

# **Referrals and Admissions to the Children's Aid Society: A Test of Four Hypotheses<sup>1</sup>**

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October 2003

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<sup>1</sup> This research project is funded by the City of London, the County of Middlesex, an anonymous donor through United Way, and United Way of London & Middlesex.

**Abstract**

Four hypotheses are tested to account for the increase in referrals and admissions of children to the care of the CAS of London and Middlesex: the threshold of measured risk between two years at referral; a lowering in the average cumulative risk assessment scores in 2001 for children admitted to CAS care compared to children admitted to CAS care in 1995; a change in the pattern of referrals from community sources; and the possible shift in the length of time children spend in CAS care. Risk is measured using the Ontario Risk Assessment Tool and the principal comparisons are made between substantiated cases of abuse seen in 1995 and 2001. It appears that it is the likelihood of instances of child maltreatment – particularly serious instances – that are now more likely to be reported than was previously the case. These results are discussed in terms of their relevance for explaining shifts in the demand for child protection services in Ontario.

**KEYWORDS:** child protection, policy, child maltreatment

## Introduction

Since the mid 1990s, there have been dramatic increases in both referrals and admissions to care to child protection agencies throughout North America (Anglin, 2001). This includes a dramatic increase in referrals and admissions to Children's Aid Societies (CASs) in Ontario. The number of investigations by CASs of children suspected of being abused or neglected in Ontario increased by 44% between 1993 and 1998 across fifty-two CASs (Trocmé, Neves, Falon, MacLaurin & Sullivan, 1998). At the CAS of London and Middlesex, a large child protection agency in southwestern Ontario, the number of children admitted to CAS care almost doubled over the past ten years (Table 1) in contrast to the demographics of the population, which has remained quite stable during the same time period (Figure 1). The total number of children and youth less than 15 years in 1996 was 86,639 and 2001 86,980.

**Table 1**

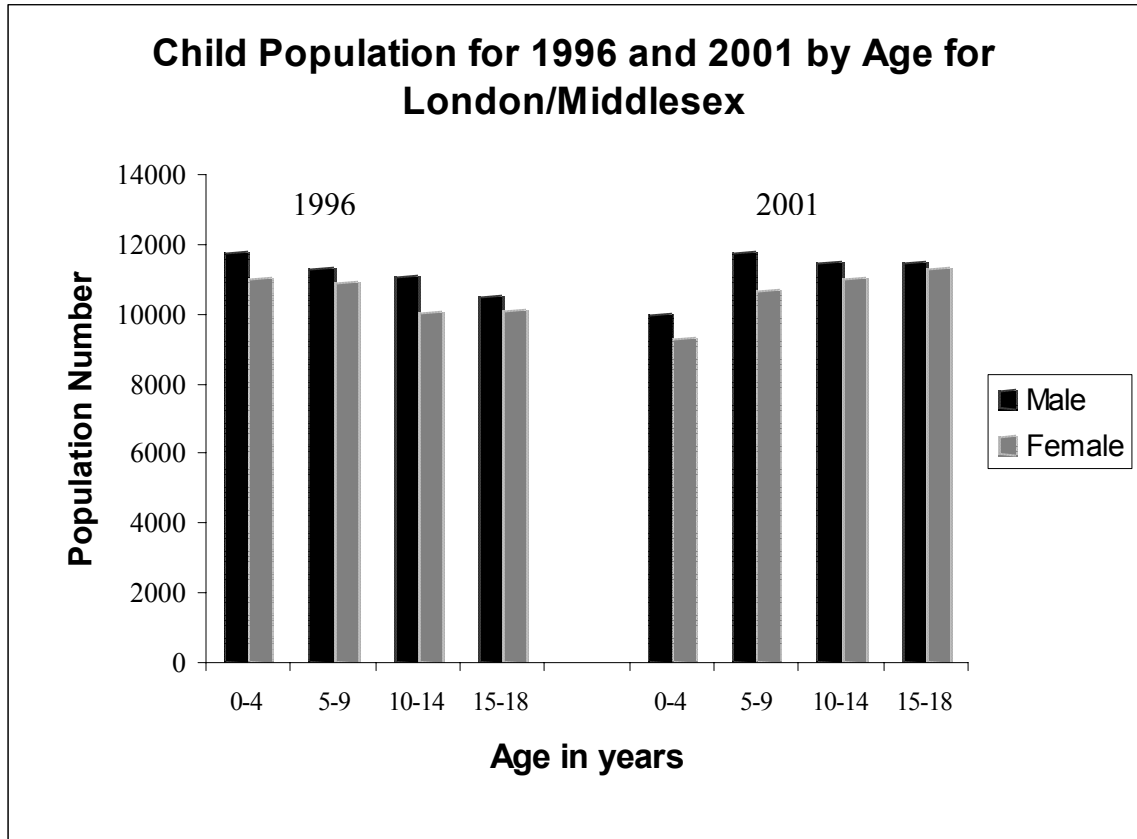
*Yearly Child Admissions to CAS Care*

<b>Year</b>	<b>Number of Child Admissions to CAS Care*</b>
1993	290
1994	371
1995	337
1996	369
1997	486
1998	437
1999	407
2000	481
2001	556
2002	544

*Note: \* number of children admitted to CAS care from January 1 – December 31 in calendar year*

**Figure 1**

*Children and Youth under Age 15 Years in London Ontario from the Census of 1996 and 2001*



In Ontario, investigations for neglect doubled between 1993 and 1998, rising from 4,400 to 8,900. The number of children admitted to the care of CAS increased from 10,419 in 1996 to 15,792 by 2001 (Rivers, Trocmé, Goodman & Marwah, 2002). By 2003, this number has increased to more than 18,000 children.

### **1.1 Accounting for the Increase in Child Protection Cases**

There has been considerable speculation regarding the reasons for the increase in both referrals and admissions to CAS care, but few empirical tests of their accuracy are reported. One obvious explanation is that there are simply more cases to be reported. Wolfe and Yuan (2001) have suggested that considerable subjectivity enters into the decision to report suspicions of child abuse and neglect to child protection agencies. Policies designed to influence the extent of reporting may account for increases in rates of reporting and admission.

## 1.2 Speculation About the Increased Rate of Reporting to Children's Aid Societies

Anglin (2002) suggests that a number of changes in how we deal with the maltreatment of children contribute to the increases in demand for service. He suggests that the three leading influences in increasing the likelihood of admissions to child protection care are the following: 1) that “paramountcy” for the protection of children over other social objectives of social welfare policy, such as community-based support for families may increase the likelihood of admitting a child to care; 2) the focus on the *risk* of harm to the child in contrast to a *determination* of abuse may accelerate the number of children admitted to protective care, serving as a pre-emptive measure to prevent physical abuse; and 3) the application of risk assessment instruments may, beyond simply standardizing data collection, actually increase the likelihood of a decision to admit a child to care.

Specifically, in Ontario three reasons have been offered for the increasing rate in both referrals of cases to the CAS, as well as admissions to CAS care. First, it is widely believed that, changes to Ontario's *Child and Family Services Act*, which took effect on 1 April, 2000, led to a marked increase in the number of children admitted to CAS care. The changes to the *Act*, it has been argued, lowered the threshold for identifying a child in need of protection by shifting the criteria from: “substantial risk” to “risk”; “severe” to “serious”; along with a move away from the universal belief “that the least disruptive course should be “followed,” to the increasingly discretionary principle of it being simply “considered” (King, Leschied, Whitehead, Chiodo & Hurley, 2003). Second, other changes were taking place in Ontario's child protection system including the introduction and use of a standardized province-wide risk assessment model to measure risk (Ontario Association of Children's Aid Societies, 2000). Risk assessment instruments and procedures standardize the collection of information on which judgements are to be made concerning the nature and type of service that children and families require. Some authors suggest that, as a result, judgements based on standardized measures are more likely to result in decisions to admit children into care than would clinical judgement alone (De Panfilis & Zuravin, 2001; Gambrill & Shlosky, 2000). Third, training that improves the detection and reporting of the suspicion of abuse and neglect will increase the number of referrals being made, particularly from professionals who are responsible for reporting cases of *suspected* maltreatment (Trocmé & Wolfe, 2001). Trocmé Siddiqi,

Fallon, MacLaurin, Sullivan (2002) report that an examination of cases from fifteen CASs in Ontario “points to a significant shift in reporting practices by [certain] professionals” (p. 1). The increases are particularly high with respect to cases of neglect and they suggest that this may be the result of “growing awareness” of child abuse and neglect that was “driven” by a number of inquests focussed on child neglect.

Several questions arise about these apparent explanations. First, if there are more referrals of children at risk of neglect on the part of professionals, are referrals by professionals disproportionately driving the increase in the total number of cases being seen by the CAS? Second, are cases that would not have been reported previously (e.g., in 1995) by professionals being reported more frequently in 1998 or later years? Presumably, we should find that cases of neglect seen in the latter period would experience, on average, a lower level of risk than would have been the case during the earlier period. Third, if the CAS is more likely to admit children to care, it may also be less likely to release them from care, thereby contributing to a larger aggregate number of children in care at any given time.

### **1.3 Purpose**

The purpose of this study is to test the validity of these assertions with data collected from the CAS of London and Middlesex, a large child protection agency in southwestern Ontario.

### **1.4 Hypotheses**

Identification of possible reasons accounting for increases in both referrals to the CAS and in admissions to CAS care is of importance in guiding policies that serve to heighten community awareness surrounding the safety of children. Given the speculation regarding possible reasons for this increase, the following hypotheses are tested:

1. If the “threshold” for a child being found in need of protection has been lowered, we should then find that the average level of risk to children who come to the attention of the CAS for child protection reasons will be lower in 2001 than in 1995.

2. If increases in the frequency of children admitted to CAS care reflects a lower standard compared to previous years, then the average risk scores of children admitted to CAS care in 2001 should be lower than in 1995.
3. Sources of referral would be expected to change over time with a greater proportion of referrals coming from professionals as compared to family members and self-referrals in the latter period in comparison to the earlier period. This would be especially true for cases of neglect.
4. The amount of time that children spend in care should be greater in 2001 than in 1995.

## **Method**

### **2.1 Design**

A retrospective file review of child protection cases seen at the CAS of London and Middlesex from the years 1995 and 2001 was conducted. In order to determine whether there are changes over time, we chose cases from the most recent year for which complete data were available (2001) and a comparison year that was well before the major child protection legislative change in 2000 (1995).

### **2.2 Participants**

Participants in this study are 1,042 children randomly selected from 2,316 child protection cases from the CAS of London and Middlesex in 1995 and 2001. The sub-sample in 1995 consisted of 450 children, of whom 176 (39%) were considered to be in need of protection and admitted to CAS care and 274 (61%) who were considered to be in need of protection, but received services from the CAS and other community agencies while living in their own homes. This latter type of intervention could range from investigation services, to protection services, which could include individual and family counseling. The sub-sample in 2001 consisted of 592 children, of whom 381 (64%) were considered in need of protection and admitted to CAS care and 211 (36%) who were considered in need of protection, but received services from the CAS and other community agencies while living in their own homes.

While the sampling was random, this method of sampling does not guarantee that the composition of the combined samples for each year is representative of the proportion

of children seen at the CAS for child protection reasons. In order to compensate for this, the data are weighted in each year such that the sample, as analysed, contains the same proportion of children admitted to care, as was the case for the total population of cases for the years from which they were drawn.

### **2.3 Materials**

Child protection files from the CAS of London and Middlesex were reviewed. A standardized coding instrument was created by the authors to guide the extraction of information from each case file. Information recorded on the family included current and historical family information, as well as the history of the family's mental health, the family's history with the CAS, family violence and access to social services. Information on children included past and present access to mental health, young offender, educational, and developmental services, as well as outcomes related to psychological, behavioural, developmental, and academic concerns. The sample is of cases opened in 1995 and 2001. Data are collected as of the time in the year that the child/family received the most intensive CAS intervention that year. A manual was created that detailed the inclusion and exclusion criteria for each item to be recorded.

The coding instrument contained the *Risk Assessment Tool*, an instrument currently in use by Ontario's CASs (Ontario Association of Children's Aid Societies, OACAS, 2000). The *Risk Assessment Tool* is part of the revised Risk Assessment Model for Child Protection in Ontario (ORAM) (OACAS, 2000) that was developed as part of the Ministry's standards for the management of child abuse and neglect cases. *The Risk Assessment Tool* represents a common risk assessment instrument across Ontario as a standardized, comprehensive approach to the assessment of risk across all CASs.

The *Risk Assessment Tool* includes five assessment categories called *influences*, related to the caregiver, child, family, intervention, and abuse/neglect (Figure 2). Within each of these *influences* are elements that relate to risk. There are 22 risk elements examined by the *Risk Assessment Tool*. Each risk element includes five scales of severity ranging from zero (0) to four (4). The Risk Assessment Scales are further defined by descriptions called *anchors*. The anchors help assign a rating by providing a narrative description that defines the status or functioning of a child, caregiver, or family.

A risk analysis was completed for all cases in 1995 and 2001. Six trained researchers completed a risk assessment form and risk analysis independently from the risk analysis completed by the CAS worker in the child protection file. For each case, the risk elements were assessed on a scale of 0 to 4, with a score of 0 being the absence of risk and a score of 4 being maximum severity. For the purpose of the current study, a risk analysis is based on a 'cumulative risk assessment score' comprised of a total score of the 22 individual risk elements. Each case could, therefore, receive a cumulative risk assessment score between 0 - 88. It is important to note that the application of Risk Assessment by Ontario CASs does not include a cumulative risk assessment score.

The Ontario *Risk Assessment Tool* was not developed and is not used across all CASs in Ontario as an outcome measure. Given that this scale was not designed as an outcome measure, the authors tested the predictive validity of the *Risk Assessment Tool*. The cumulative risk assessment scores within each area of risk form a reliable scale: Cronbach's alpha ranges from .71 - .79. The cumulative risk assessment scores are consistent with clinical judgment (i.e., the decision to admit a child to CAS care) ranging from 74 to 81 per cent of all cases. A detailed review on the empirical basis of the *Risk Assessment Tool* appears in Leschied, Chiodo, Whitehead, Hurley & Marshall (2003).

## Figure 2

### *Summary of Areas for Risk Assessment*

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1. Caregiver Influence
    - Abuse – Neglect
    - Alcohol/Drug Use
    - Expectations of child
    - Acceptance of child
    - Physical capacity to care for child
    - Mental/Emotional/Intellectual Capacity
  2. Child's Influence
    - Child's vulnerability
    - Child's response to caregiver
    - Child's behaviour
    - Child's mental health and development
    - Physical health and development
  3. Family Influence
    - Family violence
    - Ability to cope with stress
    - Availability of social supports
    - Living conditions
    - Family identity and interactions
  4. Intervention Influence
    - Caregiver's motivation
    - Caregiver's cooperation with intervention
  5. Abuse/Neglect
    - Access to child by perpetrator
    - Intention and acknowledgement of responsibility
    - Severity of abuse/neglect
    - History of abuse/neglect/Neglect committed by present caregivers
- 

## 2.4 Procedure

Five trained researchers working under the supervision of a project manager collected the data. To enhance reliability, the researchers received training prior to the beginning of data collection. Senior managers of the CAS of London and Middlesex and the research team met on a weekly basis to review concerns related to the file information, risk

assessment analysis, or data collection procedures to ensure consistency in data interpretation and collection.

The CAS workers do not compute cumulative risk assessment scores based on their ratings of the 22 risk elements of the *Risk Assessment Tool* when completing a Risk Analysis for child protection cases. The CAS worker's ratings of the individual risk elements are, however, recorded in the child protection files. Thus, it is possible to compute a cumulative risk assessment score from the ratings of the CAS worker. A reliability analysis of the cumulative risk assessment scores rated by the researchers and the cumulative risk assessment scores by the CAS workers was performed for 253 cases. Inter-rater reliability between the cumulative risk assessment scores rated by the researchers and the cumulative risk assessment scores derived from the ratings of CAS workers is extremely high (Cronbach's alpha = .86).

## **Results**

The design of the present study allows us to compare CAS cases of London and Middlesex in 2001 with those in 1995 in order to determine changes over this period of time in the following areas: 1) the level of risk experienced by children who come to the attention of the CAS; 2) whether there is a difference in the level of risk experienced by children admitted to CAS care; 3) whether patterns in the source of referral have changed; and 4) whether there is a change in the length of time children remain in CAS care.

### **3.1 All Child Protection Cases**

The cumulative risk assessment scores are used as a measure of risk to which the child is exposed. If, by 2001, persons were more likely to report cases to the CAS than they were previously, we expect to find that the level of risk for children who come to the attention of the CAS in 2001 would be lower than it was in 1995. Contrary to this expectation, the results indicate that children are rated as being of higher risk in 2001 with a mean cumulative risk score of 29.4 in 2001, contrasted with a mean cumulative risk score of 25.3 in 1995 [ $t(10.40) = 4.35, p < .001$ ] (Table 2).

### **3.2 Child Protection Cases Where Children are Admitted to CAS Care**

If by 2001, the threshold was lower and case workers are more likely to admit children to care than would have been the case in 1995, we should find that average cumulative risk assessment scores should be lower for children admitted to CAS in care in 2001 than for children admitted to CAS care in 1995. The mean cumulative risk assessment score for children admitted to CAS care in 2001, 34.7, is significantly higher than it was in 1995, 31.5 [ $t(293) = 2.88, p < .01$ ] (Table 2).

### **3.3 A Test of Paramourncy in Child Protection Decision-making**

Finally, relative to risk, the concept of paramourncy in 2001 was tested. Paramourncy is part of child welfare legislation that when in effect, suggests children will be more likely to be admitted to care even if their risk scores are similar compared to scores under previous legislation. In other words, if children score equally on the risk assessment measure in both years, children in 2001 will have a greater likelihood of being admitted to CAS care compared to a child with a similar score in 1995. This question was assessed with an Analysis of Covariance (ANCOVA). After adjusting the group means to what they would be if all children scored identically on cumulative risk, the ANCOVA across years is nonsignificant [ $F(1, 1039) = .858, ns$ ]. This suggests it is the level of risk that is accounting for differences between the numbers of children admitted to CAS care and not the particular policy in place at the different points in time.

### **3.4 Length of Time in CAS Care**

The number of children in care at any one time is a function of two sets of events: admissions to care, which we have been discussing; and discharges from care. The view that the threshold has been lowered for children admitted to CAS care has the corollary that if greater care is being taken to protect children from unsafe situations, similar pressures may exist to not return children to unsafe situations once they have been admitted to CAS care. If this were true, we would expect that the amount of time children spent in CAS care would be longer in 2001 than it was in 1995.

For the current analysis, the categorical variables of length of time children are in CAS care (i.e., less than one week, less than one month, less than three months, and less than six months) are treated as continuous variables by taking the categories' mid-point

length of time in days. For example, cases that are in CAS care for less than one week are converted to three and a half days. Only cases open from January to June in 1995 and 2001 are analyzed in order to allow for a length of time in care of at least six months. Our data do not allow for an examination of periods in CAS care of over six months.

Inconsistent with expectations, children are not spending a greater amount of time in CAS care in 2001 ( $t(207) = 1.48, ns$ ) than are children in care in 1995 of at least six months (Table 2).

**Table 2**

*Summary of Children's Cumulative Risk Assessment Scores and Length of Time in CAS Care*

Group	1995	2001
	<i>M (SD)</i>	<i>M (SD)</i>
All Child Protection Cases (n=1042)		
Cumulative Risk Assessment Score**	25.94 (12.63)	29.38 (12.71)
In Care Decision* (ANCOVA) <sup>1</sup>	1.48 (.5)	1.44 (.5)
Children Admitted to CAS Care (n=557)		
Cumulative Risk Assessment Score	31.5 (12.84)	34.71 (10.79)
Length of Time in CAS Care	35.38 (31.87)	42.83 (35.83)
Days in CAS care (n=209)		

*Note: higher cumulative risk assessment scores indicate greater severity of risk across five areas of influence (i.e., Caregiver, Child, Family, Intervention, Abuse/Neglect); standard deviations are in parentheses*

<sup>1</sup>The decision to admit a child to CAS care was converted to yes =1 and no =2 for the purposes of this analysis; \*  $p < .05$ ; \*\* $p < .001$

### **3.5 Changes in the Source of Referral**

Trocmé, Neves, Fallon, McLaurin, and Sullivan (2002) have argued that, with respect to cases of neglect, the number of reports made to Ontario CASs from community professionals such as physicians, teachers, and the police may contribute to the increase in reported referrals. There are, therefore, two questions to be addressed: is there a

proportional shift in sources of referral for all CAS cases and; is there a shift in the source of referral source for those cases that specifically involve neglect?

### **3.6 Impact on Total Cases**

With respect to all child protection cases referred to the CAS of London and Middlesex, there is no significant shift in sources of referral between 1995 and 2001 ( $\chi^2 = 3.09$ ;  $df = 7$ ,  $p > .1$ ) (Table 3). These results suggest that all sources of referral are contributing proportionately to the increase in the total number of referrals being made. Currently, the most likely source of referral is a parent (20 %), police officer (18.0%), family associate (17.3%), or other children's service professional (14.5%). Indeed, it is remarkable how the proportion of cases for each source of referral has remained stable even though the frequency of referrals for each category has increased. The same is true when we categorize the source of referral into two groups, professionals (teachers, police officers, physicians, social workers) and non-professionals (family, self, friends, babysitters). The results of this analysis also show no significant differences between professional and non-professional as sources of referrals between 1995 and 2001 ( $\chi^2 = .421$ ;  $df = 1$ ,  $p > .1$ ) (Table 3).

**Table 3**

*Frequency and Percent Describing the Source of Referral of Child Protection Cases to the CAS of London and Middlesex in 1995 and 2001*

Source of Referral	1995		2001	
	Frequency	Percent	Frequency	Percent
Child	10	2.2	9	1.5
Parent	100	22.2	118	20.0
Extended				
Family/neighbour/ anonymous/friend/ babysitter/unknown	74	16.4	102	17.3
<i>Sub total / non professionals</i>	<i>184</i>	<i>30.8</i>	<i>229</i>	<i>38.8</i>
Physician	43	9.6	50	8.5
CAS Worker	29	6.4	48	8.1
Other Agency	62	13.8	86	14.6
Police	82	18.2	106	17.9
School	50	11.1	72	12.2
<i>Sub total / professionals</i>	<i>266</i>	<i>59.1</i>	<i>362</i>	<i>61.3</i>
<b>TOTAL</b>	<b>450</b>	<b>100.0</b>	<b>592</b>	<b>100.0</b>

### 3.7 Impact on cases involving neglect

An examination of the sources of referrals for reasons of neglect for the years 1995 and 2001 addresses whether professional referrals account for a greater proportion of cases referred in 2001 than they did in 1995.

The sub-sample of cases of neglect in 1995 consists of 35 children and in 2001, 70 children. The proportion of cases of neglect for all children in CAS care does not differ significantly across the two years (10.7% vs. 14.6%) ( $x^2 = 1.286$ ,  $df = 1$ , *ns*). This suggests that cases of neglect were not disproportionately driving the higher number of children admitted to CAS care in 2001.

Consistent with expectations, a greater proportion of cases of neglect were referred by professionals in 2001 (73%) compared to the cases of neglect referred by professionals in 1995 (51%) ( $x^2 = 4.54$ ,  $df = 1$ ,  $p < .05$ ) (Table 4).

**Table 4***Frequency and Percentage of Source of Referral for Cases of Neglect*

	<b>1995 (n = 35)</b>	<b>2001 (n = 70)</b>
Cases of Neglect	Frequency (%)	Frequency (%)
Professional Referral	18 (51.4%)	50 (72.5%)
Non-Professional Referral	17 (48.6%)	19 (27.5%)

**Discussion**

Rates of referrals and admissions to care in Ontario’s CASs, similar to child protection services throughout North America, have witnessed a dramatic increase over the past decade. Numerous “reasons” have been offered to “explain” these increases. The most commonly cited has been that the criteria for children being admitted to care by child protection workers have been lowered since the mid to late 1990s. The key to this idea is that at least some children who now come to the attention of child protection workers, and are taken into care, would not have been managed similarly under previous policies and legislation. The present study challenges this perception and allows for a different interpretation of what may be happening.

When child protection cases from 1995 and 2001 are compared we find that on average the children are at greater risk in 2001 than were the children in 1995. The general pattern of referrals does not change. There are, however, many more cases in 2001 than in 1995. These findings suggest that all sources of referrals are more likely to report child abuse and neglect cases and those cases are now more likely to end up in CAS care. This may reflect a combination of explicit mandated reporting laws, the result of increasing public awareness following the media’s reporting of high profile cases of child maltreatment, and specific training provided to various professional groups such as teachers and physicians to underscore the obligations for reporting suspected child neglect.

To make sense of these findings, it is important to distinguish between “instances” of child maltreatment and those that are reported to child protection workers that become “cases.” Our findings suggest that there has been an actual increase in the

severity of the cases in 2001. Therefore, the threshold has not been lowered in the sense that a case that now leads to a child being admitted to CAS care would not have done so previously. Indeed, the severity of risk being experienced by children admitted to care has *increased*, not decreased. This is part may reflect the introduction of the *Ontario Child Welfare Eligibility Spectrum* (OACAS, 2000), a mandated tool designed to assist CAS staff in making consistent and accurate decisions about eligibility for child protection service at the time of referral.

It would appear that what has changed is that the likelihood of reporting instances of child abuse and neglect – particularly serious cases – is now higher than it was previously. That is, the threshold may now be lower, with respect to the barriers to *reporting*, than was previously the case. Our findings strongly suggest that it is not the milder instances of maltreatment that are getting increased attention. Rather, it is the more serious cases that were previously going unreported that are now being reported to the CAS. While all sources of referral have increased proportionately in the number of cases that they report, professionals have increased their awareness and reporting of cases of neglect to the greatest extent. Finally, in contrast to the perception that the severity of risk decreases as the number of cases increases, our findings indicate that reported cases have actually increased in their average severity of risk.

#### **4.1 Conclusions**

Examination of a number of popular views drawn from the literature as well as from professionals actively involved in the field of child protection regarding possible explanations for the increase in child protection referrals and admissions to care yields provocative results. There is little evidence that cases of reported child maltreatment now being reported are less severe than those that were reported in the past. In this sense, the threshold used by child protection workers has not been lowered and those same protection workers are no more likely to admit a child to CAS care than was previously the case.

The evidence presented in this paper is that what has changed is the preparedness of professionals and non-professionals to bring serious cases of child maltreatment to the attention of the Children's Aid Society. The average risk scores of children coming to

the attention of the CAS of London and Middlesex and ultimately admitted to CAS care have increased in 2001 relative to the cases referred in 1995.

Finally, the increase in the total number of children in CAS care is not the result of children being kept in care for longer periods of time up to six months. There were no significant differences in the time children spent in CAS care of up to six months between 1995 and 2001. Rather, the number of children in CAS care appears to be largely influenced by the increase in the number of children admitted to care.

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