody>
</table>

\( ^*p<.05; \ ^{**}p<.01; \ ^{***}p<.001 \)

Neither the age of the child at investigation nor child sex was related to substantiation status, \( t(4,487) = 0.8, p = .42 \) and \( \chi^2(1, N = 4,489) = 2.05, p = .15 \) respectively. Aboriginal children were significantly more likely to be the subject of a substantiated investigation compared to their non-Aboriginal counterparts, \( \chi^2(1, N = 4,489) = 78.95, p < .001 \). The presence of any physical/cognitive and/or developmental concerns increased the likelihood of substantiation, \( \chi^2(1, N = 4,489) = 98.88, p < .001 \), as did the presence of mental/emotional difficulties and/or behavioural problems \( \chi^2(1, N = 4,489) = 114.0, p < .001 \) and
The experience of at least one child functioning concern defined as other was not related to substantiation outcome, \( \chi^2(1, N = 4,489) = 4.68, p = .17 \).

**Caregiver-Level Variables**

Table 20  
*Caregiver Characteristics by Substantiation Status, N = 4,489*

<table>
<thead>
<tr>
<th>Caregiver Characteristics</th>
<th>Unsubstantiated ((N = 2,568))</th>
<th>Substantiated ((N = 1,921))</th>
<th>Total ((N = 4,489))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age category of youngest caregiver(a)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 22 years</td>
<td>159 53</td>
<td>139 47</td>
<td>298 100</td>
</tr>
<tr>
<td>22–30 years</td>
<td>916 59</td>
<td>634 41</td>
<td>1,550 100</td>
</tr>
<tr>
<td>31–40 years</td>
<td>1,059 58</td>
<td>776 42</td>
<td>1,835 100</td>
</tr>
<tr>
<td>Over 40 years</td>
<td>404 56</td>
<td>312 44</td>
<td>716 100</td>
</tr>
</tbody>
</table>

| Caregiver Functioning Concerns (household level) | | | |
| Alcohol\(***\) | | | |
| Not noted | 2,048 63 | 1,203 37 | 3,251 100 |
| Noted | 520 42 | 718 58 | 1,238 100 |
| Drug/solvents\(***\) | | | |
| Not noted | 2,084 62 | 1,285 38 | 3,369 100 |
| Noted | 484 43 | 636 57 | 1,120 100 |
| Mental health\(***\) | | | |
| Not noted | 2,066 62 | 1,269 38 | 3,335 100 |
| Noted | 502 44 | 652 56 | 1,154 100 |
| Few social supports\(***\) | | | |
| Not noted | 1,779 65 | 954 35 | 2,733 100 |
| Noted | 789 45 | 967 55 | 1,756 100 |

| Caregiver cooperation with investigation\(***\) | | | |
| Cooperative | 2,310 59 | 1,609 41 | 3,919 100 |
| Uncooperative | 202 42 | 282 58 | 484 100 |

\(a\) Based on a sample of 4,399 investigations due to missing caregiver age data

\(b\) Based on a sample of 4,403 investigations due to missing caregiver cooperation data

\(p < .05; **p < .01; ***p < .001\)
The age of the youngest caregiver was not related to substantiation $\chi^2 (3, N = 4,399) = 4.02$, $p = 0.26$. Children living in families where at least one caregiver misused alcohol were significantly more likely to be the subject of a substantiated investigation, as were children whose caregiver(s) had mental health concerns or abused drugs/solvents [$\chi^2 (1, N = 4,489) = 161.4, p < .001$, $\chi^2 (1, N = 4,489) = 119.35, p < .001$, and $\chi^2 (1, N = 4,489) = 119.18, p < .001$ respectively]. Child investigations in which at least one caregiver was identified as having few social supports were also associated with a greater likelihood of substantiation, $\chi^2 (1, N = 4,489) = 177.52, p < .001$. Finally, caregiver level of cooperation with the investigation also had a significant relationship with substantiation status at the bivariate level: children in households where at least one caregiver was rated as uncooperative with the investigation were significantly more likely to have neglect substantiated, $\chi^2 (1, N = 4,403) = 52.06, p < .001$.

**Family/Household Characteristics**

Table 21

<table>
<thead>
<tr>
<th>Family/household characteristics</th>
<th>Unsubstantiated (N = 2,568)</th>
<th></th>
<th></th>
<th>Substantiated (N = 1,921)</th>
<th></th>
<th></th>
<th>Total (N = 4,489)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td><strong>Family/household composition</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone female caregiver</td>
<td>1,073</td>
<td>56</td>
<td>860</td>
<td>44</td>
<td>1,933</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone male caregiver</td>
<td>149</td>
<td>57</td>
<td>114</td>
<td>43</td>
<td>263</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two-parent biological</td>
<td>767</td>
<td>57</td>
<td>583</td>
<td>43</td>
<td>1,350</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two-parent blended</td>
<td>422</td>
<td>64</td>
<td>235</td>
<td>36</td>
<td>657</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>157</td>
<td>55</td>
<td>129</td>
<td>45</td>
<td>286</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No. of children in household</strong></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.51</td>
<td>1.32</td>
<td>2.54</td>
<td>1.45</td>
<td>2.52</td>
<td>1.38</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001

Household composition had a significant relationship to substantiation status, with children in two-parent blended families less likely to be the subject of a substantiated neglect investigation.
compared to those in other family compositions, $\chi^2(4, N = 4,489) = 16.26, p = .003$. Based on an independent samples $t$ test, the number of children in the household was not associated with substantiation outcome, $t(3,691) = -1.64, p = 0.87$.

**Case/Maltreatment Characteristics**

<table>
<thead>
<tr>
<th>Case/maltreatment characteristics</th>
<th>Unsubstantiated ($N = 2,568$)</th>
<th>Substantiated ($N = 1,921$)</th>
<th>Total ($N = 4,489$)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>$%$</td>
<td>$n$</td>
</tr>
<tr>
<td>Mother/step mother is alleged perpetrator$^{***}$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>518</td>
<td>64</td>
<td>290</td>
</tr>
<tr>
<td>Yes</td>
<td>2,050</td>
<td>56</td>
<td>1,631</td>
</tr>
<tr>
<td>Professional source of referral$^{***}$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1,189</td>
<td>65</td>
<td>634</td>
</tr>
<tr>
<td>Yes</td>
<td>1,379</td>
<td>52</td>
<td>1,287</td>
</tr>
<tr>
<td>Previous openings (family level)$^b$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>796</td>
<td>59</td>
<td>564</td>
</tr>
<tr>
<td>One or more</td>
<td>1,738</td>
<td>57</td>
<td>1,325</td>
</tr>
<tr>
<td>Any physical harm$^{***}$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>2,500</td>
<td>58</td>
<td>1,795</td>
</tr>
<tr>
<td>Noted</td>
<td>68</td>
<td>35</td>
<td>126</td>
</tr>
<tr>
<td>Any emotional harm$^{***}$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>2,485</td>
<td>65</td>
<td>1,366</td>
</tr>
<tr>
<td>Noted</td>
<td>78</td>
<td>13</td>
<td>508</td>
</tr>
</tbody>
</table>

$^a$ Based on a sample of 4,129 investigations due to missing perpetrator data

$^b$ Based on a sample of 4,423 investigations due to missing previous opening data

$^c$ Based on a sample of 4,437 investigations due to missing data regarding emotional harm

$p < .05; **p < .01; ***p < .001$

Child investigations in which the mother/stepmother was the alleged perpetrator had an increased likelihood of substantiation, $\chi^2(1, N = 4,129) = 19.18, p < .001$. Children who were referred
by at least one professional were also more likely to have the neglect allegation substantiated, $\chi^2(1, N = 4,489) = 80.56, p < .001$ compared to those referred only by a non-professional referral source. Whether or not the investigated child lived in a household previously reported to child welfare had no relationship to substantiation status, $\chi^2(1, N = 4,423) = 1.23, p = 0.27$. Both the presence of physical or emotional harm to the investigated child significantly increased the likelihood of substantiation, $\chi^2(1, N = 4,489) = 40.65, p < .001$ and $\chi^2(1, N = 4,437) = 546.88, p < .001$ respectively.

**Poverty-Related Variables**

Table 23

<table>
<thead>
<tr>
<th>Poverty Related Characteristics by Substantiation Status, $N = 4,489$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty related indicators</td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Full-time source of income***</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>One or more housing concerns***</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

*p < .05; **p < .01; ***p < .001

Children living in households in which no caregiver had a full-time source of income were statistically significantly more likely to have neglect allegations substantiated, $\chi^2(1, N = 4,489) = 45.37, p < .001$. Child investigations were also more likely to be substantiated if the household had one or more housing concerns, $\chi^2(1, N = 4,489) = 160.08, p < .001$.

**Multivariate Analysis: Substantiation**

Based on the results of the bivariate analyses, 16 predictor variables with a statistically significant relationship to substantiation were entered into the model in theoretically relevant blocks. Results are presented in Table 24 (page 186).
Table 24

*Logistic Regression Predicting Substantiation, N = 4,352*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>β</th>
<th>SE</th>
<th>Wald</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Block 1 (Child level variables)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal child***</td>
<td>0.31</td>
<td>0.08</td>
<td>13.23</td>
<td>1.36</td>
</tr>
<tr>
<td>Physical/cognitive/intellectual disability**</td>
<td>0.28</td>
<td>0.08</td>
<td>11.21</td>
<td>1.32</td>
</tr>
<tr>
<td>Mental/emotional disability</td>
<td>0.56</td>
<td>0.10</td>
<td>0.31</td>
<td>1.06</td>
</tr>
<tr>
<td>Behavioural disability</td>
<td>-0.15</td>
<td>0.11</td>
<td>1.90</td>
<td>0.86</td>
</tr>
<tr>
<td><strong>Block 2 (Caregiver level variables)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol***</td>
<td>0.38</td>
<td>0.09</td>
<td>17.60</td>
<td>1.46</td>
</tr>
<tr>
<td>Drugs/solvents***</td>
<td>0.28</td>
<td>0.09</td>
<td>10.17</td>
<td>1.32</td>
</tr>
<tr>
<td>Mental health**</td>
<td>0.24</td>
<td>0.08</td>
<td>7.89</td>
<td>1.27</td>
</tr>
<tr>
<td>Few social supports***</td>
<td>0.40</td>
<td>0.07</td>
<td>28.69</td>
<td>1.49</td>
</tr>
<tr>
<td>Uncooperative with investigation</td>
<td>0.14</td>
<td>0.11</td>
<td>1.48</td>
<td>1.15</td>
</tr>
<tr>
<td><strong>Block 3 (Household level variables)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone female caregiver (reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone male caregiver</td>
<td>0.27</td>
<td>0.18</td>
<td>2.21</td>
<td>1.31</td>
</tr>
<tr>
<td>Two biological parents</td>
<td>0.15</td>
<td>0.09</td>
<td>3.17</td>
<td>1.17</td>
</tr>
<tr>
<td>Two parents-blended*</td>
<td>-0.26</td>
<td>0.11</td>
<td>5.20</td>
<td>0.78</td>
</tr>
<tr>
<td>Other family structure</td>
<td>0.25</td>
<td>0.15</td>
<td>2.73</td>
<td>1.29</td>
</tr>
<tr>
<td><strong>Block 4 (Case/maltreatment level variables)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any professional referral***</td>
<td>0.50</td>
<td>0.07</td>
<td>48.25</td>
<td>1.65</td>
</tr>
<tr>
<td>Mother/step mother alleged perpetrator**</td>
<td>0.29</td>
<td>0.11</td>
<td>7.06</td>
<td>1.34</td>
</tr>
<tr>
<td>Any emotional harm***</td>
<td>2.14</td>
<td>0.14</td>
<td>238.13</td>
<td>8.48</td>
</tr>
<tr>
<td>Any physical harm***</td>
<td>0.88</td>
<td>0.17</td>
<td>38.44</td>
<td>1.57</td>
</tr>
<tr>
<td><strong>Block 5 (Poverty-related variables)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No full time income</td>
<td>0.11</td>
<td>0.08</td>
<td>2.03</td>
<td>1.19</td>
</tr>
<tr>
<td>Housing concerns***</td>
<td>0.45</td>
<td>0.07</td>
<td>38.44</td>
<td>1.57</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Model</th>
<th>Block 1</th>
<th>Block 2</th>
<th>Block 3</th>
<th>Block 4</th>
<th>Block 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>-2LL (Constant)</td>
<td>5707.43</td>
<td>5464.68</td>
<td>5444.43</td>
<td>5016.39</td>
<td>4972.41</td>
</tr>
<tr>
<td>Model χ²</td>
<td>229.63</td>
<td>467.38</td>
<td>487.63</td>
<td>915.67</td>
<td>959.65</td>
</tr>
<tr>
<td>df</td>
<td>4.00</td>
<td>9.00</td>
<td>13.00</td>
<td>17.00</td>
<td>19.00</td>
</tr>
<tr>
<td>Nagelkerke R²</td>
<td>0.07</td>
<td>0.14</td>
<td>0.14</td>
<td>0.26</td>
<td>0.27</td>
</tr>
<tr>
<td>Correct Classification rate</td>
<td>60%</td>
<td>65%</td>
<td>65%</td>
<td>70%</td>
<td>70%</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001*
Child-level variables (Block 1) explained 7% of the variance in the decision to substantiate neglect, with Aboriginal children having an odds of substantiation that was 1.36 times of that non-Aboriginal children. Children who were noted to have at least one physical/cognitive/intellectual disability were also more likely to be the subject of a substantiated neglect investigation, $OR = 1.32$, $p = .001$. Neither child mental/emotional difficulties nor behavioural concerns was related to substantiation.

Caregiver-level variables (Block 2) accounted for an additional 7% of the explained variance, with children’s odds of substantiation increasing if they lived with at least one caregiver who abused alcohol ($OR = 1.46$, $p < .001$), drugs/solvents ($OR = 1.32$, $p < .001$) or who was considered to have few social supports ($OR = 1.49$, $p < .001$). Neither caregiver level of cooperation nor caregiver mental health problems were significantly related to substantiation in the multivariate model.

Household structure (Block 3) explained an additional .05% of the variance over and above the child- and caregiver-level variables (results in Table 24 have been rounded to the nearest two decimals), with children living with in two-parent blended families (one biological parent and their partner) being 78% as likely to have neglect allegations substantiated as compared to children living with a lone female caregiver, ($OR = .78$, $p = .02$). No other family structure had a significant relationship to substantiation.

Case and maltreatment-related variables (Block 4) explained the most variance of any block, accounting for 12% of the 27% explained variance of the model. Children who were referred by a professional referral source also had odds of substantiation 1.64 times that of children referred by non-professional sources. Children for whom the mother/stepmother was the alleged perpetrator of the neglect had an odds of substantiation that was 1.34 times that of children for whom the mother/stepmother was not the alleged perpetrator, ($OR = 1.34$, $p = .008$). In cases where physical harm was noted, children’s odds of substantiation were over one and a half times greater than when physical harm was not noted, $OR = 1.57$, $p < .001$. The presence of emotional harm was the strongest predictor of substantiation and children for whom emotional harm was noted had
an odds of substantiation that was over eight and a half times greater than children for whom emotional harm was not identified \( OR = 8.48, p < .001 \).

Poverty-related needs due to income or housing concerns (Block 5) accounted for the final 1% of the explained variance of the model. Living in a household where at least one caregiver had a full-time source of income did not contribute to the explained variance. However, the presence of housing concerns (i.e., at least one concern related to overcrowding, household hazards, residing in subsidized housing or a hotel/shelter, frequent moves) was significantly related to substantiation \( OR = 1.57, p < .001 \).

**Bivariate Results, Ongoing Services**

The second set of analyses in this stage of the research concerned the decision to keep a case open for ongoing services. The first step of these analyses was to examine the bivariate relationship between a series of ecological variables and the decision to keep a case open for ongoing protection services. Results of these analyses are reported below.
Child-Level Variables

Table 25
Child Characteristics by Ongoing Service Provision, N = 4,483

<table>
<thead>
<tr>
<th>Child characteristics</th>
<th>No Ongoing Service (N = 3,104)</th>
<th>Ongoing Service (N = 1,379)</th>
<th>Total (N = 4,483)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Age of investigated child</td>
<td>7</td>
<td>4.89</td>
<td>7.21</td>
</tr>
<tr>
<td>Sex of investigated child</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Female</td>
<td>1520</td>
<td>70</td>
<td>666</td>
</tr>
<tr>
<td>Male</td>
<td>1584</td>
<td>69</td>
<td>713</td>
</tr>
<tr>
<td>Child Aboriginal status***</td>
<td>2363</td>
<td>74</td>
<td>824</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>741</td>
<td>57</td>
<td>555</td>
</tr>
<tr>
<td>Child Functioning Concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical/cognitive/developmental***</td>
<td>2,278</td>
<td>75</td>
<td>756</td>
</tr>
<tr>
<td>Not noted</td>
<td>826</td>
<td>57</td>
<td>623</td>
</tr>
<tr>
<td>Mental/emotional***</td>
<td>2,627</td>
<td>75</td>
<td>898</td>
</tr>
<tr>
<td>Not noted</td>
<td>477</td>
<td>50</td>
<td>481</td>
</tr>
<tr>
<td>Behavioural***</td>
<td>2,687</td>
<td>72</td>
<td>1021</td>
</tr>
<tr>
<td>Not noted</td>
<td>417</td>
<td>54</td>
<td>358</td>
</tr>
<tr>
<td>“Other” concern*</td>
<td>2,999</td>
<td>70</td>
<td>1305</td>
</tr>
<tr>
<td>Not noted</td>
<td>105</td>
<td>59</td>
<td>74</td>
</tr>
</tbody>
</table>

*a Based on a sample of 4,483 cases due to missing ongoing service data
*p<.05; **p<.01; ***p<.001

Neither age nor sex of the investigated child was related to the decision to keep a case open for ongoing services. Aboriginal children were significantly more likely to have their case kept open for ongoing services, $\chi^2(1, N = 4,483) = 124.56, p < .001$. Children who had at least one physical/cognitive/developmental concern had an increased likelihood of ongoing service [$\chi^2(1, N = 4,483) = 150.47, p < .001$] as did children with mental/emotional difficulties [$\chi^2(1, N = 4,483) = 216.36, p < .001$]
and children with behavioural concerns noted $\chi^2(1, N = 4,483) = 104.78, p < .001$. Children with identified other concerns were also significantly more likely to be offered ongoing services, $\chi^2(1, N = 4,483) = 9.8, p = .002$.

**Caregiver-Level Variables**

**Table 26**

*Caregiver Characteristics by Ongoing Service Provision, N = 4,483*

<table>
<thead>
<tr>
<th>Caregiver characteristics</th>
<th>No Ongoing Service</th>
<th>Ongoing Service</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Age category of youngest caregiver***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 22 years</td>
<td>178</td>
<td>60</td>
<td>119</td>
</tr>
<tr>
<td>22–30 years</td>
<td>1,048</td>
<td>68</td>
<td>501</td>
</tr>
<tr>
<td>31–40 years</td>
<td>1,333</td>
<td>73</td>
<td>499</td>
</tr>
<tr>
<td>Over 40 years</td>
<td>481</td>
<td>67</td>
<td>234</td>
</tr>
<tr>
<td>Caregiver Functioning Concerns (household level)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>2,440</td>
<td>75</td>
<td>808</td>
</tr>
<tr>
<td>Noted</td>
<td>664</td>
<td>54</td>
<td>571</td>
</tr>
<tr>
<td>Drugs/solvents***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>2,566</td>
<td>76</td>
<td>798</td>
</tr>
<tr>
<td>Noted</td>
<td>538</td>
<td>48</td>
<td>581</td>
</tr>
<tr>
<td>Mental health***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>2,534</td>
<td>76</td>
<td>795</td>
</tr>
<tr>
<td>Noted</td>
<td>570</td>
<td>49</td>
<td>584</td>
</tr>
<tr>
<td>Few social supports***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>2,194</td>
<td>80</td>
<td>535</td>
</tr>
<tr>
<td>Noted</td>
<td>910</td>
<td>52</td>
<td>844</td>
</tr>
<tr>
<td>Caregiver cooperation with investigation***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooperative</td>
<td>2,784</td>
<td>71</td>
<td>1,129</td>
</tr>
<tr>
<td>Uncooperative</td>
<td>265</td>
<td>55</td>
<td>219</td>
</tr>
</tbody>
</table>

*a Based on a sample of 4,393 investigations due to missing caregiver age data
b Based on a sample of 4,397 investigations due to missing caregiver cooperation data
*p<.05; **p<.01; ***p<.001
Children in investigations where the youngest caregiver was under 22 years of age had an increased likelihood of ongoing service provision, $\chi^2(3, N = 4,393) = 25.84, p < .001$. Children who lived with at least one caregiver deemed to have few social supports [$\chi^2(1, N = 4,483) = 407.61, p < .001$], who abused alcohol [$\chi^2(1, N = 4,483) = 191.64, p < .001$], drugs/solvents [$\chi^2(1, N = 4,483) = 313.51, p < .001$], or who suffered from mental health problems [$\chi^2(1, N = 4,483) = 287.38, p < .001$] were also significantly more likely to be provided with ongoing protection services. The presence of an uncooperative caregiver in response to the investigation significantly increased the likelihood of ongoing service provision, $\chi^2(1, N = 4,397) = 54.46 p < .001$.

**Household-Level Variables**

Table 27

<table>
<thead>
<tr>
<th>Family/household characteristics</th>
<th>No Ongoing Service $(N = 3,104)$</th>
<th>Ongoing Service $(N = 1,379)$</th>
<th>Total $(N = 4,483)$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>%</td>
<td>$n$</td>
</tr>
<tr>
<td>Family/household composition**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone female caregiver</td>
<td>1,269</td>
<td>66</td>
<td>662</td>
</tr>
<tr>
<td>Lone male caregiver</td>
<td>201</td>
<td>77</td>
<td>61</td>
</tr>
<tr>
<td>Two-parent biological</td>
<td>971</td>
<td>72</td>
<td>377</td>
</tr>
<tr>
<td>Two-parent blended</td>
<td>480</td>
<td>73</td>
<td>177</td>
</tr>
<tr>
<td>Other</td>
<td>183</td>
<td>64</td>
<td>102</td>
</tr>
<tr>
<td>No. of children in household</td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>2.50</td>
<td>1.32</td>
<td>2.57</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001

Household composition was significantly related to ongoing service provision, with children living in single female-led households and households defined as other more likely to be provided ongoing service, $\chi^2(4, N = 4,483) = 30.95, p < .001$. There were no significant differences in the number of children living in the household between cases offered ongoing services and those that were not, $t(2366.85) = -1.469, p = .14$. 
### Case and Maltreatment Variables

#### Table 28

**Case and Maltreatment Characteristics by Ongoing Service Provision, N = 4,483**

<table>
<thead>
<tr>
<th>Case/maltreatment characteristics</th>
<th>No Ongoing Service (N = 3,104)</th>
<th>Ongoing Service (N = 1,379)</th>
<th>Total (N = 4,483)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td><strong>Mother/step mother alleged perpetrator</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>626</td>
<td>78</td>
<td>181</td>
</tr>
<tr>
<td>Yes</td>
<td>2,478</td>
<td>67</td>
<td>1,198</td>
</tr>
<tr>
<td><strong>Source of referral</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any professional referral source</td>
<td>1,329</td>
<td>73</td>
<td>493</td>
</tr>
<tr>
<td>No professional referral source</td>
<td>1,775</td>
<td>67</td>
<td>886</td>
</tr>
<tr>
<td><strong>Previous openings (family level)b</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1,067</td>
<td>79</td>
<td>291</td>
</tr>
<tr>
<td>One or more</td>
<td>2,007</td>
<td>66</td>
<td>1,053</td>
</tr>
<tr>
<td><strong>Substantiation status</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsubstantiated</td>
<td>2,255</td>
<td>88</td>
<td>311</td>
</tr>
<tr>
<td>Substantiated</td>
<td>849</td>
<td>44</td>
<td>1,068</td>
</tr>
<tr>
<td><strong>Any physical harm</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>3,004</td>
<td>70</td>
<td>1,285</td>
</tr>
<tr>
<td>Noted</td>
<td>100</td>
<td>52</td>
<td>94</td>
</tr>
<tr>
<td><strong>Any emotional harm</strong>*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>2,919</td>
<td>76</td>
<td>927</td>
</tr>
<tr>
<td>Noted</td>
<td>155</td>
<td>26</td>
<td>431</td>
</tr>
</tbody>
</table>

*a Based on a sample of 4,483 investigations due to missing ongoing service data

*b Based on a sample of 4,418 investigations due to missing previous opening data

*c Based on a sample of 4,432 investigations due to missing data regarding emotional harm

*p<.05; **p<.01; ***p<.001

Investigations in which at the alleged perpetrator was the mother/stepmother had a greater likelihood of ongoing service provision compared to those where the perpetrator was someone other than the mother, $\chi^2(1, N = 4,483) = 32.08, p < .001$. In cases where the source of referral was a professional, the likelihood of ongoing service provision also increased, $\chi^2(1, N = 4,483) = 19.76,
The decision to keep a case open for ongoing services was also influenced by whether or not the child’s family had a history of previous child welfare openings, with cases for which there were prior openings significantly more likely to be offered ongoing service, \( \chi^2(1, N = 4,418) = 74.9, p < .001 \). The proportion of substantiated cases offered ongoing services was almost five times that of unsubstantiated cases, \( \chi^2(1, N = 4,483) = 978.98, p < .001 \). Finally, both the presence of physical harm to the child and emotional harm increased the likelihood that a case was kept open for ongoing service, \([\chi^2(1, N = 4,483) = 29.8, p < .001\) and \(\chi^2(1, N = 4,483) = 585.03, p < .001\), respectively].

**Poverty-Related Variables**

Table 29

*Poverty Related Characteristics by Ongoing Service Provision, N = 4,483*

<table>
<thead>
<tr>
<th>Poverty indicators</th>
<th>No Ongoing Service</th>
<th>Ongoing Service</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N = 3,104)</td>
<td>(N = 1,379)</td>
<td>(N = 4,483)</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Full-time source of income***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No full time source of income</td>
<td>1,675</td>
<td>63</td>
<td>969</td>
</tr>
<tr>
<td>Full time source of income</td>
<td>1,429</td>
<td>78</td>
<td>410</td>
</tr>
<tr>
<td>One or more housing concerns***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No housing concerns</td>
<td>2,069</td>
<td>78</td>
<td>594</td>
</tr>
<tr>
<td>At least one housing concern</td>
<td>1,035</td>
<td>57</td>
<td>785</td>
</tr>
</tbody>
</table>

*a Based on a sample of 4,483 investigations due to missing ongoing service data
*p < .05; **p < .01; ***p < .001

Table 29 presents the chi-square analyses for income and housing concerns by ongoing service provision. Both the presence of income concerns (no household source of full-time income) and the presence of one or more housing concerns increased the likelihood of ongoing service provision, \(\chi^2(1, N = 4,483) = 104.93, p < .001\) and \(\chi^2(1, N = 4,483) = 220.16, p < .001\), respectively.
**Multivariate Analysis: Ongoing Services**

Based on the results of the bivariate analyses, 20 predictor variables with a statistically significant relationship to ongoing service provision were entered into the model in five blocks. Results are presented in Table 30 (page 195).
Table 30
Logistic Regression Predicting Ongoing Service Provision, N = 4,210

<table>
<thead>
<tr>
<th>Predictor</th>
<th>ß</th>
<th>SE</th>
<th>Wald</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1 (Child characteristics)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal child***</td>
<td>0.36</td>
<td>0.10</td>
<td>12.32</td>
<td>1.44</td>
</tr>
<tr>
<td>Physical/cognitive/intellectual disability*</td>
<td>0.23</td>
<td>0.10</td>
<td>4.86</td>
<td>1.25</td>
</tr>
<tr>
<td>Mental/emotional disability*</td>
<td>0.30</td>
<td>0.12</td>
<td>6.29</td>
<td>1.35</td>
</tr>
<tr>
<td>Behavioural disability**</td>
<td>0.40</td>
<td>0.13</td>
<td>10.01</td>
<td>1.49</td>
</tr>
<tr>
<td>Other disability</td>
<td>0.35</td>
<td>0.21</td>
<td>2.84</td>
<td>1.42</td>
</tr>
<tr>
<td>Block 2 (Caregiver characteristics)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youngest caregiver age under 22 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youngest caregiver age 22–30 years**</td>
<td>-0.57</td>
<td>0.17</td>
<td>10.88</td>
<td>0.57</td>
</tr>
<tr>
<td>Youngest caregiver age 31–40 years***</td>
<td>-0.93</td>
<td>0.18</td>
<td>27.57</td>
<td>0.40</td>
</tr>
<tr>
<td>Youngest caregiver age over 40 years*</td>
<td>-0.43</td>
<td>0.20</td>
<td>4.69</td>
<td>0.65</td>
</tr>
<tr>
<td>Alcohol</td>
<td>0.01</td>
<td>0.11</td>
<td>0.01</td>
<td>1.01</td>
</tr>
<tr>
<td>Drugs/solvents***</td>
<td>0.83</td>
<td>0.10</td>
<td>65.44</td>
<td>2.30</td>
</tr>
<tr>
<td>Mental health***</td>
<td>0.63</td>
<td>0.10</td>
<td>41.73</td>
<td>1.87</td>
</tr>
<tr>
<td>Few social supports***</td>
<td>0.82</td>
<td>0.09</td>
<td>85.25</td>
<td>2.27</td>
</tr>
<tr>
<td>Uncooperative with investigation</td>
<td>-0.15</td>
<td>0.13</td>
<td>1.30</td>
<td>0.86</td>
</tr>
<tr>
<td>Block 3 (Household structure)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone male</td>
<td>-0.46</td>
<td>0.24</td>
<td>3.71</td>
<td>0.63</td>
</tr>
<tr>
<td>Two biological parents</td>
<td>0.01</td>
<td>0.11</td>
<td>0.00</td>
<td>1.01</td>
</tr>
<tr>
<td>Two parents-blended</td>
<td>-0.13</td>
<td>0.14</td>
<td>0.90</td>
<td>0.88</td>
</tr>
<tr>
<td>Other family structure</td>
<td>0.14</td>
<td>0.20</td>
<td>1.50</td>
<td>1.27</td>
</tr>
<tr>
<td>Block 4 (Case/maltreatment characteristics)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother/step mother alleged perpetrator</td>
<td>0.19</td>
<td>0.15</td>
<td>1.75</td>
<td>1.21</td>
</tr>
<tr>
<td>Any professional referral</td>
<td>0.07</td>
<td>0.09</td>
<td>0.54</td>
<td>1.07</td>
</tr>
<tr>
<td>Previous opening, family level***</td>
<td>0.57</td>
<td>0.10</td>
<td>30.94</td>
<td>1.76</td>
</tr>
<tr>
<td>Neglect was substantiated***</td>
<td>1.78</td>
<td>0.09</td>
<td>381.29</td>
<td>5.91</td>
</tr>
<tr>
<td>Any physical harm**</td>
<td>0.59</td>
<td>0.20</td>
<td>8.76</td>
<td>1.79</td>
</tr>
<tr>
<td>Any emotional harm***</td>
<td>1.10</td>
<td>0.13</td>
<td>70.97</td>
<td>3.00</td>
</tr>
<tr>
<td>Block 5 (Income and housing needs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No full time income</td>
<td>0.13</td>
<td>0.10</td>
<td>1.76</td>
<td>1.14</td>
</tr>
<tr>
<td>Housing concerns***</td>
<td>0.44</td>
<td>0.09</td>
<td>24.22</td>
<td>1.55</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Block 1</th>
<th>Block 2</th>
<th>Block 3</th>
<th>Block 4</th>
<th>Block 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>-2LL (Constant) -2LL Model</td>
<td>4,790.30</td>
<td>4,236.29</td>
<td>4,216.29</td>
<td>3,499.05</td>
<td>3,471.66</td>
</tr>
<tr>
<td>Model χ²</td>
<td>370.01</td>
<td>924.02</td>
<td>944.02</td>
<td>1,661.26</td>
<td>1,688.65</td>
</tr>
<tr>
<td>df</td>
<td>5.00</td>
<td>11.00</td>
<td>15.00</td>
<td>21.00</td>
<td>23.00</td>
</tr>
<tr>
<td>Nagelkerke R²</td>
<td>0.12</td>
<td>0.28</td>
<td>0.28</td>
<td>0.46</td>
<td>0.47</td>
</tr>
<tr>
<td>Correct Classification rate</td>
<td>64%</td>
<td>72%</td>
<td>73%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001
Child-level variables (Block 1) explained 12% of the variance. Aboriginal children had odds 1.44 times that of non-Aboriginal children of being offered ongoing services, \( OR = 1.44, p < .001 \). The presence of at least one physical/cognitive/developmental concern, mental/emotional concern, or behavioural concern also significantly increased the odds of a case being kept open for ongoing services, with odds ratios between 1.25 and 1.44.

Caregiver-level variables (Block 2) accounted for an additional 16% of the variance when added to the model and constituted the Block that explained the most variance in ongoing service provision. The odds of being offered ongoing services decreased significantly if the youngest caregiver in the home was at least 22 years or older, with households with older youngest caregivers having odds of transfer to ongoing service between .40 and .65 of households where the youngest caregiver was under 22 years. Neither the presence of caregiver alcohol problems nor lack of cooperation with the investigation influenced the decision to provide ongoing services. However, children living in households where at least one caregiver abused drugs/solvents had odds of ongoing service provision that were over two times those of children whose caregiver(s) had no such problems \( (OR = 2.3, p < .001) \); those living with at least one caregiver with a mental health problem had odds of transfer to ongoing services 1.87 times the odds of children whose caregivers had no noted mental health issues; and children living with at least one caregiver considered to have few social supports had more than twice the odds of receiving ongoing services \( (OR = 2.25, p < .001) \).

Household level variables (Block 3) contributed to only 0.5% of the explained variance (data in the table is rounded to the nearest decimal). Family structure was not significantly related to the decision to keep a case open for ongoing services.

Case and maltreatment variables (Block 4) explained an additional 18% of the variance when added into the model. Neither mother/stepmother as alleged perpetrator nor source of referral was significantly related to the decision to provide ongoing services. Having at least one previous opening with child welfare services increased the odds of ongoing service provision by over 75% \( (OR = 1.76, \)
Children for whom emotional harm was noted had odds of ongoing services that were three times those of children who suffered no emotional harm due to neglect (OR = 3.0, p < .001).

Poverty-related needs (housing and income concerns) explained the final 1% of the variance accounted for by the model. Although having no source of income related to full-time employment was not a significant predictor of ongoing services, cases where at least one housing concern was present had odds of transfer to ongoing service provision over half again as high as children whose families experienced no housing concerns, OR = 1.55, p < .001.
Bivariate Results, Child Welfare Placement

Child-Level Variables

Table 31

Child Characteristics by Child Welfare Placement, N = 1,921

<table>
<thead>
<tr>
<th>Child characteristics</th>
<th>Not Placed (N = 1,548)</th>
<th>Placed (N = 373)</th>
<th>Total (N = 1,921)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of investigated child***</td>
<td>M 7.28</td>
<td>SD 4.64</td>
<td>M 6.26</td>
</tr>
<tr>
<td>Sex of investigated child</td>
<td>n 724</td>
<td>% 79</td>
<td>n 189</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>824</td>
<td>82</td>
<td>184</td>
</tr>
<tr>
<td>Child Aboriginal status***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Aboriginal</td>
<td>1,090</td>
<td>88</td>
<td>142</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>458</td>
<td>66</td>
<td>231</td>
</tr>
<tr>
<td>Child Functioning Concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical/cognitive/developmental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>933</td>
<td>81</td>
<td>214</td>
</tr>
<tr>
<td>Noted</td>
<td>615</td>
<td>79</td>
<td>159</td>
</tr>
<tr>
<td>Mental/emotional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>1,115</td>
<td>82</td>
<td>250</td>
</tr>
<tr>
<td>Noted</td>
<td>433</td>
<td>78</td>
<td>123</td>
</tr>
<tr>
<td>Behavioural*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>1,240</td>
<td>82</td>
<td>280</td>
</tr>
<tr>
<td>Noted</td>
<td>308</td>
<td>77</td>
<td>93</td>
</tr>
<tr>
<td>“Other” concern</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>1,474</td>
<td>81</td>
<td>355</td>
</tr>
<tr>
<td>Noted</td>
<td>74</td>
<td>80</td>
<td>18</td>
</tr>
</tbody>
</table>

*p < .05; **p < .01; ***p < .001

An independent samples t-test revealed that children placed were significantly younger (M = 6.26, SD = 5.0) than children who were not placed, M = 7.28, SD = 4.64, t(539.99) = 2.91, p < .001. Sex of the investigated child was not significantly related to child welfare placement at the bivariate level.
The proportion of Aboriginal children placed in out-of-home care was significantly higher, at almost three times the proportion of non-Aboriginal children, $\chi^2(1, N = 1,921) = 136.7, p < .001$. The only child functioning concern with a significant relationship to placement was behavioural difficulties, with children noted for this concern significantly more likely to be placed, $\chi^2(1, N = 1,921) = 4.62, p = .03$. Neither child mental/emotional difficulties nor physical/developmental/cognitive disabilities were related to the decision to place a child in formal out-of-home care.
### Caregiver-Level Variables

#### Table 32
Caregiver Characteristics by Child Welfare Placement, N = 1,921

<table>
<thead>
<tr>
<th>Caregiver Characteristics</th>
<th>Not Placed (N = 1,548)</th>
<th>Placed (N = 373)</th>
<th>Total (N = 1,921)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Age category of youngest caregiver***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 22 years</td>
<td>102</td>
<td>73</td>
<td>37</td>
</tr>
<tr>
<td>22–30 years</td>
<td>481</td>
<td>76</td>
<td>153</td>
</tr>
<tr>
<td>31–40 years</td>
<td>641</td>
<td>83</td>
<td>135</td>
</tr>
<tr>
<td>Over 40 years</td>
<td>266</td>
<td>85</td>
<td>46</td>
</tr>
</tbody>
</table>

Caregiver functioning concerns (household level)

#### Alcohol***

<table>
<thead>
<tr>
<th>Caregiver Characteristics</th>
<th>Not Placed (N = 1,548)</th>
<th>Placed (N = 373)</th>
<th>Total (N = 1,921)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Not noted</td>
<td>1,040</td>
<td>86</td>
<td>163</td>
</tr>
<tr>
<td>Noted</td>
<td>508</td>
<td>71</td>
<td>210</td>
</tr>
</tbody>
</table>

#### Drugs/solvents***

<table>
<thead>
<tr>
<th>Caregiver Characteristics</th>
<th>Not Placed (N = 1,548)</th>
<th>Placed (N = 373)</th>
<th>Total (N = 1,921)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Not noted</td>
<td>1,101</td>
<td>86</td>
<td>184</td>
</tr>
<tr>
<td>Noted</td>
<td>447</td>
<td>70</td>
<td>189</td>
</tr>
</tbody>
</table>

#### Mental health

<table>
<thead>
<tr>
<th>Caregiver Characteristics</th>
<th>Not Placed (N = 1,548)</th>
<th>Placed (N = 373)</th>
<th>Total (N = 1,921)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Not noted</td>
<td>1,026</td>
<td>81</td>
<td>243</td>
</tr>
<tr>
<td>Noted</td>
<td>522</td>
<td>80</td>
<td>130</td>
</tr>
</tbody>
</table>

#### Few social supports***

<table>
<thead>
<tr>
<th>Caregiver Characteristics</th>
<th>Not Placed (N = 1,548)</th>
<th>Placed (N = 373)</th>
<th>Total (N = 1,921)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Not noted</td>
<td>802</td>
<td>84</td>
<td>152</td>
</tr>
<tr>
<td>Noted</td>
<td>746</td>
<td>77</td>
<td>221</td>
</tr>
</tbody>
</table>

#### Caregiver cooperation with investigation***

<table>
<thead>
<tr>
<th>Caregiver Characteristics</th>
<th>Not Placed (N = 1,548)</th>
<th>Placed (N = 373)</th>
<th>Total (N = 1,921)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Cooperative</td>
<td>1,330</td>
<td>83</td>
<td>279</td>
</tr>
<tr>
<td>Uncooperative</td>
<td>195</td>
<td>69</td>
<td>87</td>
</tr>
</tbody>
</table>

---

*a Based on a sample of 1,861 investigations due to missing caregiver age data

*b Based on a sample of 1,891 investigations due to missing caregiver cooperation data

*p<.05; **p<.01; ***p<.001

Young caregiver age was associated with increased risk of child placement, with children whose youngest caregiver was under 22 years of age having the highest likelihood of placement, \( \chi^2(3, N = 1,861) = 19.30, p < .001 \). Both caregiver alcohol and drug/solvent abuse were also associated with increased likelihood of child placement, \( \chi^2(1, N = 1,921) = 70.82, p < .001 \) and
$\chi^2(1, N = 1,921) = 64.47, p < .001$ respectively. Children living with at least one caregiver who was deemed socially isolated (few social supports) were also more likely to be placed compared to those where social isolation was not a noted caregiver concern, $\chi^2(1, N = 1,921) = 14.7, p = .005$. Caregiver mental health concerns were not associated with placement, $\chi^2(1, N = 1,921) = .17, p = .679$.

**Household-Level Variables**

Table 33

<table>
<thead>
<tr>
<th>Family/household characteristics</th>
<th>Not Placed (N = 1,548)</th>
<th>Placed (N = 373)</th>
<th>Total (N = 1,921)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family/household composition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone female caregiver</td>
<td>672 78</td>
<td>188 22</td>
<td>860 100</td>
</tr>
<tr>
<td>Lone male caregiver</td>
<td>102 89</td>
<td>12 11</td>
<td>114 100</td>
</tr>
<tr>
<td>Two-parent biological</td>
<td>492 84</td>
<td>91 16</td>
<td>583 100</td>
</tr>
<tr>
<td>Two-parent blended</td>
<td>187 80</td>
<td>48 20</td>
<td>235 100</td>
</tr>
<tr>
<td>Other</td>
<td>95 74</td>
<td>34 26</td>
<td>129 100</td>
</tr>
<tr>
<td><strong>No. of children in household</strong></td>
<td>M 2.52 SD 1.38</td>
<td>M 2.59 SD 1.68</td>
<td>M 2.52 SD 1.35</td>
</tr>
</tbody>
</table>

*p < .05; **p < .01; ***p < .001

Family composition was associated with the decision to place a child in formal out-of-home care, with children living in lone male-led households or with two biological parents significantly less likely to be placed than those living in other family compositions, $\chi^2(4, N = 1921) = 18.57, p = .001$. There was no relationship between the number of children in the household and the decision to place the investigated child, $t(499.86) = -.679, p = .497$. 

An Exploration of the Relationship Between Poverty and Child Neglect in Canadian Child Welfare
### Case/Maltreatment Variables

**Table 34**  
*Case and Maltreatment Characteristics by Child Welfare Placement, N = 1,921*

<table>
<thead>
<tr>
<th>Case/maltreatment characteristics</th>
<th>Not Placed (N = 1,548)</th>
<th>Placed (N = 373)</th>
<th>Total (N = 1,921)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Mother/step mother alleged perpetrator*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>246</td>
<td>85</td>
<td>44</td>
</tr>
<tr>
<td>Yes</td>
<td>1,302</td>
<td>80</td>
<td>329</td>
</tr>
<tr>
<td>Source of referral***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No professional referral source</td>
<td>474</td>
<td>75</td>
<td>160</td>
</tr>
<tr>
<td>Any professional referral source</td>
<td>1,074</td>
<td>83</td>
<td>213</td>
</tr>
<tr>
<td>Previous openings (family level)***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>475</td>
<td>84</td>
<td>89</td>
</tr>
<tr>
<td>One or more</td>
<td>1,058</td>
<td>80</td>
<td>267</td>
</tr>
<tr>
<td>Any physical harm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>1,446</td>
<td>81</td>
<td>349</td>
</tr>
<tr>
<td>Noted</td>
<td>102</td>
<td>81</td>
<td>24</td>
</tr>
<tr>
<td>Any emotional harm****</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>1,142</td>
<td>84</td>
<td>224</td>
</tr>
<tr>
<td>Noted</td>
<td>359</td>
<td>71</td>
<td>149</td>
</tr>
</tbody>
</table>

*p < .05; **p < .01; ***p < .001

In child investigations where the mother/stepmother was the alleged perpetrator, there was an increased likelihood of placement, $\chi^2(1, N = 1,921) = 3.93, p = .047$. Children referred by a professional were also significantly more likely to be placed compared to those referred by non-professionals, $\chi^2(1, N = 1,921) = 20.48, p < .001$. Children in cases where there had been at least one previous child welfare opening were more likely to be placed, $\chi^2(1, N = 1,889) = 4.94, p = .03$. Although the presence of physical harm to the investigated child was not related to the decision to
place in out-of-home care, the presence of emotional harm was associated with increased likelihood of placement, $\chi^2(1, N = 1,874) = 38.85, p < .001$.

**Poverty-Related Characteristics**

Table 35

Poverty Related Characteristics by Child Welfare Placement, $N = 1,921$

<table>
<thead>
<tr>
<th>Poverty indicators</th>
<th>Not Placed $(N = 1,548)$</th>
<th>Placed $(N = 373)$</th>
<th>Total $(N = 1,921)$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>%</td>
<td>$n$</td>
</tr>
<tr>
<td>Full-time source of income***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>956</td>
<td>77</td>
<td>287</td>
</tr>
<tr>
<td>Yes</td>
<td>592</td>
<td>87</td>
<td>86</td>
</tr>
<tr>
<td>One or more housing concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not noted</td>
<td>759</td>
<td>81</td>
<td>175</td>
</tr>
<tr>
<td>Noted</td>
<td>789</td>
<td>80</td>
<td>198</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001

Children living in households where neither caregiver was employed full-time had an increased probability of placement, $\chi^2(1, N = 1,921) = 30.36, p < .001$. The likelihood of placement did not differ significantly between children whose families were experiencing one or more housing concerns and those experiencing no housing issues, $\chi^2(1, N = 1,921) = .54, p = .46$.

**Multivariate Analyses: Child Welfare Placement**

Based on the results of the bivariate analyses, 14 predictor variables with a statistically significant relationship to child welfare placement were entered into the model in five blocks. Results are presented in Table 36 (page 204).
Table 36  
_Logistic Regression Predicting Child Welfare Placement, N = 1,768_

<table>
<thead>
<tr>
<th>Predictor</th>
<th>β</th>
<th>SE</th>
<th>Wald</th>
<th>Exp(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Block 1 (Child level variables)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child age**</td>
<td>-0.06</td>
<td>0.02</td>
<td>10.72</td>
<td>0.94</td>
</tr>
<tr>
<td>Aboriginal child***</td>
<td>0.91</td>
<td>0.15</td>
<td>38.58</td>
<td>2.48</td>
</tr>
<tr>
<td>Behavioural disability*</td>
<td>0.48</td>
<td>0.17</td>
<td>6.56</td>
<td>1.56</td>
</tr>
<tr>
<td><strong>Block 2 (Caregiver level variables)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youngest caregiver under 22 years (reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youngest caregiver 22–30 years</td>
<td>-0.02</td>
<td>0.25</td>
<td>0.01</td>
<td>0.98</td>
</tr>
<tr>
<td>Youngest caregiver 31–40 years</td>
<td>-0.26</td>
<td>0.27</td>
<td>0.92</td>
<td>0.77</td>
</tr>
<tr>
<td>Youngest caregiver over 40 years</td>
<td>-1.73</td>
<td>0.33</td>
<td>0.29</td>
<td>0.84</td>
</tr>
<tr>
<td>Alcohol</td>
<td>0.21</td>
<td>0.15</td>
<td>1.81</td>
<td>1.23</td>
</tr>
<tr>
<td>Drugs/solvents**</td>
<td>0.48</td>
<td>0.14</td>
<td>11.68</td>
<td>1.62</td>
</tr>
<tr>
<td>Few social supports*</td>
<td>0.29</td>
<td>0.13</td>
<td>4.80</td>
<td>1.34</td>
</tr>
<tr>
<td>Uncooperative with investigation**</td>
<td>0.49</td>
<td>0.17</td>
<td>8.57</td>
<td>1.64</td>
</tr>
<tr>
<td><strong>Block 3 (Household level variables)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone female (reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone male</td>
<td>-0.48</td>
<td>0.41</td>
<td>1.37</td>
<td>0.62</td>
</tr>
<tr>
<td>Two biological parents*</td>
<td>-0.33</td>
<td>0.17</td>
<td>3.90</td>
<td>0.72</td>
</tr>
<tr>
<td>Two parents-blended</td>
<td>0.26</td>
<td>0.21</td>
<td>1.44</td>
<td>1.29</td>
</tr>
<tr>
<td>Other family structure</td>
<td>0.22</td>
<td>0.26</td>
<td>0.72</td>
<td>1.25</td>
</tr>
<tr>
<td><strong>Block 4 (Case and maltreatment level variables)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any professional referral*</td>
<td>-0.31</td>
<td>0.13</td>
<td>5.18</td>
<td>0.74</td>
</tr>
<tr>
<td>Mother/step mother alleged perpetrator</td>
<td>0.18</td>
<td>0.25</td>
<td>0.50</td>
<td>1.19</td>
</tr>
<tr>
<td>Previous child welfare opening</td>
<td>-0.08</td>
<td>0.16</td>
<td>0.24</td>
<td>0.93</td>
</tr>
<tr>
<td>Any emotional harm***</td>
<td>0.64</td>
<td>0.15</td>
<td>18.74</td>
<td>1.89</td>
</tr>
<tr>
<td><strong>Block 5 (Poverty related variables)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No full time income source</td>
<td>0.20</td>
<td>0.16</td>
<td>1.48</td>
<td>1.22</td>
</tr>
</tbody>
</table>

| -2LL (Constant) | 1,628.65 | 1,573.19 | 1,560.66 | 1,536.96 | 1,535.48 |
| Model χ2        | 130.75   | 186.21   | 198.74   | 222.43   | 223.92   |
| df              | 3.00     | 10.00    | 14.00    | 18.00    | 19.00    |
| Nagelkerke R²    | 0.11     | 0.16     | 0.17     | 0.19     | 0.19     |
| Correct Classification rate                    | 67%     | 67%      | 68%      | 69%      | 69%      |

*p<.05; **p<.01; ***p<.001
Overall, child-level variables (Block 1) explained the largest percentage (11%) of the variance in the placement decision of any block in the model. The age of the child was significantly related to placement; with every one unit increase in child age, the odds of placement decreased by 6% ($OR = .94, p = .001$). Aboriginal children had odds of placement almost two and half times those of non-Aboriginal children, $OR = 2.48, p < .001$. Children with a noted behavioural disability had odds of placement over one and a half times those of children without such difficulties, $OR = 1.56, p = .01$.

Caregiver-level variables (Block 2) contributed a further 5% of explained variance to the model. Most significantly, children living with at least one caregiver who abused drugs/solvents had odds of placement that were 1.62 times the odds of placement for children whose caregiver(s) did not abuse drugs. Children whose caregivers were deemed uncooperative with the investigation had an odds of placement over half again as high as children whose caregivers were assessed as cooperative, $OR = 1.64, p = .003$. Children whose caregivers were considered socially isolated also had increased odds of placement, $OR = 1.34, p = .03$. Neither the age of the youngest caregiver nor the presence of noted alcohol abuse was significantly related to placement.

Household-level variables (Block 3) accounted for an additional 2% of the variance explained by the model. Children living with both their biological parents had odds of placement that were 64% of the odds of placement for children living in single female-led households (reference category). No other family composition was significantly related to placement.

Case and maltreatment variables (Block 4) added to the predictive ability of the model by contributing an additional 2% of explained variance. Children referred by professional referral sources were less likely to be placed compared to those referred by non-professional sources, $OR = .74, p = .02$. Whether the neglect was alleged to have been perpetrated by the mother/stepmother was not a significant predictor of placement, nor was the family’s history of one or more previous child welfare openings. In cases where emotional harm was noted, children had odds of placement almost twice those of children for whom no emotional harm was evident, ($OR = 1.89, p < .001$).
The addition of source of income (Block 5) made almost no difference to the predictive ability of the model (Nagelkerke $R^2$ went from .188 to .189). Children whose caregiver(s) had no source of full-time employment had odds of placement that were not statistically significantly different than the odds for children who had one or more full-time employed caregivers.

**Summary of Objective 3 Results**

Objective 3 of the dissertation was to explore the contribution of poverty-related needs to a series of decisions in child welfare. In the first stage, analyses assessed the extent to which reporting biases might account for the disproportionate number of poor families in child welfare samples. The hypothesis was that if substantial class-based reporting bias exists, the proportion of false positives (those families investigated but not substantiated) would be higher among families experiencing greater poverty-related need, as the threshold for the referral of disadvantaged families is low; conversely, the hypothesis was that the rate of true positives (those children investigated and substantiated) would be higher for less disadvantaged families as the threshold for reporting should be, comparatively speaking, more stringent. Results did not support this hypothesis and demonstrated the highest rate of substantiation (54%) among children living in families with the greatest levels of poverty-related need. Children whose families had the lowest level of poverty-related need had the lowest rate of substantiation (31%). More detailed analysis of these findings is presented in the discussion (Chapter 8).

The next series of analyses in this phase sought to understand the contribution of poverty-related needs to case decision-making regarding substantiation, provision of ongoing services, and child welfare placement, controlling for other important child, caregiver, family, and case characteristics. The hypothesis for these analyses was that if case decision-making has a class-based bias, poverty-related needs should have a significant and unique contribution to case dispositions after controlling for important clinical factors, such as child and caregiver functioning and the severity of the maltreatment. Across analyses for all three case dispositions examined, the addition
of poverty-related variables added only minimally to the predictive ability of the multivariate model. Child, caregiver, household, case, and maltreatment variables describe the majority of the explained variance in each of the case dispositions examined. The experience of income concerns was not a significant predictor of substantiation, ongoing service provision, or placement after controlling for other factors. However, the presence of at least one housing concern was significantly related to substantiation and ongoing service provision above and beyond the contribution of the other factors. Further, several variables that, in theory, should be extraneous to these decisions emerged as significant in the models, including Aboriginal status (predictive of substantiation, ongoing service, and placement), level of cooperation with the investigation (predictive of placement), family structure (predictive of placement), and whether the mother/stepmother was the alleged perpetrator (predictive of substantiation) after controlling for other factors. A detailed analysis of the findings of the three models is presented in Chapter 8.

**Results: Objective 4**

**Summary of Research Methods, Objective 4**

The fourth objective of the research was to explore whether there are subtypes of families for whom neglect was substantiated characterized by different clusters of caregiver, child, and poverty-related needs. The analytical approach employed was a two-step cluster analysis using eight clustering variables: three child functioning concerns, four caregiver functioning concerns, and the ordinal poverty-related needs variable described in Chapter 5. The first cluster analysis was run using the full sample of 1,921 cases that had been randomly sequenced. To validate the solution generated by this analysis and to assess the cluster stability, several techniques were employed. First, the dataset was divided into two subsamples, one of 960 cases (the test sample) and the second comprised of the remaining 961 cases (the cross validation sample). The two-step cluster analysis was run on the test sample, generating three clusters; a three-cluster solution was then imposed on the cross validation
sample and the number of clusters generated by this analysis and their profiles were compared to the test sample. Similarities and differences between these solutions and the one generated using the full sample were also assessed. Given that all three analyses generated three clusters comprised of some overlapping and some different characteristics, additional validation techniques were employed to validate the three-cluster solution and assess its use as a practical heuristic. A descriptive analysis was then used to understand better the characteristics of the clusters in the final solution.

**Results, Cluster Analysis 1 (Full Sample, Random Sequence)**

The first cluster analysis was run on the full sample of 1,921 substantiated neglect only investigations, using a random sequencing of cases. Analysis of this randomized dataset generated a three cluster solution, described in Table 37.

<table>
<thead>
<tr>
<th>Clustering variable</th>
<th>Cluster 1 (N = 689)</th>
<th>Cluster 2 (N = 659)</th>
<th>Cluster 3 (N = 573)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical/cognitive/developmental***</td>
<td>232</td>
<td>542</td>
<td>0</td>
</tr>
<tr>
<td>Mental/emotional***</td>
<td>183</td>
<td>373</td>
<td>0</td>
</tr>
<tr>
<td>Behavioural***</td>
<td>116</td>
<td>285</td>
<td>0</td>
</tr>
<tr>
<td>Caregiver level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol***</td>
<td>679</td>
<td>39</td>
<td>0</td>
</tr>
<tr>
<td>Drugs/solvents***</td>
<td>409</td>
<td>115</td>
<td>112</td>
</tr>
<tr>
<td>Mental health***</td>
<td>260</td>
<td>246</td>
<td>146</td>
</tr>
<tr>
<td>Few social supports**</td>
<td>363</td>
<td>352</td>
<td>252</td>
</tr>
<tr>
<td>Poverty-related need level***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No poverty related needs</td>
<td>73</td>
<td>184</td>
<td>163</td>
</tr>
<tr>
<td>Either income or housing needs</td>
<td>285</td>
<td>252</td>
<td>235</td>
</tr>
<tr>
<td>Both income and housing needs</td>
<td>331</td>
<td>223</td>
<td>175</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001
Cluster 1 (N = 689) comprised 36% of the sample and was most strongly characterized by its high proportion of cases in which at least one caregiver was noted to abuse alcohol (99% of the cluster) and/or drugs/solvents (59% of the cluster), compared to the other two clusters. Rates of caregiver mental health problems were not significantly different between Cluster 1 (38%) and Cluster 2 (37%), $\chi^2(1, N = 1,348) = .024, p = .878$, but were significantly different between Cluster 1 and Cluster 3 (25%), based on post hoc chi-square analyses, $\chi^2(1, N = 1,262) = 21.53, p < .001$. Cluster 1 was characterized by moderate rates of child functioning concerns compared to the other two clusters; physical/cognitive/developmental concerns affected just over one-third of children in the cluster and mental/emotional concerns were a concern for just over one-quarter of the cluster. Poverty-related needs were highest in this cluster compared to either of the other two, with almost half of cases (48%) experiencing both income and housing-related concerns—a significantly higher proportion than the other two clusters; a further 41% had at least one poverty-related need (either income or housing) and only 11% had no poverty-related needs.

The second cluster (N = 659) comprised 34% of the sample. This cluster was best characterized by its high proportion of children with functioning concerns. Physical/cognitive/developmental concerns were noted for 82% of children in this cluster—a proportion significantly higher than either of the other two clusters. In fact, 70% of children for whom a physical/cognitive/developmental concern was noted were assigned to Cluster 2. Additionally, 57% of children in this cluster were dealing with concerns of a mental/emotional nature and 43% had noted behavioural concerns. This cluster had similar rates of caregiver mental health problems (37%) and social support concerns (53%) to Cluster 1. However, the proportion of cases in this cluster in which caregivers abused alcohol and/or drugs/solvents was significantly lower than Cluster 1; just 6% and 17% respectively, compared to 99% and 59% respectively in Cluster 1. Over one-quarter of cases assigned to this cluster (28%) had no identified poverty-related needs (neither income nor housing issues), a rate more than double that of Cluster 1. A little over one-third (38%) of children in Cluster 2 lived in households with either income or housing concerns (but not both) and just over
one-third (34%) lived in families for whom both income and housing concerns were present. This distribution across levels of poverty-related need is not statistically significantly different from that of Cluster 3 (described below), but demonstrates that children in this cluster experienced relatively fewer poverty-related issues compared to Cluster 1.

Cluster 3 ($N = 573$) comprised 30% of the study sample. This cluster was most striking in its complete absence of children identified with any of the child functioning concerns identified through the CIS-2008, in addition to the absence of any cases in which caregiver alcohol or drug/solvent concerns were noted. This cluster also had statistically significantly lower rates of caregiver mental health concerns (25%) compared to either Cluster 1 (38%) or Cluster 2 (37%). While the proportion of cases in which caregiver drug/solvent use was identified as a problem (20%) was only marginally higher than that noted for Cluster 2 (17%)—and this difference was not statistically significant, $\chi^2(1, N = 1,232) = .895, p = .344$—it was statistically significantly lower than the percentage of such cases in Cluster 1 (59%). Cluster 3 was further distinguished from Cluster 1 by its comparatively high rate of children living in families for whom no poverty-related concerns (i.e., neither income nor housing concerns) were identified (28% compared to 11%). Finally, while the proportion of caregivers identified as socially isolated was 44% in Cluster 3, this was the lowest proportion across all three clusters.

**Results, Split-Half Cluster Analyses**

To validate the initial cluster solution, the dataset was divided into two samples: a test sample ($N = 960$) and a cross-validation sample ($N = 961$). The two samples were first compared across all child, caregiver, and poverty-related variables to assess for difference between the samples; these analyses revealed only small, statistically insignificant differences. A two-step cluster analysis was run on the test sample and generated a three-cluster solution. A three-cluster solution was then imposed on the second half of the sample to see if clusters with similar profiles emerged. The results reported below compare the cluster profiles of the test and cross-validation samples and also compare these
solutions to the initial cluster analysis run on the randomly sequenced full sample. Table 38 (below) describes the profile of the clusters generated by the test sample and Table 39 outlines the profile of the clusters produced through the cross-validation analysis.

Table 38

_Split Half (Test Sample) Cluster Analysis, Clustering Variable Frequencies by Cluster, N = 960_

<table>
<thead>
<tr>
<th>Clustering variable</th>
<th>Cluster 1 (N = 245)</th>
<th>Cluster 2 (N = 390)</th>
<th>Cluster 3 (N = 325)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td><strong>Child level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical/cognitive/developmental***</td>
<td>194</td>
<td>79</td>
<td>123</td>
</tr>
<tr>
<td>Mental/emotional***</td>
<td>209</td>
<td>85</td>
<td>81</td>
</tr>
<tr>
<td>Behavioural***</td>
<td>153</td>
<td>62</td>
<td>36</td>
</tr>
<tr>
<td><strong>Caregiver level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol***</td>
<td>52</td>
<td>21</td>
<td>225</td>
</tr>
<tr>
<td>Drugs/solvents***</td>
<td>39</td>
<td>16</td>
<td>283</td>
</tr>
<tr>
<td>Mental health***</td>
<td>97</td>
<td>40</td>
<td>236</td>
</tr>
<tr>
<td>Few social supports</td>
<td>137</td>
<td>56</td>
<td>214</td>
</tr>
<tr>
<td><strong>Poverty-related need level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No poverty related needs***</td>
<td>74</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>Either income or housing needs***</td>
<td>94</td>
<td>38</td>
<td>165</td>
</tr>
<tr>
<td>Both income and housing needs***</td>
<td>77</td>
<td>31</td>
<td>189</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001
Table 39

<table>
<thead>
<tr>
<th>Clustering variable</th>
<th>Cluster 1 (N = 225)</th>
<th>Cluster 2 (N = 389)</th>
<th>Cluster 3 (N = 347)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td><strong>Child level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical/cognitive/developmental***</td>
<td>50</td>
<td>22</td>
<td>338</td>
</tr>
<tr>
<td>Mental/emotional***</td>
<td>0</td>
<td>0</td>
<td>207</td>
</tr>
<tr>
<td>Behavioural***</td>
<td>0</td>
<td>0</td>
<td>201</td>
</tr>
<tr>
<td><strong>Caregiver level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol***</td>
<td>53</td>
<td>24</td>
<td>149</td>
</tr>
<tr>
<td>Drugs/solvents***</td>
<td>0</td>
<td>0</td>
<td>161</td>
</tr>
<tr>
<td>Mental health***</td>
<td>0</td>
<td>0</td>
<td>163</td>
</tr>
<tr>
<td>Few social supports***</td>
<td>21</td>
<td>9</td>
<td>238</td>
</tr>
<tr>
<td><strong>Poverty-related need level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No poverty related needs***</td>
<td>97</td>
<td>43</td>
<td>72</td>
</tr>
<tr>
<td>Either income or housing needs***</td>
<td>81</td>
<td>36</td>
<td>166</td>
</tr>
<tr>
<td>Both income and housing needs***</td>
<td>47</td>
<td>21</td>
<td>151</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001

The profiles of the three clusters generated in the test and cross-validation samples had several areas of overlap, along with some dissimilarities. Both split-half analyses produced a cluster composed predominantly of children experiencing one or more of the child functioning concerns documented, in particular, physical/cognitive/developmental needs (Cluster 1 in the test sample and Cluster 2 in the cross-validation sample), similar to Cluster 2 in the full sample analysis. These three clusters were also similar in the proportion of cases in which caregivers experienced mental health issues: 37% in the full sample analysis, 40% in the test sample, and 42% in the cross-validation cluster. Further, across all three of these clusters, a little over half of the cases assigned were identified as having few social supports, although rates were not significantly different from at least one other cluster within each solution (i.e., social support issues were not significantly different across two of the three clusters in each solution). Finally, these three clusters were somewhat similar in their
poverty-related needs profiles, with cases most commonly experiencing either housing or income concerns but not both in each of the clusters. Cluster 2 of the cross-validation sample, however, had the lowest proportion of children living in households with no poverty-related needs (19%) compared to Cluster 1 in the test sample (30%) and Cluster 2 of the full sample analysis (28%).

Both the test sample and the cross-validation sample solutions produced a second cluster whose profile included a high proportion of caregivers with alcohol, drug, and mental health problems (Cluster 2 in the test sample and Cluster 3 in the cross-validation sample), although in the cross-validation sample the differences in these caregiver concerns between Cluster 3 compared to Cluster 2 were small and only statistically significantly different for alcohol problems, \( \chi^2(1, N = 736) = 4.36, p = .039 \). In one way, Cluster 2 of the test sample better resembled Cluster 1 of the full sample analysis in that both clusters were composed of statistically significantly higher proportion of caregivers with both alcohol and drug problems relative to the other clusters in their respective analyses. The proportion of caregivers with mental health concerns in Cluster 1 of the full sample (38%) was not significantly different from Cluster 2 (37%), making the test sample the only analysis in which high rates of caregiver alcohol, drug, and mental health problems clustered together (i.e., Cluster 2 test sample had a rate of all three of these problems that was statistically significantly higher than both other clusters in the solution). Another critical difference between Cluster 2 (test) and Cluster 3 (cross-validation) was the clustering of caregiver alcohol, drugs, and mental health problems with moderate rates of child functioning concerns in Cluster 2 (test), whereas in Cluster 3 (cross-validation) cases were characterized by moderate to high levels of caregiver concerns, clustering with an absence of child functioning concerns (i.e., caregiver concerns and child concerns did not cluster together in the cross-validation solution). In this regard, the test sample more closely resembled the full sample solution (Cluster 1) in that high rates of caregiver alcohol and drug problems were found in a subgroup in which approximately one-third of children were experiencing physical/cognitive/developmental issues (i.e., a clustering together of caregiver risks and child physical/cognitive/developmental problems). A final defining characteristic that was
shared across all three of these clusters was the high proportion of households experiencing both income and housing-related needs (48% in the test analysis, 46% in the cross-validation sample, and 48% in the full sample analysis) relative to the other clusters in the respective solutions.

Finally, both the test sample and the cross validation sample produced a third cluster of relatively low needs cases (Cluster 3 in the test sample and Cluster 1 in the cross-validation sample). These clusters were characterized by very low proportions of children with either mental/emotional or behavioural needs (0% and 3% respectively in the test sample and 0% and 0% respectively in the cross-validation sample), although in this regard, Cluster 1 (cross-validation) was not statistically significantly different from Cluster 3 in the cross-validation sample. Further, caregiver alcohol concerns were noted for approximately one-quarter of cases in each sample and neither drug/solvent problems nor mental health problems were evident for any of the cases assigned to either of these two clusters. Although the proportion of cases in which caregivers were noted to be socially isolated was higher in the test sample (35%) compared to the cross validation sample (9%), both clusters had statistically significantly lower rates of few social supports compared to the other two clusters in their respective solutions. Finally, although Cluster 1 in the cross validation sample was notable for having the highest proportion of cases in which neither income nor housing concerns were identified (43%) compared to the other two clusters in the solution, the proportion of such cases in Cluster 3 (test sample) was significantly lower (27%) and the distribution of cases across the levels of poverty-related need closely resembled that of Cluster 1 in the test sample. These two low needs clusters from the test and cross validation samples most closely resembled Cluster 3 in the full sample analysis based on the very low rate of child functioning concerns (0%), although the full sample cluster included a group of cases involving caregiver drug/solvent (20%) and/or mental health concerns (25%), making it different from the test and cross validation clusters in this regard (both included no cases with these concerns).

As illustrated, both similarities and differences across the three cluster solutions are apparent. Each solution was differentially influenced by the various clustering variables in partitioning the
data. For example, in the full sample solution, caregiver alcohol concerns emerged as the variable that had the most impact on how the data were partitioned (i.e., it was the variable with the greatest influence in determining cluster membership). This resulted in the creation of a cluster (Cluster 1) composed almost entirely of children living with caregivers who abused alcohol (99%), with 96% of cases in which caregiver alcohol concerns were noted assigned to this cluster; as a result, the other two clusters in this solution were characterized by a complete absence of caregiver alcohol problems. Conversely, in the test and cross validation samples, cases in which caregiver alcohol concerns were noted were assigned to all three clusters although the proportion of cases in each of the clusters differed significantly (i.e., while all clusters had some cases for which caregiver alcohol was a concern, there was a statistically significantly different proportion of cases with this concern between at least two of the three clusters in the test and cross-validation samples). For the test sample, child mental/emotional disability was the most influential variable in assigning cluster membership. This resulted in a cluster (Cluster 1) with a high proportion of children with mental/emotional concerns (85%), the highest of any of the clusters across any of the solutions. Similarly, for the cross-validation solution, the most significant variable in determining the clusters was physical/cognitive/developmental disability, leading to the creation of a cluster (Cluster 2) with a very high percentage of children with this concern (87%)—again, the highest rate of any cluster across all solutions.

**Validating the Cluster Solution**

There is no statistical test to determine the solution with the best fit to the data in cluster analysis. SPSS does produce a model summary based on the silhouette measure of cohesion and separation, which simultaneously assessments the similarity of cases within a cluster (cohesion) and how distinct a cluster is from other clusters (separation), and ranges between -1.0 and 1.0. The closer the number is to 1, the greater the cohesion and separation of the clusters. On all three analyses, this measure
was approximately 0.3 suggesting that the fit of the model to the data was in the *fair* range.26 While there was a certain degree of overlap between the clusters produced by each of the three analyses, there were also differences, suggesting that additional variations in the cluster solutions would be likely with other analyses of the data. However, all three analyses produced a three-cluster solution that included: (1) a cluster characterized by high levels of caregiver alcohol problems clustered with high levels of poverty related need; (2) a high child needs clustered with caregiver mental health problems subgroup; and (3) a relatively low needs group that was composed of a small minority of children experiencing physical/cognitive/developmental concerns in two of the three clusters, and some caregivers struggling with alcohol or drug problems. These three groups differed in the extent to which caregiver alcohol, drugs, and mental health problems clustered together—very strongly in two of the three cluster solutions—and the degree to which these caregiver concerns clustered with other child functioning issues. Social support issues were a shared concern across all three cluster profiles, although at a statistically significantly lower rate in the low needs group.

To support validation of the cluster solutions, chi-square analyses were run to assess the extent to which clusters differed in terms of their rate of child placement and ongoing service provision. As suggested by Mooir and Sarstedt (2011), criterion validity is established if variables with a theoretical relationship to the clustering variables but not included in the analysis show differential association with each cluster; in other words, significant differences between clusters on such variables enhance the credibility of the typology produced. Child, caregiver, and poverty-related need have been empirically demonstrated to predict service provision and placement decisions. Results of these analyses are shown below in Table 40.

---

26 A result ranging from .05 to 1 places the model in the *good* range, indicating a fairly high level of both cohesion (within cluster homogeneity) and separation (between cluster heterogeneity). A result falling between -1 and .2 places the solution in the *poor* range, suggesting that there is no inherent structure to the data and that the solution represents random clusters (Mooi & Sarstedt, 2011).
Table 40
Ongoing Services and Child Placement by Cluster and Cluster Solution

Randomly sequenced full sample, $N = 1,921^a$

<table>
<thead>
<tr>
<th>Criterion variable</th>
<th>Cluster 1 ($N = 688$)</th>
<th>Cluster 2 ($N = 658$)</th>
<th>Cluster 3 ($N = 571$)</th>
<th>Total ($N = 1,917$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing service***</td>
<td>n % 464 67</td>
<td>n % 397 60</td>
<td>n % 207 36</td>
<td>n % 1068 56</td>
</tr>
<tr>
<td>Child placement***</td>
<td>n % 204 30</td>
<td>n % 102 16</td>
<td>n % 67 12</td>
<td>n % 373 19</td>
</tr>
</tbody>
</table>

Split half test sample, $N = 960^b$

<table>
<thead>
<tr>
<th>Criterion variable</th>
<th>Cluster 1 ($N = 244$)</th>
<th>Cluster 2 ($N = 390$)</th>
<th>Cluster 3 ($N = 323$)</th>
<th>Total ($N = 960$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing service***</td>
<td>n % 160 66</td>
<td>n % 268 69</td>
<td>n % 97 30</td>
<td>n % 525 55</td>
</tr>
<tr>
<td>Child placement***</td>
<td>n % 40 16</td>
<td>n % 106 27</td>
<td>n % 41 13</td>
<td>n % 187 19</td>
</tr>
</tbody>
</table>

Split half cross validation sample, $N = 961^c$

<table>
<thead>
<tr>
<th>Criterion variable</th>
<th>Cluster 1 ($N = 225$)</th>
<th>Cluster 2 ($N = 389$)</th>
<th>Cluster 3 ($N = 347$)</th>
<th>Total ($N = 961$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing service***</td>
<td>n % 53 24</td>
<td>n % 278 71</td>
<td>n % 212 61</td>
<td>n % 543 57</td>
</tr>
<tr>
<td>Child placement***</td>
<td>n % 26 12</td>
<td>n % 96 25</td>
<td>n % 64 18</td>
<td>n % 186 19</td>
</tr>
</tbody>
</table>

---

$a$ For the analysis of ongoing services, $N = 1917$ due to missing data

$b$ For the analysis of ongoing services, $N = 957$ due to missing data

$c$ For the analysis of ongoing services, $N = 960$ due to missing data

*p < .05; **p < .01; ***p < .001

Table 40 illustrates that all cluster solutions demonstrated significant differences in case dispositions across clusters, supporting the notion that they represent distinct groups. Post hoc chi-square analyses were conducted to ensure that differences were statistically significantly different between each pair of clusters within each of the solutions. All differences between pairs were statistically significant ($p < .05$ or lower), with the following exceptions: the rate of placement was not statistically significantly different between Clusters 2 and 3 in the full sample solution, $\chi^2(1, N = 1,232) = 3.71, p = .054$; the proportion of cases offered ongoing services was not
significantly different between Clusters 1 and 2 in the split-half test sample, $\chi^2(1, N = 634) = .676$, $p = .411$; and the placement rate was not significantly different between Clusters 1 and 3 in the split-half test sample, $\chi^2(1, N = 570) = 1.578$, $p = .209$.

**Description of the Clusters, Full Sample Solution**

The full sample solution was considered to have adequate validity and utility as a practical heuristic. The full sample solution includes three subgroups, with consistency between the profile of each cluster and the anticipated case outcomes. For example, cases in Cluster 1—a high needs subgroup, composed of high rates of caregiver alcohol, drugs, and mental health problems and social isolation, clustered with high poverty-related need and moderate levels of child functioning concerns—had the greatest likelihood of ongoing service provision and child placement. Cases in Clusters 2 and 3 (characterized by high child needs and low child needs respectively), had significantly lower rates of both placement and transfer to ongoing services. However Cluster 2 (the high child need cluster) had a slightly higher rate of both ongoing service provision and child placement compared to the low child need cluster, although the difference was only statistically significantly different for ongoing service provision.
Table 41

Descriptive Variables by Cluster (Full Sample), $N = 1,921$

<table>
<thead>
<tr>
<th>Descriptive variable</th>
<th>Cluster 1 $(N = 689)$</th>
<th>Cluster 2 $(N = 659)$</th>
<th>Cluster 3 $(N = 573)$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$</td>
<td>%</td>
<td>$n$</td>
</tr>
<tr>
<td>Child level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child age***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–3 years</td>
<td>215</td>
<td>31</td>
<td>85</td>
</tr>
<tr>
<td>4–7 years</td>
<td>168</td>
<td>24</td>
<td>159</td>
</tr>
<tr>
<td>8–11 years</td>
<td>166</td>
<td>24</td>
<td>164</td>
</tr>
<tr>
<td>12–15 years</td>
<td>140</td>
<td>20</td>
<td>251</td>
</tr>
<tr>
<td>Aboriginal child***</td>
<td>448</td>
<td>65</td>
<td>142</td>
</tr>
<tr>
<td>Caregiver/Family level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victim of domestic violence***</td>
<td>247</td>
<td>36</td>
<td>125</td>
</tr>
<tr>
<td>Perpetrator of domestic violence***</td>
<td>147</td>
<td>21</td>
<td>57</td>
</tr>
<tr>
<td>Family structure***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone female</td>
<td>352</td>
<td>51</td>
<td>297</td>
</tr>
<tr>
<td>Lone male</td>
<td>31</td>
<td>4</td>
<td>56</td>
</tr>
<tr>
<td>Two-parent biological</td>
<td>181</td>
<td>26</td>
<td>159</td>
</tr>
<tr>
<td>Two-parent blended</td>
<td>76</td>
<td>11</td>
<td>101</td>
</tr>
<tr>
<td>Other</td>
<td>49</td>
<td>7</td>
<td>46</td>
</tr>
<tr>
<td>Case level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior openings***</td>
<td>528</td>
<td>77</td>
<td>456</td>
</tr>
<tr>
<td>Multiple incidents of neglect***</td>
<td>470</td>
<td>68</td>
<td>500</td>
</tr>
<tr>
<td>Physical harm*</td>
<td>28</td>
<td>4</td>
<td>57</td>
</tr>
<tr>
<td>Emotional harm***</td>
<td>234</td>
<td>34</td>
<td>224</td>
</tr>
</tbody>
</table>

*a Based on a sample of 1889 due to missing prior opening data
*b Based on a sample of 1874 due to missing emotional harm data
*p<.05; **p<.01; ***p<.001

Given that the validity of the full sample cluster solution was considered adequate, descriptive variables not employed in the cluster analysis were used to further explore the cluster profiles. Table 41 shows the frequencies of descriptors by cluster, which provide additional detail regarding cluster profiles and membership.
Cluster 1: (High Caregiver Needs, High Poverty)

Almost one-third of children in Cluster 1 were under three years of age. Cluster 1 was also comprised of a majority of Aboriginal children (65%); in fact, 65% of all Aboriginal children in the sample were assigned to this cluster. Children in this cluster were more likely to live with a caregiver who was a victim (36%) and/or perpetrator (19%) of domestic violence compared to the other two clusters. Over half of children assigned to Cluster 1 lived in lone female-led households, a rate significantly higher than the other two clusters. Over three-quarters of the children in Cluster 1 lived in families that had prior child welfare openings and workers noted in 68% of cases that the substantiated neglect was chronic (i.e., multiple incidents) rather than a single incident. This cluster had the lowest proportion of children for whom neglect resulted in physical harm (4%) and a similar rate of emotional harm (34%) compared to Cluster 2. Finally, as illustrated by Table 42 (page 221), 82% of children in this cluster were substantiated for failure to supervise: physical harm (51%) or physical neglect (31%).

Cluster 2: High Child Needs

Cluster 2 had the lowest rate of infants and toddlers (13%) and the highest proportion of adolescents (38%) compared to the other two clusters. Cluster 2 also had the lowest proportion of young caregivers (those under 22 years) and the highest proportion of older caregivers (those over 40 years of age); almost half (45%) of children in this cluster lived in lone female-led households. Over two-thirds (69%) of children in this cluster lived in households that were previously known to child welfare and workers noted that the neglect was chronic for just over three-quarters of children. Cluster 2 had the highest rate of neglect leading to physical harm (9%) and a rate of emotional harm consistent with Cluster 1 (34%). As shown in Table 42, just over half of children in this cluster were substantiated for failure to supervise: physical harm (29%) or physical neglect (23%).
Cluster 3: Low Child Needs, Low Alcohol, Low/Moderate Drugs, and Mental Health

Cluster 3 was comprised of a significantly higher proportion of infants and toddlers (45%) compared to the other two clusters. In keeping with this, only 10% of the children in this cluster were adolescents. Less than one-fifth (17%) of children in Cluster 3 were Aboriginal. This cluster had the lowest proportion of children living with caregivers who were either victims (15%) or perpetrators (4%) of domestic violence. Almost half of the children in this cluster (48%) had a caregiver under the age of 31. Children in Cluster 3 were more likely to live with both biological parents (42%) than children assigned to the other two clusters, and were least likely to live in a lone female-led household. Over half (56%) of children in Cluster 3 lived in households previously known to child welfare services and for just over half of children in this cluster, workers identified the neglect as chronic. Although 7% of children were identified as physically harmed, only 9% were noted to have suffered any emotional harm—by far the lowest proportion across clusters. As illustrated by Table 42, 80% of children were substantiated for failure to supervise: physical harm (46%) or physical neglect (34%).

Table 42
Form of Substantiated Neglect by Cluster (Full Sample), N = 1,921

<table>
<thead>
<tr>
<th>Form of substantiated neglect</th>
<th>Cluster 1 (N = 689)</th>
<th>Cluster 2 (N = 659)</th>
<th>Cluster 3 (N = 573)</th>
<th>Total (N = 1,921)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Failure to supervise: physical harm***</td>
<td>348</td>
<td>51</td>
<td>188</td>
<td>29</td>
</tr>
<tr>
<td>Failure to supervise: sexual harm</td>
<td>7</td>
<td>1</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>Permitting criminal behaviour</td>
<td>3</td>
<td>0</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Physical neglect***</td>
<td>217</td>
<td>31</td>
<td>152</td>
<td>23</td>
</tr>
<tr>
<td>Medical neglect</td>
<td>16</td>
<td>2</td>
<td>59</td>
<td>9</td>
</tr>
<tr>
<td>Failure to provide psych. Treatment</td>
<td>4</td>
<td>1</td>
<td>42</td>
<td>6</td>
</tr>
<tr>
<td>Abandonment</td>
<td>45</td>
<td>7</td>
<td>66</td>
<td>10</td>
</tr>
<tr>
<td>Educational neglect</td>
<td>24</td>
<td>3</td>
<td>93</td>
<td>14</td>
</tr>
<tr>
<td>Inadequate nurturing/affection</td>
<td>25</td>
<td>4</td>
<td>27</td>
<td>4</td>
</tr>
</tbody>
</table>

Note: Chi-square analyses run only for failure to supervise: physical harm, and physical neglect due to small cell sizes for all other forms of neglect
*p<.05; **p<.01; ***p<.001
Summary of Findings, Objective 4

Objective 4 of the research was to explore the use of subtypes for substantiated cases of child neglect. Two-step cluster analysis was used to partition the data into subgroups using the eight clustering variables representing child and caregiver clinical concerns and the composite variable reflecting relative level of poverty-related need. In total, three cluster analyses were run: the first using the randomly sequenced full sample \((N = 1,921)\), and two split-half analyses comprised of 960 cases (test sample) and 961 cases (cross-validation sample).

Both the full sample analysis and the test sample analysis were conducted using the option of allowing the statistical procedure to select the optimal number of clusters for the data. Both produced a three-cluster solution, which was then imposed on the cross-validation sample. Each three-cluster solution included clusters with several similarities along with some differences. For example, each solution produced a single cluster most notable for the following: (1) a cluster characterized by high levels of caregiver alcohol problems clustered with high levels of poverty-related need; (2) a cluster whose profile included high levels of child needs clustered with caregiver mental health problems; and (3) a relatively low needs cluster that was composed of very low levels of children experiencing mental/emotional or behavioural concerns, relatively low levels of caregiver alcohol, drugs and mental health concerns and low to moderate levels of poverty-related need.

The validity and stability of the cluster profiles were considered to be adequate, but with the caution that each analysis produced a cluster profile that, while similar in many ways, also differed along some dimensions. Additional analyses were conducted to assess the criterion validity of the clusters. Findings showed that the cluster with the highest level of need in each solution was also the cluster with the most intrusive child welfare intervention, based on placement rate and proportion of cases transferred to ongoing services. Based on these findings, a final analysis was conducted to describe further the profiles of the clusters from the full sample solution.
Further descriptive analyses of these clusters demonstrated that they also differed across several additional characteristics of the children, caregivers, and maltreatment. For example, children in the high child need cluster (Cluster 2) were significantly older children than children in the other two clusters: mean age = 9.13, compared to a mean age of 6.75. This is consistent with the findings previously described in the descriptive analyses: that the oldest children in the sample were those with the highest level of child functioning concerns. In the same vein, the cluster with the lowest level of child functioning need was the cluster to which the majority of young children (those under three years) were assigned. Other defining characteristics of the clusters included the high proportion of Aboriginal children (65%) in the high caregiver alcohol, high poverty cluster (Cluster 1) and several low risk characteristics associated with the low needs cluster (Cluster 3), including the significantly higher proportion of children assigned to this cluster living in two-parent biological families, with no prior openings to child welfare and for whom the substantiated neglect was considered to be a single incident.
Chapter 8: Discussion and Conclusion

Study Overview

The focus of this thesis was on a series of questions about poverty and its relationship to child neglect in Canada. There were four primary objectives of the research:

1) to document the nature and frequency of presenting child and caregiver clinical concerns and poverty-related needs for both substantiated and unsubstantiated neglect investigations;

2) to understand the types of service referrals facilitated for both substantiated and unsubstantiated neglect investigations and to assess the extent to which services represented a rehabilitative (treatment oriented), concrete (attention to material needs), or combined approach to families’ difficulties;

3) to explore a series of potential confounds in the relationship between poverty and neglect in the CIS data that may result from class-based biases in reporting and/or worker decision-making; and

4) to assess whether substantiated cases of neglect could be divided into subtypes, representing different constellations of clinical and poverty-related needs.

Findings from these analyses add to the knowledge base about the concerns of families referred to child welfare services in Canada for reasons of neglect, and the extent to which poverty-related needs influence the child welfare response to families for whom neglect is a concern. This thesis also contributes to knowledge about the heterogeneity of the neglect context and provides an empirical examination of the frequently held belief that what the child welfare field refers to as neglect is, in fact, poverty.

The questions addressed by the study were informed by an ecological model of neglect, which necessitates that all factors in a child’s and family’s environment are considered to influence
not only the risk of maltreatment, but also the quality and outcomes of caregiving. The use of an ecologically-based definition of neglect, which stipulates neglect occurs whenever children’s needs go unmet, “regardless of cause” (Dubowitz et al., 1993), is consistent with a children’s rights approach to child welfare as rights-based definitions “always push the boundaries to encompass social and environmental harm because from a child’s perspective these can be indistinguishable (Reading et al., 2009, p. 333).” In particular, poverty-related need has been conceptualized as both a characteristic of individual families and as a by-product of Canadian social and economic policies, both current and historical; in this way, implications for intervention can move beyond the focus on individuals and towards the possibility of societal change as a contributor to ameliorating the problem of child neglect.

A social justice framework was used alongside the ecological model to buttress the model’s inclusion of the micro through macro levels. It provides a lens that situates factors such as Aboriginal status, gender, and poverty related-need not only as demographic characteristics of individual children, caregivers, and families but also as structural issues insofar as they are associated with differential power, privilege, and access. Further, the use of a social justice lens requires that even when considering risk factors at the individual level (e.g., caregiver addictions, mental health problems), consideration is given to what places people at risk of these risks.

The historical literature reviewed in Chapter 2 provides a context for understanding concerns about class-based biases in child welfare. This chapter chronicles the emergence of neglect as a recognized social and legal phenomenon and demonstrates that child welfare intervention on behalf of children labeled neglected developed out of competing motivations: on the one hand, a middle class concern for the plight of poor children and on the other hand, worries about self-preservation, social stability, and the need to protect the future of the nation from the vices of the “dangerous classes.” What emerges from the review of the historical literature is that in its original conceptualization, neglect was a label developed by middle class child savers and applied to poor, disadvantaged families. The review of theoretical perspectives in Chapter 3 highlights
the disconnection between the distinguishing characteristic of social work (viewing the person in
environment), the values of the profession (the reduction of social inequality), and the typically
individualized approach taken to understand and intervene in cases of child neglect. The review of
the empirical literature in Chapter 4 illustrates that the vast majority of research on the correlates of
neglect has concentrated on the deficits of individual caregivers, contributing to interventions that
aim to fix these problems at the individual caregiver level. It should be noted that the evidence base
for some of these interventions, such as parent training programs, has yet to be established.

Chapter 8 is divided into a discussion of the results from (1) descriptive analyses assessing
child, caregiver, and poverty-related needs and the child welfare response; and (2) the multivariate
analyses conducted through this study exploring the extent of class-based biases in decision-making
and the existence of a subgroup of cases known to child welfare for reasons of poverty alone.
Connections are drawn to existing empirical research and theory, and implications for practice and
policy are discussed. The chapter concludes with recommendations for future study.

**Child and Family Needs and the Child Welfare Response**

Results of the descriptive analyses presented in Chapter 6 document the caregiver, child, and
poverty-related concerns experienced in the households of children investigated for child neglect.
Unlike the majority of studies in which only the presenting needs of substantiated investigations are
documented, the current research assessed family needs in both substantiated and unsubstantiated
cases. It has been the explicit premise of this research that both substantiated and unsubstantiated
investigations represent an opportunity for intervention, whether through the child welfare system,
referrals to community-based services, or advocacy for social and economic policy changes to
reduce the inequity experienced by poor families.

Findings from the current study demonstrate that substantiated and unsubstantiated neglect
investigations involve families with both clinical and material needs; 62% of unsubstantiated cases
and 82% of substantiated cases are noted to include caregivers with at least one clinical concern;
further, at least one physical/developmental/intellectual, mental/emotional, and/or behavioural concern is noted for 36% of children who were the subject of an unsubstantiated investigation and 53% of children for whom neglect was substantiated. Finally, the majority of both substantiated and unsubstantiated cases (78% and 65% respectively) experience one or more need related to inadequate income and/or housing, findings consistent with previous research that demonstrates the material and economic disadvantage of families referred to child welfare services (Fluke, Yuan, Hedderson, & Curtis, 2003; Swift, 1995b; Wolock & Horowitz, 1979).

As evidenced by these results, service needs are present not only for substantiated cases; a sub-group of unsubstantiated cases also presents with clear service needs. These findings lend some credence to the argument made by Khol, Jonson-Reid, and Drake (2009) that substantiation should not be considered a prerequisite for services; although in practice, this appears to be largely the case given the strong association between substantiation status and ongoing service provision. The notion that it is need for service rather than verification of maltreatment that should drive decisions about service provision is further underscored by the results of the current study, which demonstrate that of the 2,568 children in the sample for whom neglect was unsubstantiated, 68% (N = 1,738) lived in households with one or more previous child welfare openings; the families of 70% of children for whom neglect was substantiated had one or more previous opening.27 What these data suggest is that regardless of substantiation status, many children investigated for neglect continue to grow up in environments that may not meet their basic needs, despite previous identification and possible intervention by child welfare services.

There is a large body of American research that questions the distinction between substantiated and unsubstantiated cases, with some studies showing that there are few or no significant differences in children’s developmental outcomes, whether they are the subject of a substantiated versus unsubstantiated investigation (U.S. Department of Health and Human Services, 2008). The

27 It is important to note that these data represent the proportion of cases in the sample for which there was a prior child welfare opening at the family level, not the rate of re-referral for all substantiated versus unsubstantiated cases. To properly assess the rate of re-referral (and substantiated re-referral), prospective, entry cohort data are required.
applicability of these findings to cases investigated by Canadian child welfare services has not been established. Although there were clear and statistically significant differences in the proportion of substantiated versus unsubstantiated cases presenting with caregiver risk factors such as alcohol, drugs, and mental health concerns, along with differences in poverty-related need in the current study, longitudinal research is required to assess the extent to which outcomes differ over the longer term between substantiated and unsubstantiated investigated children in Canada. As noted by Khol et al. (2009), it may be the degree of difference rather than the existence of statistically significant differences that should guide thinking about the distinction between substantiated and unsubstantiated cases and the need for service.

Despite the high level of need, half of investigated cases in the study sample received no service referrals at the conclusion of the investigation. The proportion receiving no referrals was greater for unsubstantiated cases than for substantiated cases (63% versus 34% respectively), which was likely based, in part, on the greater likelihood of substantiated cases presenting with clinical risk factors. Analysis of the nature of the service referral response underlines the predominantly rehabilitative (i.e., services designed to change or treat individuals) approach to families investigated for neglect. For example, in cases presenting with both clinical and poverty-related needs (50% of unsubstantiated and 72% of substantiated cases were thus characterized), the predominant service referral response was either no referrals made (55% of unsubstantiated and 28% of substantiated investigations) or only rehabilitative referrals (23% of unsubstantiated and 42% of substantiated referrals). The service referral response for cases presenting with clinical and material/concrete needs was characterized by attention to both of these needs in only 21% of substantiated cases and 11% of unsubstantiated cases. Overall, the most commonly employed service referrals were to parenting/family support services (e.g., parenting skills classes) and clinical/treatment services (e.g., mental health/addictions, psychiatric/psychological counseling) for both substantiated and unsubstantiated cases. Although referrals to improve parenting were the most common of those facilitated, it is important to recognize that the assessed need for such services far outweighs the evidence of effectiveness of these services.
While a plethora of models and programs are in existence, only a few have been rigorously tested and demonstrate effectiveness with families where maltreatment is a concern, such as the Triple P program (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009). Further, despite the accumulated evidence for such programs, they remain largely unavailable to the majority of families.

Findings of the service referrals analyses suggest that despite the privileged position of the ecological model in social work education for understanding clients’ problems (Saleeby, 2001) and the widespread belief that neglect more so than any other form of maltreatment is related to clients’ material disadvantage, Canadian child welfare workers, in practice, may be inclined to adopt an individualized, psychological/psycho-educational approach to the problem of child neglect. Whether this stems from workers’ beliefs about the root causes of neglect or from their understanding of the paid work of child welfare (i.e., to treat individual parents versus addressing structural/material issues) cannot be determined by the current study. Pelton (2008) argues that the imperative to attend to the concrete needs of clients rests not only in clients’ demonstrated need for such services but in the fact that unlike rehabilitative interventions, which are notoriously difficult to evaluate and require sophisticated research designs, concrete interventions have excellent face validity and demonstrated effectiveness. For example, if inadequate housing is a presenting risk factor, helping a client to obtain better housing or to repair household hazards will be exceptionally effective in reducing that risk.

Given the large proportion of clients struggling with both individual issues and more concrete/material disadvantage, findings of the current research suggest a partial mismatch between client needs and worker responses in cases of child neglect. For example, while over 70% of all investigations had at least one poverty-related need identified, only 17% of these cases received any referrals related to assisting families with material or concrete needs. This possibility is supported by previous research demonstrating differences in client and workers’ perception of needs, with clients most often identifying the need for material and instrumental resources compared to workers’ focus on risk to children due to individually-based problems such as addictions, mental health, and poor knowledge
of children’s development (O’Brien, 2005). Elaborating on this disconnect, O’Brien (2005, p. 4) states that “clients have consistently viewed the impact on themselves of environmental issues as a more pressing problem than have workers.” Cameron and Freymond (2003) come to similar conclusions, noting that in the more than 108 interviews and focus groups of Ontario child welfare clients and service providers they conducted a general theme was the lack of incorporation of clients’ material disadvantage into either assessments or helping strategies. Summarizing their findings, they state that “it is a concern that the child protection interventions in our research were not particularly congruent with the day to day needs and expectations of these children or parents” (p. 9).

The following sections provide a discussion of the most commonly identified caregiver, child, and poverty-related needs, with implications for policy and practice. The significance of data regarding the presenting needs of investigated children and their families is that they represent service requirements for those who are currently in the system. Although this thesis has questioned the utility of interventions that target only individual children and families, it is recognized that it equally inappropriate to ignore the individual needs of clients in the here and now, regardless of whether the origins of these needs are individually- or structurally-based.

**Caregiver Social Support and Child Welfare Response**

Results of the descriptive analyses demonstrate that few social supports was by far the most common concern endorsed by child welfare workers for cases of investigated neglect in the sample. The high rate of children living with caregivers identified as socially isolated—half of all children in substantiated cases and almost one-third of all children for whom neglect was unsubstantiated—is consistent with previous research identifying social isolation as a correlate of neglect (Coohey, 1996; Gaudin, 2001) and points to the need for services that increase caregivers’ and children’s connections with helpful others in their community. Data from the current study are consistent with recent Canadian research assessing the needs of families known to a children’s aid society in Ontario for reasons of neglect, from both worker and client perspectives. In this study, O’Brien
(2005) found that caregivers consistently referenced their desire for both formal and informal social and recreational support. For example, parents in this study identified the need to increase their social support networks as a means of coping with stress, and specifically wished for more social/recreational opportunities for themselves and their children.

The literature notes that social support is comprised of several constructs, including *social embeddedness* (the degree to which caregivers interact with and are connected to others in their community), *enacted social support* (the provision of concrete or instrumental help from others, such as assistance with child care), and *perceived social support* (the extent to which caregivers feel valued and cared for and able to count on others for help when need arises) (Coohey, 1996). Research has demonstrated that mothers’ perceptions of the quality of their social connections may be more important than the actual size of their social support network in determining maltreatment outcomes (Beeman, 1997). Several formalized interventions such as Family Connections and the Nurse Family Partnership Program developed by David Olds incorporate stated objectives of increasing social support for families through a combination of in-home assistance and social/recreational opportunities. Both of these programs have been rigorously evaluated and demonstrate evidence of their effectiveness (DePanfilis & Dubowitz, 2005; Olds et al., 1999; Zielinski, Eckenrode, & Olds, 2009), although recent replication and evaluation of the Olds model in Canada has not shown results as promising as those noted in the United States (MacMillan et al., 2005), underlining the importance of continued evaluation of interventions.

Although lack of social support was the most frequently noted of the caregiver concerns, referrals related to increasing informal social support networks (i.e., those designed to connect families to social and/or recreational opportunities so that they might develop/increase informal support relationships, such as through cultural centres or church groups) were the least common type of service referral made at the conclusion of the investigation; only 2% of child investigations resulted in any referrals designed to facilitate social/recreational support. These findings are consistent with previous research conducted by Blackstock (2008), who noted very few referrals
made on behalf of families to recreation/social support in the cases of 210 Aboriginal and non-Aboriginal children in care in Nova Scotia.

The limited referrals made to increase social supports despite the high endorsement for this need may be a result of several factors. First, the data represent referrals at approximately 30 days into service. Therefore, for those cases that are kept open for ongoing services, additional assessment and referrals are likely yet to come and the study data are assumed to under-represent service referrals across all categories. It is also possible that when workers recommend certain informal supports for families, such as community, cultural, or spiritual groups they may not consider these as service referrals and therefore they may not have been captured by the study. As a result, data used in the current study (i.e., service referral data) may not be an accurate measure of the extent to which workers consider social support needs in formulating their response to neglect and results should be interpreted with some caution. However, with these limitations in mind, results of both the current study and previous research suggest there may be an under-prioritization of clients’ social and recreational support needs.

The answer to why workers acknowledge but may not address social support needs of families may be related to the tendency to see the causes of and, thus, the remedies to neglect as rooted in individual parental deficits. Another possible explanation for this may be that increasing social supports for caregivers goes beyond facilitating referrals to informal and formal support services; it involves the need to work with parents on increasing the skills required to successfully participate and engage in mutually supportive relationships with members of their networks (Beeman, 1997). Although whether or not workers engage in these approaches cannot be assessed using the available data, in a time of scarce child welfare resources and large caseloads, workers may not have the time (or possibly the necessary skills) to devote to this task, which may seem secondary to the primary mandate of protecting children from harm. While social support difficulties on their own may not merit ongoing child welfare intervention, they point to the importance of assisting clients to access community-based services that might enhance social support networks, particularly for
those cases where ongoing services through child welfare are not provided (i.e., the vast majority of unsubstantiated cases).

**Alcohol, Drugs, and Mental Health and Child Welfare Response**

Descriptive analyses show that after few social supports, the three most frequently noted clinical concerns experienced by the caregivers of children in both substantiated and unsubstantiated neglect investigations were alcohol problems, drug/solvent abuse, and mental health problems (referred to collectively as ADM). Approximately one-third of children who were the subject of a substantiated investigation and one-fifth of children who were the subject of an unsubstantiated neglect investigation were living with caregivers for whom alcohol, drugs, and/or mental health problems were a noted concern. These findings are consistent with several other studies that have identified substance abuse and mental health issues as common correlates of neglect in both Canadian and American samples (e.g., Carter & Myers, 2007; Dufour et al., 2007; Dunn et al., 2002).

Documenting the high rate of caregiver alcohol, drugs, and mental health difficulties in cases of neglect is important for determining the service needs of caregivers in these cases; however, it is also equally informative for assessing the potential needs of children. Longitudinal research demonstrates that caregiver ADM problems are significant predictors of insecure attachment in children due to the association between substance abuse and/or mental health issues and caregivers’ ability to sensitively and consistently respond to the needs of their children. Further, research has also demonstrated that these difficulties are associated with subsequent externalizing behavioural difficulties in children (Libby, Orton, Barth, & Burns, 2007; Suchman, Mayes, Conti, Slade, & Rounsaville, 2004), suggesting the need for interventions with both adults and children in many families where caregiver ADM problems are noted.

The high rate of substance misuse and mental health problems experienced by caregivers referred to child welfare services for neglect points to the need for caregivers to have access to evidence-based addictions and mental health treatment programs. In the case of Aboriginal
children and families, it is imperative that they not only have access to services but that these services are culturally appropriate and take into account “the context of the economic poverty of many [Aboriginal] communities” (Blackstock, Cross, George, Brown, & Formsma, 2006, p. 11). Further, several authors have noted that such programs, when offered to child welfare clients, should also take into account the impact of addictions and mental health problems on parenting rather than treating the parenting needs of addicted/mentally ill child welfare clients as separate from their clinical concerns (Libby et al., 2007; Suchman et al., 2004).

Analysis of service referrals conducted in the current study suggest that when caregivers present with clinical needs, they are likely to receive referrals to services that are treatment-oriented (e.g., referrals to psychiatric/psychological counseling, addictions services, etc.), although the study did not match specific clinical concerns (e.g., addictions, mental health) to specific referrals (e.g., addictions and/or mental health treatment). Further, as previously noted, a significant limitation of the current analysis matching needs to referrals is that whether or not clients actually received services is unknown. Findings from a previous Canadian study note that when the primary caregivers of children who were placed in care presented with addictions and/or mental health problems at the time of placement, there was a direct relationship between the noted needs and the provision of assessment, treatment, and supportive services to address these needs (Blackstock, 2008), although the sample size of the study was non-representative and it was conducted using children and families in Nova Scotia only. Conversely, in a recent analysis using American data from the National Survey of Child and Adolescent Well-Being (NSCAW), researchers concluded that families experienced significant gaps between identified need and access to treatment services for ADM. In this study, the mental health needs of Native Americans were highlighted as particularly unlikely to result in referrals for service and, in turn, actual receipt of service (Libby et al., 2007). Further research is required to understand the extent to which families served by child welfare systems in Canada have access to and receive evidence-informed addictions and mental health services, although it
should be noted that lack of access to such services in First Nations communities is already well-documented (Blackstock, 2005).

**Special Consideration: Domestic Violence in Cases of Neglect**

Almost one-quarter (24%) of children in substantiated investigations were living with a caregiver who was a victim of domestic violence; the comparable statistic for children for whom neglect was not substantiated was 19%. These findings are consistent with previous research that has noted the overlap between neglect and domestic violence (Antle et al., 2007) and the rate cited through the current study is almost certainly an underestimation of the co-occurrence of these problems due to the intentional exclusion of cases substantiated for both neglect and exposure to intimate partner violence from the sample. Cases of co-occurring neglect were not included in the sample to simplify interpretation of the findings as associated with the neglect context rather than with the experience of another form of maltreatment altogether or co-occurring maltreatment. However, in light of the specific exclusion of co-occurring neglect/exposure to intimate partner violence (IPV) from the study sample, it is difficult to interpret these findings. It is possible that when workers were indicating that a caregiver in the home (almost always the mother) was a victim of domestic violence for cases in the study sample, there was no concomitant concern about exposure to domestic violence for the children; in other words, workers may have decided that although the mother was a victim of IPV, the children were neither aware nor affected. It is also possible that some cases investigated for neglect and exposure to IPV were substantiated for neglect rather than exposure to IPV, as the worker considered the mother’s failure to protect the children from witnessing violence as a form of neglect, rather than a form of exposure to IPV. Although this is not how neglect was defined in the study (and workers were extensively trained on the study definitions and how to complete the data collection form), failure to protect has been categorized as a form of neglect in other jurisdictions.

The child welfare system continues to struggle with how to provide services to children and families where domestic violence is an issue, (Black, Trocmé, Fallon, & MacLaurin, 2008)
and recent research has questioned whether a maltreatment lens is an appropriate one through which to assess affected families. As in cases of neglect, there is a notable absence of fathers in the research considering the problem of parenting in the context of domestic violence (Kelleher et al., 2008) and as with neglect, the child welfare system has been criticized for positioning the problem of domestic violence in families with children as one which is best resolved by working with the mother and holding her solely responsible for children's well-being (Jenney, 2011). Consequently, the combination of child neglect in a home in which the mother is also a victim of intimate partner violence, whether children are exposed or not, potentially represents a double set of gendered judgments: first, that a woman may have failed at the basics of mothering (neglect) and second, that inherent in her own victimization is the possibility that she has also failed to protect herself and her children from violence. Workers must be careful that their interventions move beyond holding mothers individually responsible for both neglect and domestic violence. Careful attention to holding men accountable as both potential sources of risk and as well as support is required for both neglect and cases where neglect occurs in homes with domestic violence (Dubowitz, 2006; Dubowitz et al., 2000; Strega et al., 2008; Walmsley, n.d.).

**Children’s Needs**

**Infants and Toddlers**

Findings from the descriptive analyses highlight the difficulties experienced by children investigated for neglect. As expected, the youngest children (those three years and under) presented with the lowest frequency of concerns, influenced in part by the nature of the difficulties documented by the CIS-2008, many of which are most associated with older children (e.g., suicidal thoughts, self-harm, substance abuse, running, and criminal activity). Not surprisingly, the most commonly identified problems for the youngest children related to attachment issues and failure to meet developmental milestones, although these were noted for only a small proportion of children who were the subject
of a substantiated neglect investigation (10% and 14% respectively), and an even smaller percentage of children for whom neglect was unsubstantiated (3% and 7% respectively).

The low rate of attachment concerns noted for infants and toddlers who are the subject of a substantiated neglect investigation is somewhat counter to the literature that identifies high rates of insecure or disorganized attachment among neglected infants and preschoolers (Carlson, Cicchetti, Barnett, & Braunwald, 1989; Crittenden & Ainsworth, 1989; Egeland & Sroufe, 1981a). Further, the low proportion of young children in the sample identified with developmental difficulties (i.e., failure to meet developmental milestones) is surprising given the evidence in the research literature that neglect occurring during a child's first years has a significant, negative impact across physical, cognitive, social, and behavioural development (Glaser, 2000; Hildyard & Wolfe, 2002). Research demonstrates that the age of onset of neglect is critical in determining the developmental trajectory, with neglect beginning in early childhood leaving children particularly vulnerable to poor developmental outcomes (Manly, Kim, Rogosch, & Cicchetti, 1991).

There are several possible interpretations of these results, which are influenced by the limitations of the data. First, it is possible that the negative sequelae of neglect for these young children in the sample are not yet evident and will manifest themselves later in their developmental trajectories. As the CIS-2008 data are cross-sectional, the age of onset of neglect for older children in the sample, a group presenting with higher rates of attachment and developmental concerns, is not known. It is also possible that some child welfare workers—many of whom are young and inexperienced (Fallon, MacLaurin, Trocmé, & Felstiner, 2003)—require more training and experience in assessing the development of very young children. It is the role of investigating workers to collect evidence to corroborate maltreatment within fairly restrictive time frames (approximately 30 days from the receipt of referral based on provincial policies and standards), and they may have neither the training nor the time to conduct a full developmental assessment. As a result, data in the CIS-2008 dataset based on worker judgment after 30 days may be construed as too blunt an instrument to truly measure the extent of developmental and/or attachment concerns in Canadian child welfare.
Therefore, the low rate of problems endorsed for the youngest children in this sample compared to the peer reviewed literature should be viewed with some caution. The importance of focusing on developmental issues for children who become child welfare clients at an early age is highlighted by longitudinal research using American data that demonstrate that children whose first contact with child welfare occurs at a young age are at high risk for developmental delay and neurological impairment (Wulczyn et al., 2005), although the extent to which these findings can be generalized to Canadian samples needs to be established.

Finally, it is also possible that what Canadian child welfare services refer to as neglect represents lapses in caregiving that, although less than optimal, result in minimal impact on these young children, calling into question the maltreatment lens for these problems. This possibility is reminiscent of the distinction made by Slep and Heyman (2006) between problematic parenting and maltreatment. Longitudinal research using a Canadian sample is required to determine whether these early experiences called neglect by Canadian child welfare authorities have similarly poor outcomes over the longer term compared to those noted in other studies of neglected infants and toddlers. For example, American studies have followed cohorts of children for several years and in some cases, decades. Results of these studies demonstrate the profound effects of early neglect on children’s neuro-development (Perry, 2002), attachment style (Carlson et al., 1989), and later behavioural and emotional functioning (Egeland, 2009). Similar studies are required to understand better the vulnerability of infants and toddlers known to Canadian child welfare authorities for reasons of neglect. Future research would also need to use control groups to separate out the long-term sequelae of poverty from those related to the experience of neglect, given that many of the poor child outcomes associated with neglect are also found for children growing up in poverty even without the experience of maltreatment (Brooks-Gunn & Duncan, 1997).

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28 As a point of comparison, measures used in the peer reviewed studies mentioned include Ainsworth’s Strange Situation test, along with other standardized assessment tools such as the Bayley Scales of Infant Development (a tool that assesses constructs such as enthusiasm, frustration tolerance, impulse control, problem-solving, and flexibility), and tests of IQ and expressive and receptive language, making them much more sensitive and specific than the assessment methods commonly used during child welfare investigation. Few, if any of these tools and assessments are available to investigating child welfare workers.
**School-Aged Children**

**Academic Needs**

For elementary school-aged children (those aged 4–7 years and 8–11 years) and for adolescents (children aged 12–15 years), academic difficulties emerged as a problem for a substantial minority, including both substantiated and unsubstantiated cases. These difficulties were so prevalent for adolescents who were the subject of substantiated investigations that those who were not noted as having academic problems were in the slight minority. Although less frequently noted, this was also a common concern for children in unsubstantiated investigations. Given the very high rate of academic difficulties across all school-aged groups—findings consistent with multiple studies of child welfare populations (Brownell & Roos, 2010; Kufeldt, 2006; Wulczyn, Smithgall, & Chen, 2009)—the question of whether child welfare workers should intervene to support children’s academic achievement is a pressing one. Academic achievement is a critical maker of child well-being but it is unclear whether the protection-focused mandate of Canadian child welfare services supports intervention in this area for children served at home with their families; the imperative to support children’s school achievement is, comparatively, more clear for children in care. Similar debate has taken place in the United States, with scholars noting that despite the liberal use of the term well-being in child welfare legislation and discourse around mission-critical outcomes, residual policies in place do not support intervention in cases where well-being (as opposed to child safety) is the primary concern (Wulczyn et al., 2005). Further, academic achievement is an outcome for which child welfare services cannot be held solely accountable (Wulczyn, Orlebeke, & Haight, 2009); it is a responsibility shared with other sectors, including education, and calls for collaboration between schools and child welfare agencies to support children (Gallagher-Mackay, 2010).
Mental/Emotional and Behavioural Support Needs

Some of the most common concerns noted for investigated children included anxiety/depression (noted for almost one-quarter of children aged 8–11 years and over one-third of children aged 12–15 years who were the subject of substantiated investigations and for over one-quarter of adolescents who were the subject of unsubstantiated investigations). Further, school-aged children across both substantiated and unsubstantiated cases presented with concerns related to aggressive behaviour, an issue of particular note for adolescents in both substantiated and unsubstantiated cases (34% and 20% of teenagers respectively). Adolescents who were the subject of substantiated investigations emerge as a particularly vulnerable group in other areas, with noted concerns related to drug/solvent abuse for almost one-quarter of these young people. As previously discussed, the cross-sectional nature of the data limits the ability to attribute children’s mental/emotional and behavioural issues directly to their experience of neglect. Longitudinal research is particularly critical in unpacking the relationship between childhood experiences of neglect and later child outcomes. Prospective, longitudinal designs have the ability to control for other important variables such as socio-economic status, an issue of particular relevance as many studies have shown that academic difficulties along with internalizing and externalizing problems are all associated with family poverty, even after controlling for potentially confounding factors such as maternal age, education, and family structure (Duncan, Brooks-Gunn, & Klebanov, 1994; McLeod & Shannahlan, 1993).

Findings related to the mental/emotional and behavioural support needs of school-aged children point to similar recommendations as those made for caregiver needs; most importantly, the requirement for children to have access to evidence-based mental health services that are also culturally appropriate. The need to integrate and/or coordinate services between child welfare and children’s mental health has been noted by both researchers and practitioners concerned with the fragmentation of services for vulnerable children and families. To this point, advocates note that additional funding for services is not the only key factor; clients require access to effective and coordinated services in addition to services designed to prevent childhood mental health problems (Waddell, 2007).
Poverty-Related Needs and Child Welfare Response

Adequacy of housing and income were the two poverty-related needs assessed by the research. Data on income, education, and specific job classification—preferred components of measures for socioeconomic status (SES)—were not available in the CIS-2008, which was a significant limitation of the study. The measure of income adequacy relied on data regarding full-time employment and housing adequacy relied on a series of variables that measure whether children lived in homes owned by their families or another type of housing, number of moves, over-crowding, and the presence of at least one of a long list of household hazards. While not ideal measures of poverty or SES, these variables were considered adequate proxy measures due to their association with low income and SES.

The majority of families in the sample did not derive their income from full-time employment (59%). Most children who were substantiated for neglect lived in households where either part-time/seasonal work for one or both caregivers or social assistance was the primary source of income. These data are consistent with almost every other study to look at source of income, with most studies noting the high proportion of social assistance recipients on child welfare caseloads. Despite the high level of children living in families receiving social assistance or relying on low/unstable employment, limited referrals were made to meet concrete/material needs. For example, despite the vast majority of families having either low income or poor housing, only 17% of cases received referrals designed to meet concrete needs (e.g., food banks, financial assistance, winter coat funds, employment services, etc.). Further, even when the only identified concerns of the family were poverty-related (i.e., inadequate housing and/or low/unstable income with no clinical concerns identified), families were as likely to receive rehabilitative referrals as those designed to address concrete needs. And when identified needs were both poverty-related and clinical, the overwhelming service response was clinical in nature.
As would be expected given the high rates of social assistance, the vast majority of families in the study did not own their own home (79%). Almost a quarter of children substantiated for neglect lived in unsafe housing (i.e., there was at least one household hazard) and many (approximately one-fifth) lived in some form of public housing (band-owned or otherwise). Public housing, while often more affordable, means that these children may be growing up in neighbourhoods characterized by poverty, crime, and social stigma commonly associated with subsidized housing (Bartz, Joseph, & Chaskin, 2011). For children living in band housing, studies and First Nations leaders have noted the poor conditions of Aboriginal housing both on- and off-reserve, citing problems with overcrowding, air circulation (leading to mold), heating, plumbing, and electrical wiring (IHC, 2003).

Some of the housing difficulties experienced by families cannot be solely addressed at the individual family level and in fact, an individual approach may solve some problems but lead to others. For example, child welfare workers often advocate for clients to obtain public housing as a solution to housing problems due to the affordability of these accommodations, despite the attendant difficulties in many public housing neighbourhoods. However, the conditions surrounding public housing may be amenable to community-based interventions offered through children's aid societies or other social service programs. One such example is the Community Corner project, initiated by Ontario’s Children’s Aid Society of Algoma in collaboration with 13 community partners. The program operated out of a two-bedroom unit provided by the housing corporation of a public housing complex in the Chappel/Albion neighbourhood of Sault Ste. Marie, where there is a high density of at-risk families. Programs were led by CAS staff with expertise in family preservation services and focused on developing awareness of healthy families, improved parenting practices, and community pride. An evaluation of this program indicated that tenants reported increased connections within their neighbourhood, caring more about their neighbours, participating more readily in community activities, having a greater sense of safety, and feeling less shame about living in a subsidized housing complex (Boston & Broad, 2007). Evaluators noted that the program also helped to “develop social capital (i.e., trusting social relations) in the neighbourhood by connecting
people in the neighbourhood and from different positions and backgrounds, thereby linking disadvantaged communities with external resources and information” (p. 5).

**For Reasons of Poverty Alone?**

Scholars and critics alike have articulated the possibility that what child welfare authorities call *neglect* is really poverty, and many have raised social justice concerns about highly intrusive interventions into poor families in the name of “maltreatment” (Besharov & Laumann, 1997; Blackstock, 2008; Charlow, 2002; Wexler, 2010). While analyses conducted in this dissertation have certain important limitations, they shed some light on the notion of neglect as a classless phenomenon whose strong association with poverty is an artefact of middle-class bias.

**Reporting Bias**

In the first analysis designed to assess reporting bias, the hypothesis that children from families with lower levels of poverty-related need would represent somewhat more serious situations due to the presumed higher threshold for referral of these families was not supported by the data. Not only were neglect allegations for children in low poverty-related need cases (those with neither income nor housing concerns) substantiated at a significantly lower rate than allegations involving children experiencing higher poverty-related need, but additional analyses demonstrated that caregiver concerns (e.g., alcohol, drugs, mental health problems) presented by parents/guardians in low poverty-related need cases were significantly less frequent than cases characterized by moderate and high levels of poverty-related need. These findings are consistent with American research (see Johnson-Reid, Drake & Khol, 2009), in which allegations of maltreatment for non-poor families (defined as those not receiving social assistance) were rated as less serious, as were the caregiver concerns presented by less poor parents. This connection between poverty and level of caregiver clinical concerns, particularly alcohol, drugs, and mental health, is noted throughout the addictions and mental health literature (Eaton & Muntaner, 1999; Mirowsky & Ross, 2001).
Results of the bivariate analyses show that rates of substantiation are highest for children whose families are experiencing the greatest level of poverty-related need (i.e., both income and housing problems rather than one, the other, or neither); substantiation rates for those children living in houses with moderate poverty-related need (either housing or income concerns but not both) were also higher than children from low poverty households, but lower than for children from households experiencing the highest level of poverty-related need. Although poverty is not measured as a continuous variable in the current study, these findings are consistent with previous research showing that even among economically deprived samples, incremental increases in poverty level are associated with higher rates of neglect (Pelton, 1994).

Results of the analyses suggest that referrals of children experiencing significant poverty-related need do not appear to be diluted by a high level of false positives. Similarly, referrals characterized by lower levels of poverty-related need do not appear to be the most serious cases, based on their comparatively lower rate of substantiation and the lower levels of caregiver risk factors present in low poverty-related need cases. As this analysis was limited by the data available and only investigated cases are represented in the CIS-2008 sample, it is not known to what extent the screening process may have corrected for a potential reporting bias (i.e., poor children reported for relatively minor concerns or due to poverty alone may have been screened out before investigation). Further, as data are not available for all suspected cases of neglect (both reported and unreported), analysis is not able to determine the extent of under-reporting for poor versus less poor families.

One possible explanation for the findings of the bivariate analysis is that workers too may share reporters’ class-related biases and like reporters, may be more inclined to look for and thus find maltreatment in poor families. Additionally, as the chi-square tests employed were bivariate analyses, they only take into account the relationship between two variables: relative poverty-related needs and substantiation level. Findings from the regression analyses (summarized in Table 43, page 245) shed additional light on the extent to which, controlling for other factors, poverty-related variables predict decision-making in cases of child neglect.
### Table 43

*Summary of Relationship of Predictor Variables to Case Dispositions in the Multivariate Analyses*

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>Substantiation</th>
<th></th>
<th>Ongoing Services</th>
<th></th>
<th>Placement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Odds Ratio</td>
<td>Pseudo R²/R²</td>
<td>Odds Ratio</td>
<td>Pseudo R²/R²</td>
<td>Odds Ratio</td>
<td>Pseudo R²/R²</td>
</tr>
<tr>
<td>Child level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td></td>
<td>0.94</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Aboriginal status</td>
<td>1.36</td>
<td>Nagelkerke</td>
<td>1.44</td>
<td>Nagelkerke</td>
<td>2.48</td>
<td>Nagelkerke</td>
</tr>
<tr>
<td>Physical/cognitive/developmental</td>
<td>1.32</td>
<td>R²: 7%</td>
<td>1.25</td>
<td>R²: 12%</td>
<td>N/A</td>
<td>R²: 11%</td>
</tr>
<tr>
<td>Mental/emotional</td>
<td>ns</td>
<td></td>
<td>1.35</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Behavioural</td>
<td>ns</td>
<td></td>
<td>1.49</td>
<td></td>
<td></td>
<td>1.56</td>
</tr>
<tr>
<td>Caregiver level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youngest caregiver age &lt; 22 years</td>
<td>N/A</td>
<td>0.57</td>
<td>ns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(reference)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youngest caregiver age 22–30 years</td>
<td>N/A</td>
<td>0.40</td>
<td>ns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youngest caregiver age 31–40 years</td>
<td>N/A</td>
<td>R² change: 7%</td>
<td>0.65</td>
<td>R² change: 16%</td>
<td>ns</td>
<td>R² change: 5%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>1.39</td>
<td>R² change: 7%</td>
<td>ns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug/solvents</td>
<td>1.46</td>
<td></td>
<td>2.30</td>
<td></td>
<td>1.62</td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td>1.27</td>
<td></td>
<td>1.87</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Few social supports</td>
<td>1.49</td>
<td></td>
<td>2.27</td>
<td></td>
<td>1.34</td>
<td></td>
</tr>
<tr>
<td>Level of cooperation</td>
<td>ns</td>
<td></td>
<td>ns</td>
<td></td>
<td></td>
<td>1.64</td>
</tr>
<tr>
<td>Family/Household level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lone female (reference)</td>
<td>ns</td>
<td></td>
<td>ns</td>
<td></td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Lone male</td>
<td>ns</td>
<td>R² change: 0%</td>
<td>ns</td>
<td>R² change: 0%</td>
<td>.72</td>
<td>R² change: 1%</td>
</tr>
<tr>
<td>Two biological parents</td>
<td>0.78</td>
<td></td>
<td>ns</td>
<td></td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Two parents-blended</td>
<td>ns</td>
<td>R² change: 0%</td>
<td>ns</td>
<td>R² change: 0%</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Other family structure</td>
<td>ns</td>
<td></td>
<td>ns</td>
<td></td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Number of children in household</td>
<td>N/A</td>
<td></td>
<td>ns</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Case/Maltreatment level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any professional referral</td>
<td>1.65</td>
<td></td>
<td>ns</td>
<td></td>
<td>0.74</td>
<td></td>
</tr>
<tr>
<td>Mother/step mother as alleged</td>
<td>1.34</td>
<td>R² change: 12%</td>
<td>2.60</td>
<td>R² change: 18%</td>
<td>ns</td>
<td>R² change: 2%</td>
</tr>
<tr>
<td>perpetrator</td>
<td>N/A</td>
<td>R² change: 12%</td>
<td>1.76</td>
<td>R² change: 18%</td>
<td>ns</td>
<td></td>
</tr>
<tr>
<td>Previous openings</td>
<td>N/A</td>
<td></td>
<td>5.91</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neglect was substantiated</td>
<td>1.57</td>
<td></td>
<td>1.79</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Physical harm</td>
<td>8.48</td>
<td></td>
<td>3.00</td>
<td></td>
<td>1.89</td>
<td></td>
</tr>
<tr>
<td>Emotional harm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poverty-related</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No full time income</td>
<td>ns</td>
<td>R² change: 1%</td>
<td>ns</td>
<td>R² change: 1%</td>
<td>ns</td>
<td>R² change: 0%</td>
</tr>
<tr>
<td>Housing concerns</td>
<td>1.57</td>
<td></td>
<td>1.55</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

Note: Only odds ratios significant at p<.05 or lower are reported; N/A denotes variables not included in the multivariate model due to lack of significance at the bivariate level

*a Based on the results presented in Table 24 (Substantiation), Table 30 (Ongoing Services), and Table 36 (Placement)
In sum, none of the analyses provided evidence of a significant, unique contribution for poverty-related needs in decision-making. By adding poverty-related needs as the last block of variables, these models produced a conservative estimate of the amount of variance explained by income and/or housing concerns in the outcome variables of interest. After controlling for child, caregiver, household, case, and maltreatment factors, poverty-related need accounted for just 1% of the explained variance in the models predicting substantiation and ongoing services and explained none of the variance in the model predicting placement. Despite these findings, while having no full-time income was not a significant predictor of decision-making in any of the models, the presence of one or more housing concerns increased the odds of substantiation and ongoing services by over half again as much compared to cases where no such concerns were noted; however, contrary to previous American (Courtney, McMurty, & Zinn, 2004) and Canadian research (Chau, Fitzpatrick, Hulchanski, Leslie, & Schiata, 2009), housing concerns did not influence the decision to place a child in out-of-home care after controlling for all other factors in the multivariate model. Results indicating that poverty-related need was not a significant predictor of placement run counter to a body of American research conducted over several years demonstrating that poverty is the single-best predictor of the decision to place a child in out-of-home care (Garbarino & Stocking, 1981; Page, 1987; Lindsey, 1994; Testa & Goerge, 1988), although the extent to which these studies controlled for other risk factors varies.

Overall, the lack of significance of income concerns and the minimal contribution of housing concerns to case dispositions for neglect is encouraging. Results do not support the notion of systematic bias in decision-making and demonstrate that it is predominantly the risk factors and/or needs of the caregivers, children, and families along with severity of maltreatment that form the basis of workers’ decisions. A more detailed discussion of this follows below.
The Influence of Harm and Risk

Results of the multivariate analyses also corroborated previous research demonstrating that decision-making in child welfare is strongly influenced by evidence of harm and risk (English et al., 1998; Stevens, 1998; Trocmé et al., 2004; Trocmé et al., 2009; Winefield & Bradley, 1992). Evidence of emotional harm and/or physical harm significantly predicted substantiation, ongoing service provision and placement (with the exception of physical harm for the latter), although to varying degrees. For substantiation and ongoing services, the presence of emotional harm was very influential, increasing odds of the event by more than eight times for placement and by three times for ongoing services. Children also had increased odds of placement when physical harm was evident, although the effect size was smaller ($OR = 1.89$). The effect of physical harm was less pronounced than emotional harm but nonetheless significantly related to substantiation and ongoing services, increasing odds of these events by over half again as much compared to cases where no physical harm was noted. Caregiver and child risks/needs were also significant predictors of each decision, although the influence varied along with the nature of the specific risks. For example, substantiation was significantly related to all four caregiver functioning concerns documented (alcohol, drugs, mental health, and social isolation), whereas alcohol was not significantly related to the decision to keep a case open for ongoing services or to child placement, and mental health was not included in the model predicting placement due to lack of significance at the bivariate level. With respect to child functioning concerns, all three documented by the study (physical/cognitive/developmental, mental/emotional, and behavioral) were significant predictors of ongoing service provision, but only the first of these predicted substantiation and the last of these predicted placement.

The age of the child did not emerge as significant at the bivariate level for any of the three case dispositions except placement. Findings of the multivariate analysis predicting placement indicated that young children have increased odds of placement, after controlling for all other variables in the model. Specifically, with every one year increase in age, children’s odds of placement decreased by 6%. These findings are consistent with those of recent American analyses conducted using the
National Child Abuse and Neglect Data System (NCANDS) data, in which researchers note the particularly high risk of placement for children under the age of one (Wulczyn, 2009). The high rate of placement for young children is usually interpreted as the increased vulnerability of infants and toddlers due to their greater dependency and need for care. In this way, young child age is seen as a risk factor, as the same experience (e.g., physical neglect or lack of supervision) may have significantly more impact on an infant than on an older child who is able to prepare his or her own breakfast or remain unattended for periods of time. Further, American research has demonstrated that infants coming in to care are often those exposed to substances, suggesting an interaction between young child age, caregiver substance abuse, and risk of placement.

**The Influence of Extraneous Variables**

Despite the encouraging findings related to risk and evidence of harm as some the best predictors of short-term case outcomes, findings highlight three other variables that, in theory, should be extraneous to decision-making but emerged as significant in the models: mother/stepmother as alleged perpetrator (substantiation), professional source of referral (substantiation and placement), and Aboriginal child (all three case dispositions).

**Mothers as Perpetrators**

Findings that neglect is more likely to be substantiated when the alleged perpetrator is the mother/stepmother suggest a potentially gendered approach to allegations of neglect. Daniel and Taylor (2005) note that most identified perpetrators of neglect are mothers, due in part to the fact that mothers still comprise the vast majority of primary and often sole caregivers. However, they argue that even in homes where both mothers and fathers are present, “the identification of mothers as perpetrators requires a deep-rooted assumption that fathers cannot be held responsible for the neglect of children” (p. 431). Although this explains why more mothers than fathers are assumed responsible, it does not quite explain why, when fathers are the alleged perpetrators (as opposed to
mothers), neglect is less likely to be substantiated. As a potential explanation, Swift (1995) proposes that due to the gendered assumption that women are natural carers, it is less acceptable for women (mothers) to experience lapses in care compared to men (fathers), making it more likely that such lapses are considered deviant (i.e., maltreatment) when perpetrated by women. Findings that cases in which mothers/stepmothers were the alleged perpetrator of neglect were more likely to be substantiated than cases where only non-mothers (i.e., fathers, stepfathers, grandparents, foster parents, etc.) were the alleged party responsible cannot be explained by the high proportion of single mother-led families referred to child welfare, as family structure was also controlled for in the model. Further study is necessary to understand these findings.

**Professional Referrals**

Children referred by professionals had odds of substantiation 1.65 times those of children referred by non-professional sources after controlling for other important characteristics of the case. These findings are similar to other analyses of CIS data in which referrals from the police in particular were significantly related to substantiation of neglect (Trocmé et al., 2009). Further, they call to mind the results of American studies exploring the predictors of substantiation in which professional referrals were more likely to predict verified maltreatment (English et al., 1998). Possible interpretations of these data are that professional sources of referral are simply seen as more credible or that other factors associated with being referred by a professional that were not measured by the model explain the significance of professional referrals.

**Aboriginal Children**

Lastly, and most troubling, were findings that Aboriginal children had increased odds of substantiation and ongoing service (36% to 44% higher) and placement (almost two and a half times as high) compared to non-Aboriginal children, after controlling for all other factors in the model. In writing about disproportionality in child welfare in the United States, Drake cautions
that the significant policy issue is not in demonstrating that certain groups are overrepresented, but in understanding whether bias or risk plays a greater role in driving front-end disproportionality. Speaking specifically of the overrepresentation of African American children in the American child welfare system, he concludes that although research shows limited evidence of systemic bias, “the evidence that African American families face higher risk than White families is nothing short of overwhelming” (Drake, 2011).

Scholars grappling with issues related to the disproportionality of Aboriginal children in Canadian child welfare have come to similar conclusions, noting the increased risk of structural problems (i.e., poor housing, poverty, and substance abuse) for Aboriginal families, which might explain their overrepresentation in cases of neglect in Canada (Blackstock, 2003; Blackstock, 2008; Trocmé et al., 2006). For example, in a previous multivariate analysis using data from the first cycle of the Canadian Incidence Study (CIS-1998), researchers found that once clinical risks and poverty-related issues were controlled for, Aboriginal children had rates of placement consistent with their non-Aboriginal counterparts (Trocmé et al., 2004). This analysis included all investigated maltreatment and was not specific to neglect. The current findings are particularly concerning as they suggest that in cases of neglect, the decision to place a child is influenced by Aboriginal status above and beyond known clinical and poverty-related risk factors. In other words, increased risk (at least those risks measured by the model) does not fully explain the increased likelihood of placement for Aboriginal children. In fact, Aboriginal status of the child was the single best predictor of placement in the model.

In looking at the models predicting ongoing service provision, the odds of ongoing service are almost half again as high for Aboriginal children. Interpretation of these findings hinges, in part, on how ongoing services are conceptualized. For example, they may be considered supportive services that in times of scarce child welfare resources, should be offered first to the families most in need. In this way, an argument can be made that Aboriginal families might be seen as more “at risk” (akin to Drake’s theory) and therefore in the best position to benefit from service. However, the counter-argument to this is that ongoing services represent continued surveillance of Aboriginal families
by a system that may provide little in the way of support. Whichever of these interpretations is considered more accurate rests, to a certain extent, on the demonstrated benefits to families of child welfare services, an assertion with limited empirical support (Dufour & Chamberland, 2003; Flynn & Bouchard, 2005; Pecora, Seelig, Zirps, & Davis, 1996; Wolfe & Wekerley, 1993). Although the effect size of Aboriginal status was smallest for the model predicting substantiation, Aboriginal children had odds of substantiation over one-third again as high as their non-Aboriginal counterparts. Further research to understand these findings is required.

**Clustering of Child, Caregiver, and Poverty-Related Needs**

Results of the cluster analyses documented in Chapter 7 suggest that substantiated cases of neglect can be partitioned into three subgroups. This three-cluster solution was determined to have adequate stability and validity and is comprised of three subgroups characterized by the following constellations of clinical and poverty-related need: (1) high caregiver alcohol/drugs/mental health (ADM), high poverty-related need, moderate child need; (2) high child need, low caregiver alcohol/drugs, moderate mental health, moderate poverty need; and (3) low child need, low caregiver alcohol/drugs, moderate mental health, low/moderate poverty need.

An important finding of this stage of the research was that no cluster (or clusters) emerged in these analyses characterized by poverty needs alone. This finding demonstrates empirically that what Canadian child welfare services determine as child neglect is not synonymous with poverty per se. Although poverty is certainly a unifying characteristic of many families known to child welfare and, in particular, those referred for reasons of neglect, the results of the cluster analyses support the notion that it is poverty-related need along with caregiver alcohol, drugs, and/or mental health problems rather than poverty alone that represents the context in which the most intrusive interventions (i.e., ongoing protection services and child placement) occur. The subgroup in which high child needs were evident, coupled with moderate caregiver mental health and low alcohol/drugs, also had high rates of ongoing service provision but comparatively low rates of child
An Exploration of the Relationship Between Poverty and Child Neglect in Canadian Child Welfare

placement. In keeping with the low-needs profile of the third cluster, this subgroup had the smallest proportion of children who were placed at the conclusion of the investigations and whose cases were kept open for ongoing services.

Several descriptive analyses were run to understand further the profile of the three subgroups. Analyses highlighted the fact that the high caregiver ADM/high poverty-related need/moderate child need cluster (i.e., the context in which the most intrusive child welfare interventions took place) was comprised in the majority, of Aboriginal children, who represented 65% of the children in this cluster. In fact, 65% of all Aboriginal children in the study sample were assigned to this cluster. This finding must be placed within the larger question of the factors that render children (and their families and communities) at risk of the risks that characterize this subgroup (i.e., substance abuse, mental health problems, low income, and poor housing). As the root causes of these risks for First Nations people are somewhat different than for non-Aboriginal people—for example, Canada’s history of colonialism along with government policies that have “fostered systemic poverty in many Aboriginal communities” (Quinn & Saini, 2012, p. 9)—there is an argument that neglect in Aboriginal communities needs to be thought about and responded to differently. In sum, findings support the argument advanced by Blackstock (2003) that structural risks characterize a significant subgroup of Aboriginal children investigated by Canadian child welfare services. She notes that the most significant remedies to address these problems are found through the provision of culturally-based child welfare service and Aboriginally-driven socio-economic development. However, the data suggest that one of the predominant services offered to these families is foster care, given the high rate of placement in this cluster.

It is also important to note that this cluster was characterized by a high proportion of single female-led families, with 77% having prior openings with child welfare services. Almost one-third of children in this cluster were under the age of four, further underlining the urgent requirement to understand and address the immediate service needs of these families given that prior child welfare investigation and intervention have not resulted in sustained reduction of risks to these
children. As this cluster had the lowest rate of physical harm across all three clusters coupled with the highest rate of caregiver problems known to impact attachment and development, these children in particular might be better thought of in terms of endangered development and well-being (Trocmé & Chamberland, 2003) and services might be better organized around promoting family welfare rather than child safety.

The second cluster (high child needs, low caregiver alcohol/drugs, moderate caregiver mental health) was composed of predominantly older children, consistent with the descriptive data that demonstrate the oldest children in the sample present with the highest rates of functioning concerns. Over one-third of children in this cluster were adolescents (12 and older) and only 13% were under the age of four. Similar to the “high needs” cluster, many of these children live with single female caregivers and the vast majority of households have been previously known to child welfare services. This group also had the highest rate of physical harm compared to the other two clusters. Further, children in this cluster had the highest frequency of developmental, mental, and behavioural support needs, indicating a group of clients that likely have considerable overlap with children’s mental health services, further advancing the argument made by Waddell (2007) of the need for effective and coordinated services between the two sectors. Caregivers in this cluster also have mental health needs but relatively low need for addiction services. In this regard, cases in this cluster resemble the third cluster (low needs), with relatively low rates of caregiver alcohol/drug problems but with more pronounced rates of caregiver mental health needs. The significant difference between Cluster 2 and Cluster 3 is the absence of noted child functioning concerns in Cluster 3, which is consistent with the child age profile—almost half of children in Cluster 3 were under the age of four. However, based on the preponderance of infants and toddlers in Cluster 3, it might be more appropriate to characterize this low needs cluster as one which, nonetheless, represents a potentially vulnerable population due to the young age of the children in these cases of substantiated neglect. Cluster 3 may be amenable to a form of differential response, either within child welfare services or through community-based services due to the relatively low risk profile of the caregivers coupled with the need to support
positive parenting and promote the well-being of these infants and toddlers. However, when cases are diverted to the community, significant outreach may be required to engage families in services, a role not typically assumed by non-mandated services.

**Bringing It All Together**

**A Theory of Intersectionality for Child Neglect**

The current study was made up of a series of smaller analyses, each designed to explore a certain aspect of the relationship between poverty and child neglect. Although each of these analyses was conducted separately to address slightly different objectives, their findings, when taken as a whole, suggest that a constellation of issues at multiple levels characterize the neglect context and influence the nature and intensity of child welfare intervention. For example, while descriptive analyses highlighted the most common caregiver, child, and poverty-related needs, it is important to acknowledge the interconnectedness of these issues rather than viewing them as separate, unrelated factors. Many of the concerns noted for caregivers are not experienced in isolation and together, can create a particular context for child rearing that becomes more serious than the sum of its parts. For example, the literature notes that substance abusing parents are often lacking in social support due to the fact that their networks frequently consist of other users who are unable to provide either emotional or instrumental assistance in times of need (Dore, Doris, & Wright, 1995). Similar concerns about the impoverishment of social connections exist for parents with mental health problems. Further, beyond the micro system of individual parents and families, communities with high levels of neglect are often those with other social problems such as poverty, violence, delinquency, poor housing, and sub-standard schools (Drake & Pandey, 1996)—what Garbarino (1995) refers to as **socially toxic or socially impoverished** neighbourhoods. Thus the needs experienced by the caregivers and children in this study are also characteristics of the broader neighbourhoods in which many of them live.
Intersectionality, a theory popularized by the work of Crenshaw (1991), may be a particularly helpful framework in which to understand the interconnectedness of many of the common needs identified for families through this study. In speaking of the basic assumptions of intersectionality, Brah and Phoenix (2004, p. 76) note that “different dimensions of social life cannot be separated into discrete or pure strands.” This is particularly relevant in trying to understand the relationship between poverty, child neglect, and other child and family difficulties. Although the methodology utilized to assess bias in decision making (logistic regression) proposed to be able to assess the unique contribution of poverty controlling for other relevant clinical and case characteristics, the results of the cluster analysis illustrate the inter-relatedness of several factors associated with social disadvantage in addition to poverty (i.e., mental health and addictions clustered together most strongly with high poverty need). Further, the finding that the cluster experiencing the highest rates of caregiver alcohol, drugs, and mental health problems and poverty needs was characterized by a majority of Aboriginal children, and was the cluster that experienced the highest rate of child placement, suggests the need for an analysis that “strives to understand what is created and experienced at the intersection of [multiple] axes of oppression” (Havinsky et al., 2010, p. 3). For Aboriginal children and their families, in particular, neglect may result from the cumulative sources of oppression, both current and historical, that shape their lives, and assessment and intervention strategies should be informed by this understanding.

**Neglect: Maltreatment or Social Disadvantage?**

The term *child maltreatment* is usually defined as various acts of commission and/or omission committed by a parent or caregiver that result in harm or risk of harm to the child. Neglect, as a recognized form of child maltreatment is typically concerned with caregiver acts of omission (i.e., the failure of caregivers to provide for a child’s basic needs). By framing child neglect as a form of maltreatment, the focus is on parents as perpetrators; child welfare investigations typically seek to verify maltreatment, identify the responsible parties, and fix the individually-based deficits of
caregivers. The focus on the individual treatment needs of caregivers and children in this study compared to their significant material/concrete needs lends credence to the notion that child welfare service to cases investigated for neglect takes a predominantly rehabilitative approach (i.e., treating the risks that individual caregivers pose to their children).

Viewing neglect through a maltreatment lens acknowledges that for some children, typically those who experience serious neglect beginning from an early age, pervasive and long-term harm may result. It is important to note, however, that rather than being at risk of imminent physical harm—an underlying assumption of the protection-driven model—the majority of children investigated for neglect in Canada appear to be at risk of what Trocmé and Chamberland (2003) term endangered development and well-being. Further, the majority of the cases in the current study do not meet the threshold for neglect outlined in Slep and Heyman’s (2006) definitional criteria (egregious acts of omission resulting in more than inconsequential physical or emotional harm).

Social disadvantage is often defined using the overlapping concepts of poverty, deprivation, and social exclusion (Saunders, Naidoo, & Griffiths, 2007), involving restricted access to resources and impoverishment of both expectation and opportunity (UNICEF, 2010). Understanding that what the child welfare system in Canada—and other countries with similar policies, such as the Unites States—refers to as child neglect may well have some of its origin in social disadvantage and structural inequalities requires attention to the ways in which society contributes to the neglect of children and opens up the possibility of societal change as a means of intervention. A social disadvantage approach incorporates a children’s rights perspective that holds society, institutions, and governments responsible for meeting the needs of children and not just individual caregivers and families.


Currently, Canadian child welfare legislation employs definitions of neglect consistent with a parental omissions in care approach. These definitions are aligned with the residual, protection-driven model
of child welfare that characterizes services in both Canada and the United States and frames the intervention of the State into the private family sphere as only appropriate when children have been harmed or are at serious risk of harm. The use of a maltreatment lens to understand the problem of child neglect is entirely consistent with this model. The question raised by the current study is the appropriateness of a protection-driven, maltreatment-oriented approach to the problems experienced by children and families referred to child welfare in Canada for reasons of neglect. Data from the current study demonstrate that the majority of both unsubstantiated and substantiated cases have at least one prior child welfare opening (68% and 70% respectively), and yet the majority are not provided with ongoing services, suggesting an in-and-out approach to the concerns of these families that may not reach the threshold for child protection until the situation has become so chronic that very intrusive action is taken. Further, many of these families do not receive referrals to community-based supports at the conclusion of the investigation, despite the fact that the literature notes the critical need for an early—and often intensive and sustained—cross-sectoral response to the needs of these families (DePanfilis, 2006; Dubowitz, 1999; Gaudin, 1993; Stevenson, 1998).

In an overview of Sweden’s policies and services to address children in need, Andersson (2002) notes that the term “child and family welfare is very convenient for Swedish conditions” because there is no separation between services to support families and to protect children (p. 5). Eligibility for services in this system does not rest on demonstration that a child has been maltreated or is at risk of maltreatment, but rather on demonstration of need or concern that without services, a child may “fare badly” (p. 23). Further, Andersson stresses that family support services, while aimed at improving and strengthening the family environment, also, by the very nature of these goals act to protect children from abuse and neglect.

A central component in determining the policy orientation for child welfare across nations rests in how dominant ideology balances the role of the State versus the family in the responsibility for children (Furstenberg, 1997). Nations with a family welfare or family support orientation to child welfare have tended to view services to support children and families, such as daycare and health care,
the provision of affordable, safe housing, and paid parental leave as normal ways that the State assists families in promoting the well-being of children. This institutional approach to social policy may act to remove stigma from those who also utilize means-tested supports for vulnerable families. A family support orientation to child welfare services is consistent with a children’s rights perspective, and in many European nations which have adopted a family support approach to child welfare, the value base for these services is the United Nations Convention on the Rights of the Child.

Data from the current study suggest that many children and families investigated for reasons of neglect in Canada might be well served through a family welfare/family support approach to assessment and services. The vast majority of the children in these cases have not suffered physical harm and yet they live in family environments with known risk factors for poor developmental outcomes over the longer term, e.g., poverty, social isolation, and caregivers struggling with addictions and mental health. These needs might be met better through a system whose mandate is to conduct a holistic assessment of family strengths and difficulties, and to provide sustained support and service coordination, along with an orientation that engages parents as partners in services rather than as subjects under investigation. Further, given the high proportion of Aboriginal children and single mothers who are the subjects of neglect investigations, populations that suffer disproportionately from poverty, there is a clear imperative to advocate for social and economic policies that address structural inequities that further undermine these families’ abilities to care for their children, and to promote their full participation in activities enjoyed by the majority in Canadian society.

The introduction of differential response models in several provinces in Canada (i.e., Ontario, Alberta and Manitoba) may work to infuse a more family support-like approach into service for many cases. In theory, differential response is designed to provide a customized approach to services, taking into account the risk level of the case, with those cases deemed at low to moderate risk usually diverted away from a traditional child protection investigation towards a more tailored and flexible response, with emphasis on client engagement and voluntary involvement (MCYS,
2007; Trocmé et al., in press; Waldfogel, 1998). In practice, as differential response models in these provinces are imbedded within provincial policies that remain residual and protection focused, it is not clear to what extent they have been successful in providing a truly different form of service. Research regarding differential response models in Canada, who they serve and in what “spirit”, along with outcomes for children and families served through alternate streams would help in assessing the success of this approach in bridging the gap between the wider set of family needs presented by families where neglect is a concern and the narrow protection mandate inherent in much of Canadian child welfare policy.

**Summary**

The current research started from a desire to understand the validity of common critiques about the way child welfare services conceptualize and respond to neglect: in other words, the concern that neglect is most commonly viewed in terms of deficits in individual caregivers, most notably mothers, and that intrusive interventions including ongoing surveillance and child placement might be unduly influenced by a family’s poverty status rather than actual maltreatment. Analyses explored (1) the nature and frequency of clinical and poverty-related concerns in both substantiated and unsubstantiated neglect investigations; (2) the response of Canadian child welfare services to these concerns; (3) the relative influence of poverty in case decision-making; and (4) the extent to which there exists different subtypes or clusters of neglectful families characterized by different constellations and levels of personal and poverty-related hardships. Several findings worthy of discussion have emerged from these analyses.

First, at the most basic descriptive level, the majority of children referred to child welfare services for reasons of neglect, whether substantiated or not, live in households experiencing both poverty-related and clinical need. However despite this, the predominant response of the system at the conclusion of investigation, based on an analysis of referrals made, can be characterized as rehabilitative in nature (i.e., designed to treat or change the individual in some way) regardless of
the presence of poverty-related or material needs. Workers appear to focus more on individual risks rather than structural risks and/or clients’ needs for concrete material support, despite the strong association between poverty, material hardship, and neglect.

Although there have been many critiques of class-based biases in child welfare decision-making, the current study, similar to other previous studies, found limited evidence of poverty-related biases. In other words, poverty-related need did not account for significant variance in decision-making within the study sample after controlling for a number of relevant factors, such as severity of maltreatment and the clinical concerns of the case. In particular, the experience of low/unstable income (i.e., children whose caregivers had no full-time employment) was not a significant predictor of decision-making, although the experience of one or more housing concerns did increase children’s odds of substantiation and ongoing service. While child and caregiver risk factors along with evidence of harm predicted the majority of variance in decision-making (an encouraging finding), both the regression analyses and the cluster analyses highlighted the fact that Aboriginal status of the child in combination with other factors most commonly considered markers of social disadvantage (i.e., poor housing, mental health problems, and substance abuse), combined to create a context in which the most intrusive child welfare interventions take place. These findings underscore the previously articulated need to (1) shift control of child welfare services for Aboriginal children to Aboriginal communities; and (2) to develop approaches that position child welfare services within a larger framework of community development focused on enhancing the spiritual, social, and economic well-being of First Nations communities (Blackstock, Trocmé, & Bennett, 2004).

The current study raises the question of whether a maltreatment lens for the majority of child neglect cases is necessary and whether many of these cases might not be better served through a family welfare/family support approach to intervention. Intervention through the child welfare system should focus on holistic assessment of family need, the provision of culturally-appropriate
services to address these needs, and the careful documentation of clients’ shared struggles to advocate for social and economic policy change.

**Study Limitations**

Several limitations of the data and the study methods have been noted throughout but are important to clearly outline to assist in the interpretation of the findings. The CIS-2008 dataset is comprised of cross-sectional data about child welfare investigations conducted during a three-month period at randomly selected child welfare agencies across Canada. Data reflect workers’ assessments of children, caregivers, and case and maltreatment characteristics at the conclusion of the investigation—approximately 30 days after the receipt of referral. There is no long-term follow up of investigated children and therefore, longer-term outcomes and services are not known. Cases in the dataset represent only those cases investigated by child welfare authorities; they do not include cases screened out prior to investigation, those cases never reported to child welfare, cases investigated only by the police, or unknown cases of child maltreatment.

Although data collected through the study are limited to information that workers regularly collect during the course of investigation, they have not been independently verified. Further, information about complicated constructs (e.g., children’s attachment issues, caregiver social support) is measured using single, dichotomous variables as opposed to standardized or robust assessment scales. Variables (e.g., mental health concerns, drug/solvent abuse) are measured as either present or absent and do not capture the specific nature (e.g., depression, schizophrenia, marijuana use, crack cocaine use) severity, and/or chronicity of the problem. Poverty, a construct central to the dissertation, is measured using proxy indicators with known association to low income in the absence of continuous income data.

As has been noted in most other analyses using CIS data, worker’s assessment of case characteristics may not be independent of one another; ratings on one variable (e.g., substantiation) may affect other variables (e.g., the level of caregiver risk factors endorsed) or vice versa. Workers
may have answered the questions on the data collection form in such a way as to justify certain case decisions. For example, the decision to keep a case open for ongoing services may have caused workers to note that a case was substantiated.

Some of the methods used by the study also have some inherent limitations. Multiple bivariate analyses were conducted without statistical adjustment, increasing the possibility that some significant findings may have been due to chance. Regression analysis assumes independence of observations yet some of the investigated children whose cases formed the sample were sibling groups sharing the same caregivers and clusters of cases shared the same workers. Although these clusters were small, there remains a chance of Type I error due to inter-cluster correlations. Further, cluster analysis is an exploratory technique only. The two-step method is impacted by the ordering of the cases and the cluster membership and profiles were not entirely stable across the different solutions. Despite several areas of overlap in terms of the cluster profiles, there were also areas of dissimilarity and each solution demonstrated differential impact of the clustering variables in partitioning the data.

**Conclusions**

This dissertation set out to explore certain aspects of the relationship between poverty and child neglect using a nationally representative dataset of Canadian child welfare investigations. Of particular interest was the analysis of the extent to which what the child welfare system refers to as *neglect*—a form of child maltreatment—is in fact better characterized as poverty. Results demonstrate that the majority of children investigated live in families experiencing poverty-related needs due to low income and/or housing concerns. In addition to this, many parents and children in these families are struggling with personal (i.e., clinical) difficulties as well. While poverty-related need on its own does not explain the high proportion of poor families investigated for reasons of neglect by the child welfare system, nor does it account for significant variance in the decision to provide ongoing services or to place a child in out of home care, cluster analysis of substantiated cases suggests that there exists a subgroup of families perhaps best characterized by social disadvantage.
For this subgroup, the high rate of personal struggles (i.e., mental health, alcohol, and drugs) experienced by the caregivers, in combination with their poverty and predominantly Aboriginal heritage, necessitates a more structural understanding of the root causes of neglect and requires interventions that not only address the immediate individual needs of these children and families but also tackle issues of discrimination and inequality at a broader policy level. Other subgroups of families labelled neglectful present with lower levels of risk and need, and might benefit from a more family support/family welfare oriented approach to child welfare services, which could be facilitated through differential response models.

There is an increasing movement to view child maltreatment from a children’s rights perspective. Inherent in these approaches is the notion that responsibility for ensuring children’s right to protection from abuse and neglect, service provision, and equal participation in society rests not only with individual parents but with the larger community and society in which they are embedded. This is consistent with an ecological approach to defining the problem of child neglect, which stipulates that neglect occurs whenever children’s needs go unmet, regardless of cause. Although typically not considered within the realm of child welfare services, defining neglect in this way opens up the notion that societal neglect may be a contributor to the problem through policies, laws, and practices that exacerbate the marginalization and exclusion of those most commonly referred to child welfare for this reason.
References


An Exploration of the Relationship Between Poverty and Child Neglect in Canadian Child Welfare


An Act Respecting Industrial Schools, Chapter 29, section 4 (1874).


Appendix A: CIS-2008 Guidebook
Site Agency/Office: ___________________________
Case Selection Starts: ________________________
Case Selection Ends: _________________________

Return all completed forms to your local Agency/Office Contact Person: 
________________________, located at ________________________________.

If your Site Researcher is not available, and you need immediate assistance, 
please contact the CIS Central Office in Toronto, at (416) 978-2527
BACKGROUND


The CIS-2008 is funded by the Public Health Agency of Canada. Additional funding has been provided by the provinces of Alberta, British Columbia, Manitoba, Ontario, Quebec and Saskatchewan and the Centre of Excellence for Child Welfare with significant in-kind support provided by every province/territory. The project is managed by a team of researchers at McGill University’s Centre for Research on Children and Families, the University of Toronto’s Factor-Inwentash Faculty of Social Work, the University of Calgary’s Faculty of Social Work, the Université de Laval’s Ecole de service social, the Centre Jeunesse de Montréal-Institut Universitaire and the First Nations Child and Family Caring Society.

OBJECTIVES

The primary objective of the CIS-2008 is to provide reliable estimates of the scope and characteristics of reported child abuse and neglect in Canada. Specifically, the study is designed to

- determine rates of investigated and substantiated physical abuse, sexual abuse, neglect, emotional maltreatment and exposure to domestic violence, as well as multiple forms of maltreatment;
- investigate the severity of maltreatment as measured by forms of maltreatment, duration, and physical and emotional harm;
- examine selected determinants of health that may be associated with maltreatment;
- monitor short-term investigation outcomes, including substantiation rates, out-of-home placements, use of child welfare court and criminal prosecution; and
- compare 1998, 2003, and 2008 rates of substantiated physical abuse, sexual abuse, neglect, emotional maltreatment, and exposure to domestic violence; the severity of maltreatment; and short-term investigation outcomes.

SAMPLE

The primary sampling unit for the CIS-2008 is a study-designed child welfare service area (CWSA). A CWSA is a distinct child geographic area served by a child welfare agency/office.¹

One hundred and eighteen child welfare agencies/offices across Canada were randomly selected

¹ Some distinct geographic areas are served by more than one child welfare agency/office.
from the 411 CWSAs. A minimum of one CWSA was chosen from each province and territory. Provinces were allocated additional CWSAs based on both the provincial proportion of the Canadian child population and on oversampling funds provided in Alberta, British Columbia, Manitoba, Ontario, Quebec and Saskatchewan. Oversampling funding provided by certain provinces allowed for the selection of additional CWSAs in these provinces, which permits researchers to generate estimates of the incidence of abuse and neglect specific to that province. Additional funds were also provided to oversample First Nations child welfare agencies.

In smaller agencies, information will be collected on all child maltreatment investigations opened during the three-month period between October 1, 2008, and December 31, 2008. In larger agencies, a random sample of 250 investigations will be selected for inclusion in the study.

**CIS MALTREATMENT ASSESSMENT FORM**

The CIS Maltreatment Assessment Form was designed to capture standardized information from child welfare investigators on the results of their investigations. It consists of four yellow legal-sized pages with “Canadian Incidence Study of Reported Child Abuse and Neglect—CIS-2008” clearly marked on the front sheet.

The CIS Maltreatment Assessment Form comprises an Intake Face Sheet, a Comment Sheet (which is on the back of the Intake Face Sheet), a Household Information Sheet, and two Child Information Sheets. The form takes ten to fifteen minutes to complete, depending on the number of children investigated in the household.

The CIS Maltreatment Assessment Form examines a range of family, child, and case status variables. These variables include source of referral, caregiver demographics, household composition, key caregiver functioning issues, housing and home safety. It also includes outcomes of the investigation on a child-specific basis (including up to three forms of maltreatment), nature of harm, duration of maltreatment, identity of alleged perpetrator, placement in care, child welfare and criminal court involvement.

**TRAINING**

Most training sessions will be held in October 2008 for all workers involved in the study. Your Site Researcher will visit your agency/office prior to the data collection period and will continue to make regular visits during the data collection process. These on-site visits will allow the Site Researcher to collect forms, enter data, answer questions and resolve any problems that may arise. If you have any questions about the study, contact your Site Researcher (see contact information on the front cover of the CIS-2008 Guidebook).

**CONFIDENTIALITY**

Confidentiality will be maintained at all times during data collection and analysis.

To guarantee client confidentiality, all near-identifying information (located at the bottom of the Intake Face Sheet) will be coded at your agency/office. Near-identifying information is data that could potentially identify a household (e.g., agency/office case file number, the first two letters of the primary caregiver’s surname and the first names of the children in the household). This information is required for purposes of data verification only. This tear-off portion of the Intake
Face Sheet will be stored in a locked area at your agency/office until the study is completed, and then will be destroyed.

The completed CIS Maltreatment Assessment Form (with all identifying information removed) will be sent to the University of Toronto or McGill University sites for data entry and will then be kept under double lock (a locked RCMP–approved filing cabinet in a locked office). Access to the forms for any additional verification purposes will be restricted to select research team members authorized by the Public Health Agency of Canada.

Published analyses will be conducted at the national level. Provincial analyses will be produced for the provinces gathering enough data to create a separate provincial report (Alberta, British Columbia, Manitoba, Ontario, Quebec and Saskatchewan). No agency/office, worker or team-specific data will be made available to anyone, under any circumstances.

COMPLETING THE CIS MALTREATMENT ASSESSMENT FORM

The CIS Maltreatment Assessment Form should be completed by the investigating worker when he or she is writing the first major assessment of the investigation. In most jurisdictions this report is required within four weeks of the date the case was opened.

It is essential that all items on the CIS Maltreatment Assessment Form applicable to the specific investigation be completed. Use the “Unknown” response if you are unsure. If the categories provided do not adequately describe a case, provide additional information on the Comment Sheet. If you have any questions during the study, contact your Site Researcher. The contact information is listed on the front cover of the CIS-2008 Guidebook.

FREQUENTLY ASKED QUESTIONS

1. FOR WHAT CASES SHOULD I COMPLETE A CIS MALTREATMENT ASSESSMENT FORM?

In smaller agencies, information will be collected on all child maltreatment investigations opened during the three-month period between October 1, 2008, and December 31, 2008. Generally, if your agency/office counts an investigation in its official opening statistics reported to a Ministry or government office, then the case is included in the sample and a CIS Maltreatment Assessment Form should be completed, unless your Site Researcher indicates otherwise. The Site Researcher will establish a process in your agency/office to identify to workers the openings or investigations included in the agency/office sample for the CIS-2008.

In larger agencies, a random sample of 250 investigations will be selected for inclusion in the study. Workers in large agencies will be provided with a case list of all eligible cases, and should complete a CIS Maltreatment Assessment Form for all cases selected through this process.
2. SHOULD I COMPLETE A FORM FOR ONLY THOSE CASES WHERE ABUSE AND/OR NEGLECT ARE SUSPECTED?

Complete an Intake Face Sheet and the tear-off portion of the Intake Face Sheet for all cases opened during the data selection period at your agency/office (e.g., maltreatment investigations as well as prenatal counselling, child/youth behaviour problems, request for services from another agency/office, and, where applicable, screened-out cases) or for all cases identified in the random selection process. If maltreatment was alleged at any point during the investigation, complete the remainder of the CIS Maltreatment Assessment Form (both Household Information and Child Information Sheets). Maltreatment may be alleged by the person(s) making the report, or by any other person(s), including yourself, during the investigation (e.g., complete a CIS Maltreatment Assessment Form if a case was initially referred for parent/adolescent conflict, but during the investigation the child made a disclosure of physical abuse or neglect). Also complete a Household Information Sheet and relevant items on the Child Information Sheet (questions 25 through 30, and questions 39 through 41) for any child for whom you conducted a risk assessment. For risk assessments only, do not complete the questions regarding a specific event or incident of maltreatment. An event of child maltreatment refers to something that may have happened to a child whereas a risk of child maltreatment refers to something that probably will happen.

3. SHOULD I COMPLETE A CIS MALTREATMENT ASSESSMENT FORM ON SCREENED-OUT CASES?

The procedures for screening out cases vary considerably across Canada. Although the CIS does not attempt to capture informally screened-out cases, we will gather Intake Face Sheet information on screened-out cases that are formally counted as case openings by your agency/office. If in doubt, contact your Site Researcher.

4. WHEN SHOULD I COMPLETE THE CIS MALTREATMENT ASSESSMENT FORM?

Complete the CIS Maltreatment Assessment Form at the same time that you prepare the report for your agency/office that documents the conclusions of the investigation (usually within four weeks of a case being opened). For some cases, a comprehensive assessment of the family or household and a detailed plan of service may not be complete yet. Even if this is the case, complete the form to the best of your abilities.

5. WHO SHOULD COMPLETE THE CIS MALTREATMENT ASSESSMENT FORM IF MORE THAN ONE PERSON WORKS ON THE INVESTIGATION?

The CIS Maltreatment Assessment Form should be completed by the worker who conducts the intake assessment and prepares the assessment or investigation report. If several workers investigate a case, the worker with primary responsibility for the case should complete the CIS Maltreatment Assessment Form.

6. WHAT SHOULD I DO IF MORE THAN ONE CHILD IS INVESTIGATED?

The CIS Maltreatment Assessment Form primarily focuses on the household; however, the Child Information Sheet is specific to the individual child being investigated. Complete one child sheet for each child investigated for an incident of maltreatment or for whom you conducted a risk assessment. If you had no maltreatment concern about a child in the home, or you did not conduct a risk assessment, then do not complete a Child Information Sheet for that child. Additional pads of Child Information Sheets are available in your training package.

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7. WILL I RECEIVE TRAINING FOR THE CIS MALTREATMENT ASSESSMENT FORM?

All workers who complete investigations in your agency/office will receive training prior to the start of the data collection period. If a worker is unable to attend the training session or is hired after the start of the CIS-2008, he or she should contact the Site Researcher regarding any questions about the form. Your Site Researcher’s name and contact information is on the front cover of the CIS-2008 Guidebook.

8. WHAT SHOULD I DO WITH THE COMPLETED FORMS?

Give the completed CIS Maltreatment Investigation Form to your Agency/Office Contact Person. All forms will be reviewed by the Site Researcher during a site visit, and should he or she have additional questions, he or she will contact you during this visit. Your Agency/Office Contact Person is listed on the inside cover of the CIS-2008 Guidebook.

9. IS THIS INFORMATION CONFIDENTIAL?

The information you provide is confidential, and no identifying information will leave your agency/office. Your Site Researcher will code any near-identifying information from the bottom portion of the Intake Sheet. Where a name has been asked for, the Site Researcher will black out the name prior to the form leaving your agency/office. Refer to the section above on confidentiality.

DEFINITIONS: INTAKE FACE SHEET

QUESTION 1: DATE REFERRAL WAS RECEIVED

This date refers to the day that the referral source made initial contact with your agency/office.

QUESTION 2: DATE CASE OPENED

This refers to the date the case was opened. In some agencies/offices, this date will be the same as the referral date.

QUESTION 3: SOURCE OF ALLEGATION/REFERRAL

Fill in all sources of referral that are applicable for each case. This refers to separate and independent contacts with the child welfare agency/office. If a young person tells a school principal of abuse and/or neglect, and the school principal reports this to the child welfare authority, you would fill in the circle for this referral as “School.” There was only one contact and referral in this case. If a second source (neighbour) contacted the child welfare authority and also reported a concern for this child, then you would also fill in the circle for “Neighbour/friend.”

- Custodial parent: Includes parent(s) identified in Question 5: Caregiver(s) in the home.
- Non-custodial parent: Contact from an estranged spouse (e.g., individual reporting the parenting practices of his or her former spouse).
- Child (subject of referral): A self-referral by any child listed on the Intake Face Sheet of the CIS Maltreatment Assessment Form.
QUESTION 4: PLEASE DESCRIBE REFERRAL, INCLUDING ALLEGED MALTREATMENT OR RISK OF MALTREATMENT (IF APPLICABLE) AND RESULTS OF INVESTIGATION

For jurisdictions that have a differential or alternate response approach at the investigative stage, identify the nature of the approach used during the course of the investigation:

- **A customized or alternate response** investigation refers to a less intrusive, more flexible assessment approach that focuses on identifying the strengths and needs of the family, and coordinating a range of both formal and informal supports to meet those needs. This approach is typically used for lower-risk cases.

- **A traditional child protection investigation** refers to the approach that most closely resembles a forensic child protection investigation, and often focuses on gathering evidence in a structured and legally defensible manner. It is typically used for higher-risk cases or those investigations conducted jointly with the police.

Provide a short description of the referral, including, as appropriate, the investigated maltreatment or the reason for a risk assessment, and major investigation results (e.g., type of maltreatment,
QUESTION 5: CAREGIVER(S) IN THE HOME
Describe up to two caregivers in the home. Only caregiver(s) in the child’s primary residence should be noted in this section. Provide each caregiver’s age and sex in the space indicated.

QUESTION 6: LIST ALL CHILDREN IN THE HOME (<20 YEARS)
Include biological, step-, adoptive and foster children.

a) List first names of all children (<20 years) in the home at time of referral: List the first name of each child who was living in the home at the time of the referral.
b) Age of child: Indicate the age of each child living in the home at the time of the referral. Use 00 for children younger than 1.
c) Sex of child: Indicate the sex of each child in the home.
d) Primary caregiver’s relationship to child: Describe the primary caregiver’s relationship to each child, using the codes provided.
e) Other caregiver’s relationship to child: Describe the other caregiver’s relationship to each child (if applicable), using the codes provided. Describe the caregiver only if the caregiver is in the home.
f) Referred: Indicate which children were noted in the initial referral.
g) Risk investigation only: Indicate if the child was investigated because of risk of maltreatment only. Include only situations in which no allegation of maltreatment was made, and no specific incident of maltreatment was suspected at any point during the investigation (e.g., include referrals for parent–teen conflict; child behaviour problems; parent behaviour such as substance abuse, where there is a risk of future maltreatment but no concurrent allegations of maltreatment. Investigations for risk may focus on risk of several types of maltreatment (e.g., parent’s drinking places child at risk for physical abuse and neglect, but no specific allegation has been made and no specific incident is suspected during the investigation).
h) Investigated incident of maltreatment: Indicate if the child was investigated because of an allegation of maltreatment. In jurisdictions that require that all children be routinely interviewed for an investigation, include only those children where, in your clinical opinion, maltreatment was alleged or you investigated an incident or event of maltreatment (e.g., include three siblings ages 5 to 12 in a situation of chronic neglect, but do not include the 3-year-old brother of a 12-year-old girl who was sexually abused by someone who does not live with the family and has not had access to the younger sibling).

TEAR-OFF PORTION OF INTAKE FACE SHEET
The semi-identifying information on the tear-off section will be kept securely at your agency/office, for purposes of verification. It will be destroyed at the conclusion of the study.
WORKER’S NAME
This refers to the person completing the form. When more than one individual is involved in the investigation, the individual with overall case responsibility should complete the CIS Maltreatment Assessment Form.

FIRST TWO LETTERS OF PRIMARY CAREGIVER’S SURNAME
Use the reference name used for your agency/office filing system. In most cases this will be the primary caregiver’s last name. If another name is used in the agency/office, include it under “Other family surname” (e.g., if a parent’s surname is “Thompson,” and the two children have the surname of “Smith,” then put “TH” and “SM”). Use the first two letters of the family name only. Never fill in the complete name.

CASE NUMBER
This refers to the case number used by your agency/office.

DEFINITIONS: COMMENT SHEET
The back of the Intake Face Sheet provides space for additional comments about an investigation. Use the Comment Sheet only if there is a situation regarding a household or a child that requires further explanation.

There is also space provided at the top of the Comments Sheet for situations where an investigation or/assessment was unable to be completed for children indicated in 6(g) or 6(h).

DEFINITIONS: HOUSEHOLD INFORMATION SHEET
The Household Information Sheet focuses on the immediate household of the child(ren) who have been the subject of an investigation of an event or incident of maltreatment or for whom a risk assessment was conducted. The household is made up of all adults and children living at the address of the investigation at the time of the referral. Provide information for the primary caregiver and the other caregiver if there are two adults/caregivers living in the household (the same caregivers identified on the Intake Face Sheet).

If you have a unique circumstance that does not seem to fit the categories provided, write a note on the Comment Sheet under “Comments: Household information.”

Questions A8–A13 pertain to the primary caregiver in the household. If there was a second caregiver in the household at the time of referral, complete questions B8–B13 for the second caregiver. If both caregivers are equally engaged in parenting, identify the caregiver you have had most contact with as the primary caregiver. If there was only one caregiver in the home at the time of the referral, endorse “no other caregiver in the home” under “second caregiver in the home”.

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QUESTION 8: PRIMARY INCOME
We are interested in estimating the primary source of the caregiver’s income. Choose the category that best describes the caregiver’s source of income. Note that this is a caregiver-specific question and does not include income from the second caregiver.

- **Full time**: Individual is employed in a permanent, full-time position.
- **Part time (fewer than 30 hours/week)**: Refers to a single part-time position.
- **Multiple jobs**: Caregiver has more than one part-time or temporary position.
- **Seasonal**: This indicates that the caregiver works at either full- or part-time positions for temporary periods of the year.
- **Employment insurance**: Caregiver is temporarily unemployed and receiving employment insurance benefits.
- **Social assistance**: Caregiver is currently receiving social assistance benefits.
- **Other benefit**: Refers to other forms of benefits or pensions (e.g., family benefits, long-term disability insurance, child support payments).
- **None**: Caregiver has no source of legal income. If drugs, prostitution or other illegal activity are apparent, specify on Comment Sheet under “Comments: Household information.”
- **Unknown**: Check this box if you do not know the caregiver’s source of income.

QUESTION 9: ETHNO-RACIAL GROUP
Examining the ethno-racial background can provide valuable information regarding differential access to child welfare services. Given the sensitivity of this question, this information will not be published out of context. This section uses an abbreviated checklist of ethno-racial categories used by Statistics Canada in the 1996 Census.

Check the ethno-racial category that best describes the caregiver. Select “Other” if you wish to identify two ethno-racial groups, and specify.

QUESTION 10: IF ABORIGINAL
a) **On or off reserve**: Identify if the caregiver is residing “on” or “off” reserve.
b) **Caregiver’s status**: First Nations status (caregiver has formal Indian or treaty status, that is, registered with the Department of Indian and Northern Affairs), Inuit, First Nations non-status, Métis or Other (specify and use the Comment Sheet if necessary).
c) **Caregiver attended residential school**: Identify if the caregiver attended a residential school.
d) **Caregiver’s parent attended residential school**: Identify if the caregiver’s parent (i.e., the children’s grandparent) attended residential school.

QUESTION 11: PRIMARY LANGUAGE
Identify the primary language of the caregiver: English, French, or Other and specify. If bilingual, choose the language spoken in the home.
QUESTION 12: CONTACT WITH CAREGIVER IN RESPONSE TO INVESTIGATION
Would you describe the caregiver as being overall cooperative or non-cooperative with the child welfare investigation? Check “Not contacted” in the case that you had no contact with the caregiver.

QUESTION 13: CAREGIVER RISK FACTORS
These questions pertain to the primary caregiver and/or the other caregiver, and are to be rated as “Confirmed,” “Suspected,” “No,” or “Unknown.” Fill in “Confirmed” if problem has been diagnosed, observed by you or another worker, or disclosed by the caregiver. Use the “Suspected” category if your suspicions are sufficient to include in a written assessment of the household or a transfer summary to a colleague. Fill in “No” if you do not believe there is a problem and “Unknown” if you are unsure or have not attempted to determine if there was such a caregiver functioning issues. Where applicable, use the past six months as a reference point.

• Alcohol abuse: Caregiver abuses alcohol.
• Drug/solvent abuse: Abuse of prescription drugs, illegal drugs or solvents.
• Cognitive impairment: Caregiver has a cognitive impairment.
• Mental health issues: Any mental health diagnosis or problem.
• Physical health issues: Chronic illness, frequent hospitalizations or physical disability.
• Few social supports: Social isolation or lack of social supports.
• Victim of domestic violence: During the past six months the caregiver was a victim of domestic violence, including physical, sexual or verbal assault.
• Perpetrator of domestic violence: During the past six months the caregiver was a perpetrator of domestic violence.
• History of foster care/group home: Indicate if this caregiver was in foster care and/or group home care during his or her childhood.

QUESTION 14: OTHER ADULTS IN THE HOME
Fill in all categories that describe adults (excluding the primary and other caregivers) who lived in the house at the time of the referral to child welfare. Note that children (<20 years of age) in the home have already been described on the Intake Face Sheet. If there have been recent changes in the household, describe the situation at the time of the referral. Fill in all that apply.

QUESTION 15: CAREGIVER(S) OUTSIDE THE HOME
Identify any other caregivers living outside the home who provide care to any of the children in the household, including a separated parent who has any access to the child(ren). Fill in all that apply.

QUESTION 16: CHILD CUSTODY DISPUTE
Specify if there is an ongoing child custody/access dispute at this time (court application has been made or is pending).

QUESTION 17: HOUSING
Indicate the housing category that best describes the living situation of this household.

• Own home: A purchased house, condominium or townhouse.

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• **Public housing:** A unit in a public rental-housing complex (i.e., rent subsidized, government-owned housing), or a house, townhouse or apartment on a military base. Exclude Band housing in a First Nations community.
• **Unknown:** Housing accommodation is unknown.
• **Other:** Specify any other form of shelter.
• **Rental:** A private rental house, townhouse, or apartment.
• **Band housing:** Aboriginal housing built, managed and owned by the band.
• **Hotel/Shelter:** An SRO hotel (single room occupancy), homeless or family shelter, or motel accommodations.

**QUESTION 18: HOME OVERCROWDED**
Indicate if household is made up of multiple families and/or overcrowded.

**QUESTION 19: NUMBER OF MOVES IN PAST YEAR**
Based on your knowledge of the household, indicate the number of household moves within the past year or twelve months.

**QUESTION 20: HOUSING SAFETY**

a) **Accessible weapons:** Guns or other weapons that a child may be able to access.
b) **Accessible drugs or drug paraphernalia:** Illegal or legal drugs stored in such a way that a child might access and ingest them, or needles stored in such a way that a child may access them.
c) **Drug production or trafficking in the home:** Is there evidence that this home has been used as a drug lab, narcotics lab, grow operation or crack house? This question asks about evidence that drugs are being grown (e.g., marijuana), processed (e.g., methamphetamine) or sold in the home. Evidence of sales might include observations of large quantities of legal or illegal drugs, narcotics, or drug paraphernalia such as needles or crack pipes in the home, or exchanges of drugs for money. Evidence that drugs or narcotics are being grown or processed might include observations that a house is “hyper-sealed” (meaning it has darkened windows and doors, with little to no air or sunlight).
d) **Chemicals or solvents used in production:** Industrial chemicals/solvent stored in such a way that a child might access and ingest or touch.
e) **Other home injury hazards:** The quality of household maintenance is such that a child might have access to things such as poisons, fire implements or electrical hazards.
f) **Other home health hazards:** The quality of living environment is such that it poses a health risk to a child (e.g., no heating, feces on floor/walls).

**QUESTION 21: HOUSEHOLD REGULARLY RUNS OUT OF MONEY FOR BASIC NECESSITIES**
Indicate if the household regularly runs out of money for necessities (e.g., food, clothing).

**QUESTION 22: CASE PREVIOUSLY OPENED**
Describe case status at the time of the referral.

**Case previously opened:** Has this family previously had an open file with a child welfare agency/office? For provinces where cases are identified by family, has a caregiver in this family been part of a previous investigation even if it was concerning different children? Respond if there is documentation, or if you are aware that there have been previous openings. Estimate the number
of previous openings. This would relate to case openings for any of the children identified as living in the home (listed on the Intake Face Sheet).

a) If case was opened before, how long since previous opening: How many months between the time the case was last opened and this current opening?

QUESTION 23: CASE WILL STAY OPEN FOR ONGOING CHILD WELFARE SERVICES
At the time you are completing the CIS Maltreatment Investigation Form, do you plan to keep the case open to provide ongoing services?

a) If yes, is case streamed to differential or alternative response: If case is remaining opened for ongoing service provision, indicate if the case is streamed to differential or alternative response.

QUESTION 24: REFERRAL(S) FOR ANY FAMILY MEMBER
Indicate referrals that have been made to programs designed to offer services beyond the parameters of “ongoing child welfare services.” Include referrals made internally to a special program provided by your agency/office as well as referrals made externally to other agencies/services. Note whether a referral was made and is part of the case plan, not whether the young person or family has actually started to receive services. Fill in all that apply.

- No referral made: No referral was made to any programs.
- Parent support group: Any group program designed to offer support or education (e.g., Parents Anonymous, Parenting Instruction Course, Parent Support Association).
- In-home family/parenting counselling: Home-based support services designed to support families, reduce risk of out-of-home placement, or reunify children in care with their family.
- Other family or parent counseling: Refers to any other type of family or parent support or counseling not identified as “parent support group” or “in-home family/parenting counseling” (e.g., couples or family therapy).
- Drug or alcohol counselling: Addiction program (any substance) for caregiver(s) or children.
- Welfare or social assistance: Referral for social assistance to address financial concerns of the household.
- Food bank: Referral to any food bank.
- Shelter services: Regarding domestic violence or homelessness.
- Domestic violence services: Referral for services/counselling regarding domestic violence, abusive relationships or the effects of witnessing violence.
- Psychiatric or psychological services: Child or parent referral to psychological or psychiatric services (trauma, high risk behaviour or intervention).
- Special education placement: Any specialized school program to meet a child’s educational, emotional or behavioural needs.
- Recreational services: Referral to a community recreational program (e.g., organized sports leagues, community recreation, Boys and Girls Clubs).
- Victim support program: Referral to a victim support program (e.g., sexual abuse disclosure group).
• **Medical or dental services:** Any specialized service to address the child’s immediate medical or dental health needs.
• **Child or day care:** Any paid child or day care services, including staff-run and in-home services.
• **Cultural services:** Services to help children or families strengthen their cultural heritage.
• **Other:** Indicate and specify any other child- or family-focused referral.

**DEFINITIONS: CHILD INFORMATION SHEET**

**QUESTION 25: CHILD NAME AND SEX**
Indicate the first name and sex of the child for which the Child Information Sheet is being completed. Note, this is for verification only.

**QUESTION 26: AGE**
Indicate the child’s age.

**QUESTION 27: TYPE OF INVESTIGATION**
Indicate if the investigation was conducted for a specific incident of maltreatment, or if it was conducted to assess risk of maltreatment only. Refer to page 8, question 6 g) and h) for a detailed description of “risk investigation only” versus investigation of an “incident of maltreatment.”

**QUESTION 28: ABORIGINAL STATUS**
Indicate the Aboriginal status of the child for which the CIS Maltreatment Assessment Form is being completed: Not Aboriginal, First Nations status (caregiver has formal Indian or treaty status, that is, is registered with the Department of Indian and Northern Affairs), First Nations non-status, Métis, Inuit or Other (specify and use the Comment Sheet if necessary).

**QUESTION 29: CHILD FUNCTIONING**
This section focuses on issues related to a child’s level of functioning. Fill in “Confirmed” if problem has been diagnosed, observed by you or another worker, or disclosed by the parent or child. Suspected means that, in your clinical opinion, there is reason to suspect that the condition may be present, but it has not been diagnosed, observed or disclosed. Fill in “No” if you do not believe there is a problem and “Unknown” if you are unsure or have not attempted to determine if there was such a child functioning issue. Where appropriate, use the past six months as a reference point.

• **Depression/anxiety/withdrawal:** Feelings of depression or anxiety that persist for most of every day for two weeks or longer, and interfere with the child’s ability to manage at home and at school.
• **Suicidal thoughts:** The child has expressed thoughts of suicide, ranging from fleeting thoughts to a detailed plan.
• **Self-harming behaviour:** Includes high-risk or life-threatening behaviour, suicide attempts, and physical mutilation or cutting.
• **ADD/ADHD:** ADD/ADHD is a persistent pattern of inattention and/or hyperactivity/impulsivity that occurs more frequently and more severely than is typically
seen in children of comparable levels of development. Symptoms are frequent and severe enough to have a negative impact on children’s lives at home, at school or in the community.

- **Attachment issues:** The child does not have a physical and emotional closeness to a mother or preferred caregiver. The child finds it difficult to seek comfort, support, nurturance or protection from the caregiver; the child’s distress is not ameliorated or is made worse by the caregiver’s presence.
- **Aggression:** Behaviour directed at other children or adults that includes hitting, kicking, biting, fighting, bullying others or violence to property, at home, at school or in the community.
- **Running (Multiple incidents):** Has run away from home (or other residence) on multiple occasions for at least one overnight period.
- **Inappropriate sexual behaviour:** Child displays inappropriate sexual behavior, including age-inappropriate play with toys, self or others; displaying explicit sexual acts; age-inappropriate sexually explicit drawing and/or descriptions; sophisticated or unusual sexual knowledge; prostitution or seductive behaviour.
- **Youth Criminal Justice Act involvement:** Charges, incarceration or alternative measures with the Youth Justice system.
- **Intellectual/developmental disability:** Characterized by delayed intellectual development, it is typically diagnosed when a child does not reach his or her developmental milestones at expected times. It includes speech and language, fine/gross motor skills, and/or personal and social skills, e.g., Down syndrome, autism and Asperger syndrome.
- **Failure to meet developmental milestones:** Children who are not meeting their development milestones because of a non-organic reason.
- **Academic difficulties:** Include learning disabilities that are usually identified in schools, as well as any special education program for learning difficulties, special needs, or behaviour problems. Children with learning disabilities have normal or above-normal intelligence, but deficits in one or more areas of mental functioning (e.g., language usage, numbers, reading, work comprehension).
- **FAS/FAE:** Birth defects, ranging from mild intellectual and behavioural difficulties to more profound problems in these areas related to in utero exposure to alcohol abuse by the biological mother.
- **Positive toxicology at birth:** When a toxicology screen for a newborn tests positive for the presences of drug or alcohol.
- **Physical disability:** Physical disability is the existence of a long-lasting condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting or carrying. This includes sensory disability conditions such as blindness, deafness, or a severe vision or hearing impairment that noticeably affects activities of daily living.
- **Alcohol abuse:** Problematic consumption of alcohol (consider age, frequency and severity).
- **Drug/solvent abuse:** Include prescription drugs, illegal drugs and solvents.
- **Other:** Specify any other conditions related to child functioning; your responses will be coded and aggregated.
QUESTION 30: IF RISK INVESTIGATION ONLY, IS THERE A SIGNIFICANT RISK OF FUTURE MALTREATMENT?

Only complete this question in cases in which you selected “Risk investigation only” in “Question 27: Type of investigation”. Indicate, based on your clinical judgment, if there is a significant risk of future maltreatment.

Note: If this is a risk investigation only, once you have completed question 30, skip to question 39, and complete only questions 39, 40, 41 and 42.

QUESTION 31: MALTREATMENT CODES

The maltreatment typology in the CIS-2008 uses five major types of maltreatment: Physical Abuse, Sexual Abuse, Neglect, Emotional Maltreatment, and Exposure to Intimate Partner Violence. These categories are comparable to those used in the previous cycles of the CIS, the Ontario Incidence Study. Because there is significant variation in provincial and territorial child welfare statutes, we are using a broad typology. Rate cases on the basis of your clinical opinion, not on provincial, territorial or agency/office-specific definitions.

Select the applicable maltreatment codes from the list provided (1–32), and write these numbers clearly in the boxes below Question 31. Enter in the first box the form of maltreatment that best characterizes the investigated maltreatment. If there is only one type of investigated maltreatment, choose all forms within the typology that apply. If there are multiple types of investigated maltreatment (e.g., physical abuse and neglect), choose one maltreatment code within each typology that best describes the investigated maltreatment. All major forms of alleged, suspected or investigated maltreatment should be noted in the maltreatment code box regardless of the outcome of the investigation.

Physical Abuse

The child was physically harmed or could have suffered physical harm as a result of the behaviour of the person looking after the child. Include any alleged physical assault, including abusive incidents involving some form of punishment. If several forms of physical abuse are involved, identify the most harmful form and circle the codes of other relevant descriptors.

- **Shake, push, grab or throw**: Include pulling or dragging a child as well as shaking an infant.
- **Hit with hand**: Include slapping andspanking, but not punching.
- **Punch, kick or bite**: Include as well any other hitting with other parts of the body (e.g., elbow or head).
- **Hit with object**: Includes hitting with a stick, a belt or other object, throwing an object at a child, but does not include stabbing with a knife.
- **Choking, poisoning, stabbing**: Include any other form of physical abuse, including choking, strangling, stabbing, burning, shooting, poisoning and the abusive use of restraints.
- **Other physical abuse**: Other or unspecified physical abuse.
Sexual Abuse

The child has been sexually molested or sexually exploited. This includes oral, vaginal or anal sexual activity; attempted sexual activity; sexual touching or fondling; exposure; voyeurism; involvement in prostitution or pornography; and verbal sexual harassment. If several forms of sexual activity are involved, identify the most intrusive form. Include both intra-familial and extra-familial sexual abuse, as well as sexual abuse involving an older child or youth perpetrator.

- **Penetration:** Penile, digital or object penetration of vagina or anus.
- ** Attempted penetration:** Attempted penile, digital, or object penetration of vagina or anus.
- ** Oral sex:** Oral contact with genitals either by perpetrator or by the child.
- ** Fondling:** Touching or fondling genitals for sexual purposes.
- **Sex talk or images:** Verbal or written proposition, encouragement or suggestion of a sexual nature (include face to face, phone, written and Internet contact, as well as exposing the child to pornographic material).
- **Voyeurism:** Include activities where the alleged perpetrator observes the child for the perpetrator’s sexual gratification. Use the “Exploitation” code if voyeurism includes pornographic activities.
- **Exhibitionism:** Include activities where the perpetrator is alleged to have exhibited himself or herself for his or her own sexual gratification.
- **Exploitation:** Include situations where an adult sexually exploits a child for purposes of financial gain or other profit, including pornography and prostitution.
- **Other sexual abuse:** Other or unspecified sexual abuse.

Neglect

The child has suffered harm or the child’s safety or development has been endangered as a result of a failure to provide for or protect the child. Note that the term “neglect” is not consistently used in all provincial/territorial statutes, but interchangeable concepts include “failure to care and provide for or supervise and protect,” “does not provide,” “refuses or is unavailable or unable to consent to treatment.”

- **Failure to supervise: physical harm:** The child suffered physical harm or is at risk of suffering physical harm because of the caregiver’s failure to supervise or protect the child adequately. Failure to supervise includes situations where a child is harmed or endangered as a result of a caregiver’s actions (e.g., drunk driving with a child, or engaging in dangerous criminal activities with a child).
- **Failure to supervise: sexual abuse:** The child has been or is at substantial risk of being sexually molested or sexually exploited, and the caregiver knows or should have known of the possibility of sexual molestation and failed to protect the child adequately.
- **Permitting criminal behaviour:** A child has committed a criminal offence (e.g., theft, vandalism, or assault) because of the caregiver’s failure or inability to supervise the child adequately.
- **Physical neglect:** The child has suffered or is at substantial risk of suffering physical harm caused by the caregiver(s)’ failure to care and provide for the child adequately. This includes inadequate nutrition/clothing, and unhygienic, dangerous living conditions. There must be evidence or suspicion that the caregiver is at least partially responsible for the situation.
- **Medical neglect (includes dental):** The child requires medical treatment to cure, prevent, or alleviate physical harm or suffering and the child’s caregiver does not provide, or refuses, or is unavailable, or unable to consent to the treatment. This includes dental services when funding is available.

- **Failure to provide psych. treatment:** The child is suffering from either emotional harm demonstrated by severe anxiety, depression, withdrawal, or self-destructive or aggressive behaviour, or a mental, emotional or developmental condition that could seriously impair the child’s development. The child’s caregiver does not provide, or refuses, or is unavailable, or unable to consent to treatment to remedy or alleviate the harm. This category includes failing to provide treatment for school-related problems such as learning and behaviour problems, as well as treatment for infant development problems such as non-organic failure to thrive. A parent awaiting service should not be included in this category.

- **Abandonment:** The child’s parent has died or is unable to exercise custodial rights and has not made adequate provisions for care and custody, or the child is in a placement and parent refuses/is unable to take custody.

- **Educational neglect:** Caregivers knowingly permit chronic truancy (5+ days a month), or fail to enroll the child, or repeatedly keep the child at home. If the child is experiencing mental, emotional or developmental problems associated with school, and treatment is offered but caregivers do not cooperate with treatment, classify the case under failure to provide treatment as well.

**Emotional Maltreatment**

The child has suffered, or is at substantial risk of suffering, emotional harm at the hands of the person looking after the child.

- **Terrorizing or threat of violence:** A climate of fear, placing the child in unpredictable or chaotic circumstances, bullying or frightening a child, threats of violence against the child or child’s loved ones or objects.

- **Verbal abuse or belittling:** Non-physical forms of overtly hostile or rejecting treatment. Shaming or ridiculing the child, or belittling and degrading the child.

- **Isolation/confinement:** Adult cuts the child off from normal social experiences, prevents friendships or makes the child believe that he or she is alone in the world. Includes locking a child in a room, or isolating the child from the normal household routines.

- **Inadequate nurturing or affection:** Through acts of omission, does not provide adequate nurturing or affection. Being detached, uninvolved; failing to express affection, caring and love, and interacting only when absolutely necessary.

- **Exploiting or corrupting behaviour:** The adult permits or encourages the child to engage in destructive, criminal, antisocial, or deviant behaviour.

**Exposure to Intimate Partner Violence**

- **Direct witness to physical violence:** The child is physically present and witnesses the violence between intimate partners.

- **Indirect exposure to physical violence:** Includes situations where the child overhears but does not see the violence between intimate partners; or sees some of the immediate consequences of the assault (e.g., injuries to the mother); or the child is told or overhears conversations about the assault.
• **Exposure to emotional violence:** Includes situations in which the child is exposed directly or indirectly to emotional violence between intimate partners. Includes witnessing or overhearing emotional abuse of one partner by the other.

• **Exposure to non-partner physical violence:** A child has been exposed to violence occurring between a caregiver and another person who is not the spouse/partner of the caregiver (e.g., between a caregiver and a neighbour, grandparent, aunt or uncle).

**QUESTION 32: ALLEGED PERPETRATOR**

This section relates to the individual who is alleged, suspected or guilty of maltreatment toward the child. Fill in the appropriate perpetrator for each form of identified maltreatment as the primary caregiver, second caregiver or “Other.” If “Other” is selected, specify the relationship of the alleged perpetrator to the child (e.g., brother, uncle, grandmother, teacher, doctor, stranger, classmate, neighbour, family friend). If you select “Primary Caregiver” or “Second Caregiver,” write in a short descriptor (e.g., “mom,” “dad,” or “boyfriend”) to allow us to verify consistent use of the label between the Household Information and Child Information Sheets. Note that different people can be responsible for different forms of maltreatment (e.g., common-law partner abuses child, and primary caregiver neglects the child). If there are multiple perpetrators for one form of abuse or neglect, fill in all that apply (e.g., a mother and father may be alleged perpetrators of neglect). Identify the alleged perpetrator regardless of the level of substantiation at this point of the investigation.

**If Other Perpetrator**

If Other alleged perpetrator, identify

a) **Age:** If the alleged perpetrator is “Other,” indicate the age of this individual. Age is essential information used to distinguish between child, youth and adult perpetrators. If there are multiple alleged perpetrators, describe the perpetrator associated with the primary form of maltreatment.

b) **Sex:** Indicate the sex of the “Other” alleged perpetrator.

**QUESTION 33: SUBSTANTIATION** *(fill in only one substantiation level per column)*

Indicate the level of substantiation at this point in your investigation. Fill in only one level of substantiation per column; each column reflects a separate form of investigated maltreatment, and thus should include only one substantiation outcome.

- **Substantiated:** An allegation of maltreatment is considered substantiated if the balance of evidence indicates that abuse or neglect has occurred.
- **Suspected:** An allegation of maltreatment is suspected if you do not have enough evidence to substantiate maltreatment, but you also are not sure that maltreatment can be ruled out.
- **Unfounded:** An allegation of maltreatment is unfounded if the balance of evidence indicates that abuse or neglect has not occurred.

If the maltreatment was substantiated or suspected, answer 33 a) and 33b).

a) **Substantiated or suspected maltreatment, is mental or emotional harm evident?**

Indicate whether child is showing signs of mental or emotional harm (e.g., nightmares, bed wetting or social withdrawal) following the maltreatment incident(s).

b) **If yes, child requires therapeutic treatment:** Indicate whether the child requires treatment to manage the symptoms of mental or emotional harm.

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If the maltreatment was unfounded, answer 33 c) and 33d).

c) **Was the unfounded report a malicious referral?** Identify if this case was intentionally reported while knowing the allegation was unfounded. This could apply to conflictual relationships (e.g., custody dispute between parents, disagreements between relatives, disputes between neighbours).

d) **If unfounded, is there a significant risk of future maltreatment?** If maltreatment was unfounded, indicate, based on your clinical judgment, if there is a significant risk of future maltreatment.

**QUESTION 34: WAS MALTREATMENT A FORM OF PUNISHMENT?**

Indicate if the alleged maltreatment was a form of punishment.

**QUESTION 35: DURATION OF MALTREATMENT**

Check the duration of maltreatment as it is known at this point of time in your investigation. This can include a single incident or multiple incidents. If the maltreatment type is unfounded, then the duration needs to be listed as “Not Applicable (Unfounded).”

**QUESTION 36: PHYSICAL HARM**

Describe the physical harm suspected or known to have been caused by the investigated forms of maltreatment. Include harm ratings even in accidental injury cases where maltreatment is unfounded, but the injury triggered the investigation.

- **No harm:** There is no apparent evidence of physical harm to the child as a result of maltreatment.
- **Broken bones:** The child suffered fractured bones.
- **Head trauma:** The child was a victim of head trauma (note that in shaken-infant cases the major trauma is to the head, not to the neck).
- **Other health condition:** Other physical health conditions, such as untreated asthma, failure to thrive or STDs.
- **Bruises/cuts/scrapes:** The child suffered various physical hurts visible for at least 48 hours.
- **Burns and scalds:** The child suffered burns and scalds visible for at least 48 hours.
- **Fatal:** Child has died; maltreatment was suspected during the investigation as the cause of death. Include cases where maltreatment was eventually unfounded.

**QUESTION 37: SEVERITY OF HARM**

a) **Medical treatment required:** In order to help us rate the severity of any documented physical harm, indicate whether medical treatment was required as a result of the injury or harm for any of the investigated forms of maltreatments.

b) **Health or safety seriously endangered by suspected or substantiated maltreatment:** In cases of “suspected” or “substantiated” maltreatment, indicate whether the child’s health or safety was endangered to the extent that the child could have suffered life-threatening or permanent harm (e.g., 3-year-old child wandering on busy street, child found playing with dangerous chemicals or drugs).

c) **History of injuries:** Indicate whether the investigation revealed a history of previously undetected or misdiagnosed injuries.
QUESTION 38: PHYSICIAN/NURSE PHYSICALLY EXAMINED CHILD AS PART OF THE INVESTIGATION

Indicate if a physician or nurse conducted a physical examination of the child over the course of the investigation.

QUESTION 39: PLACEMENT DURING INVESTIGATION

Check one category related to the placement of the child. If the child is already living in an alternative living situation (emergency foster home, receiving home), indicate the setting where the child has spent the most time.

- No placement required: No placement is required following the investigation.
- Placement considered: At this point of the investigation, an out-of-home placement is still being considered.
- Informal kinship care: An informal placement has been arranged within the family support network (kinship care, extended family, traditional care); the child welfare authority does not have temporary custody.
- Kinship foster care: A formal placement has been arranged within the family support network (kinship care, extended family, customary care); the child welfare authority has temporary or full custody and is paying for the placement.
- Family foster care (non kinship): Include any family-based care, including foster homes, specialized treatment foster homes and assessment homes.
- Group home: Out-of-home placement required in a structured group living setting.
- Residential/secure treatment: Placement required in a therapeutic residential treatment centre to address the needs of the child.

QUESTION 40: CHILD WELFARE COURT

There are three categories to describe the current status of child welfare court at this time in the investigation. If investigation is not completed, answer to the best of your knowledge at this time. Select one category only.

a) Referral to mediation/alternative response: Indicate whether a referral was made to mediation, family group conferencing, an Aboriginal circle, or any other alternative dispute resolution (ADR) process designed to avoid adversarial court proceedings.

QUESTION 41: PREVIOUS REPORTS

a) Child previously reported to child welfare for suspected maltreatment: This section collects information on previous reports to Child Welfare for the individual child in question. Report if the child has been previously reported to Child Welfare authorities because of suspected maltreatment. Use “Unknown” if you are aware of an investigation but cannot confirm this. Note that this is a child-specific question as opposed to the previous report questions on the Household Information Sheet.
b) If yes, was the maltreatment substantiated: Indicate if the maltreatment was substantiated with regard to this previous investigation.

QUESTION 42: CAREGIVERS USE SPANKING AS A FORM OF DISCIPLINE
Indicate if caregivers use spanking as a form of discipline. Use “Unknown” if you are unaware of caregivers using spanking.

QUESTION 43: POLICE INVOLVEMENT IN ADULT DOMESTIC VIOLENCE INVESTIGATION
Indicate level of police involvement specific to a domestic violence investigation. If police investigation is ongoing and a decision to lay charges has not yet been made, select the investigation-only item.

QUESTION 44: POLICE INVOLVEMENT IN CHILD MALTREATMENT INVESTIGATION
Indicate level of police investigation for the present child maltreatment investigation. If police investigation is ongoing and a decision to lay charges has not yet been made, select the investigation-only item.

THANK YOU FOR YOUR SUPPORT AND INTEREST IN THE THIRD CYCLE OF THE CANADIAN INCIDENCE STUDY.
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<td>Physical Harm</td>
<td>19</td>
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<tr>
<td>CIS Maltreatment Assessment Form</td>
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<td>Police Involvement</td>
<td>21</td>
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<tr>
<td>Comment Sheet</td>
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<td>Primary Income Source</td>
<td>9</td>
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<td>Referral for Any Family Member</td>
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<td>Describing Referral</td>
<td>6</td>
<td>Risk</td>
<td>7</td>
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<td>Ethno-Racial Group</td>
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<td>Sexual Abuse</td>
<td>16</td>
</tr>
<tr>
<td>Exposure to Intimate Partner Violence</td>
<td>17</td>
<td>Source of Allegation/Referral</td>
<td>5</td>
</tr>
<tr>
<td>Frequently Asked Questions</td>
<td>3</td>
<td>Substantiation</td>
<td>18</td>
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<tr>
<td>Household Information Sheet</td>
<td>8</td>
<td>Training</td>
<td>2</td>
</tr>
<tr>
<td>Housing</td>
<td>10</td>
<td>Unsafe Housing</td>
<td>11</td>
</tr>
</tbody>
</table>

**CANADIAN INCIDENCE STUDY-CIS-2008 23**
Appendix B: Maltreatment Assessment Form
### 1. Date referral was received:  
### 2. Date case opened:

### 3. Source of allegation/referral (Fill in all that apply)
- Police
- Community agency
- Anonymous
- School
- Other child welfare service
- Day care centre
- Other: ___________________________________
- Neighbour/friend
- Social assistance worker
- Crisis service/shelter
- Community/recreation centre
- Custodial parent
- Non-custodial parent
- Child (subject of referral)
- Relative

### 4. Please describe referral, including alleged maltreatment or risk of maltreatment (if applicable) and results of investigation

In jurisdictions with differential/alternative response choose one:
- Child welfare worker
- Customized/alternate response
- Traditional protection investigation

### 5. Caregiver(s) in the home

#### Primary caregiver
- a) Sex
  - Male
- b) Age
  - <16
  - 16-18 yrs
  - 19-21 yrs
  - 22-30 yrs
  - 31-40 yrs
  - 41-50 yrs
  - 51-60 yrs
  - >60 yrs

#### Second caregiver in the home at time of referral
- a) Sex
  - Male
- b) Age
  - <16
  - 16-18 yrs
  - 19-21 yrs
  - 22-30 yrs
  - 31-40 yrs
  - 41-50 yrs
  - 51-60 yrs
  - >60 yrs

---

This information will remain confidential, and no identifying information will be used outside your own agency.

This tear-off portion of the instrument will be destroyed by the site researcher at this agency/office upon completion of data collection.

McGill University, Centre for Research on Children and Families, 3506 University Street, Suite 106, Montréal QC H3A 2A7  •  t: 514-398-5399  •  f: 514-398-5287

University of Toronto, Faculty of Social Work, 246 Bloor Street West, Toronto ON M5S 1A1  •  t: 416-978-2527  •  f: 416-978-7072

University of Calgary, Faculty of Social Work, 2500 University Drive, NW, Calgary AB T2N 1N4  •  t: 403-220-4698  •  f: 403-282-7269

First Nations Child and Family Caring Society of Canada, 251 Bank Street, Suite 302, Ottawa ON K2P 1X3  •  t: 613-230-5885  •  f: 613-230-3080

08/08

Worker’s name: ________________________________________________________________

First two letters of primary caregiver’s surname:  
Other family surname, if applicable:  
Case number:  

---

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08/08
PROCEDURES
1. The Intake Face Sheet should be completed on every case that you assess/investigate, even if there is no suspected maltreatment.
2. The entire CIS Maltreatment Assessment form (Intake Face Sheet, Household Information Sheet and Child Information Sheet(s)) should be completed for each investigation. Each investigated child requires a separate Child Information Sheet.
   Note: Currently open/active cases with new allegations of child maltreatment are not included in the CIS.

COMPLETION INSTRUCTIONS
To ensure accuracy and minimize response time, the CIS Maltreatment Assessment should be completed when you complete the standard written assessment/investigation report for the child maltreatment investigation.

Note: all information must be completed by the investigating worker.
Complete all items to the best of your knowledge. To increase accuracy of data scanning, please avoid making marks beyond the fill-in circles.

Thank you for your time and interest.

Currently open/active cases with new allegations of child maltreatment are not included in the CIS.

Comments: Intake information

Comments: Household information

Comments: Child information

This information will remain confidential, and no identifying information will be used outside your own agency.
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An Exploration of the Relationship Between Poverty and Child Neglect in Canadian Child Welfare

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An Exploration of the Relationship Between Poverty and Child Neglect in Canadian Child Welfare

CIS Maltreatment Assessment: Household Information

Primary Caregiver: 

A. Primary income
- Full time
- Part time (less 35 hours)
- Employment insurance
- Unemployment insurance
- Overtime job
- Social assistance
- Other

A.1. Ethnocultural background
- White
- Black
- Latin American
- Asian
- Arab
- Other

A.2. If Aboriginal
- On reserve
- Off reserve

B. Child history
- First Nations status
- First Nations non-status
- Métis
- Other

C. Caregiver attended residential school
- Yes
- No
- Unknown

D. Caregiver's parent attended residential school
- Yes
- No
- Unknown

E. Primary language
- English
- French
- Other

F. Contact with caregiver in response to investigation
- Cooperative
- Not cooperative
- Not contacted

A.2. Caregiver risk factors
- Alcohol abuse
- Domestic violence
- Criminal involvement
- Mental health issues
- Physical health issues
- Transient
- Witness to domestic violence
- Perpetrator of domestic violence
- History of foster care placement

16. Other adults in the home
- Non-family member
- Children >10
- Other

16. Caregiver(s) outside the home
- None
- Father
- Mother
- Other

16. Child custody dispute
- Yes
- No
- Unknown

17. Housing
- Own home
- Rent
- Public housing
- Homestay
- Hostel/Shelter
- Other

18. Home overcrowded
- Yes
- No
- Unknown

19. Number of moves in past year
- 0
- 1
- 2 or more
- Unknown

20. Housing safety
- Accessible accommodation
- Accessible home
- Drug or alcohol abuse
- Drug production or trafficking
- Violence or sexual abuse
- Other

21. Household income
- Yes
- No
- Unknown

22. Case history
- Yes
- No
- Unknown

23. Case will stay open for ongoing child welfare services
- Yes
- No

24. Reformalized for any family member
- Yes
- No
- Unknown

25. Support services
- Parent support program
- Special education placement
- In-home family counseling
- Victim support program
- Drug or alcohol counseling
- Domestic violence assistance
- Food bank
- Shelter services
- Domestic violence services
- Other
### CIS Maltreatment Assessment: Child Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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<tbody>
<tr>
<td>First Name</td>
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</tr>
<tr>
<td>22. Sex</td>
<td>Male</td>
</tr>
<tr>
<td>25. Age</td>
<td>[Input Field]</td>
</tr>
</tbody>
</table>

#### 26. Aboriginal Status
- [ ] First Nations
- [ ] Metis
- [ ] Inuit
- [ ] Other

#### 27. Type of Investigation
- [ ] Investigation into maltreatment
- [ ] Risk Investigation only

#### 28. Child Functioning
- [ ] Behaviorally inappropriate
- [ ] Communication difficulties
- [ ] Social-emotional problems
- [ ] Cognitive delays/limitations
- [ ] Physical disabilities
- [ ] Medical conditions
- [ ] Psychiatric conditions
- [ ] Other

#### 29. Abuse
- [ ] Physical
- [ ] Sexual
- [ ] Emotional

#### 30. Neglect
- [ ] Failure to provide basic needs
- [ ] Failure to provide medical care
- [ ] Failure to provide educational opportunities
- [ ] Failure to provide safety

#### 31. Exposure to Intimate Partner Violence
- [ ] Yes
- [ ] No
- [ ] Unknown

#### 32. Placement During Investigation
- [ ] No placement required
- [ ] Placement in care
- [ ] Foster care
- [ ] Child in care
- [ ] Group home
- [ ] Residential treatment

#### 33. Substance Abuse
- [ ] Yes
- [ ] No

#### 34. Was Maltreatment a Form of Punishment?
- [ ] Yes
- [ ] No
- [ ] Unknown

#### 35. Duration of Maltreatment
- [ ] 1-3 months
- [ ] 4-6 months
- [ ] 7-9 months
- [ ] 10-12 months
- [ ] Over 1 year

#### 36. Physical Harm
- [ ] Yes
- [ ] No

#### 37. History of Maltreatment
- [ ] Yes
- [ ] No

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