The Disproportionality of Poverty, Race, and Ethnicity With Child Maltreatment Reporting

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In this issue of *Pediatrics*, Rebbe et al[1] used a population-based linked administrative data set to analyze data on nearly 4000 children <3 years of age who were hospitalized for child maltreatment. The study used diagnostic codes that were specific for, or suggestive of, maltreatment. The main findings identified that a disproportionate number of children with public health insurance (used as a proxy for poverty) were reported to Child Protective Services (CPS) as compared to children with private insurance, and this was true within each maternal race and ethnicity category. Findings regarding race and ethnicity showed that fewer children of Asian or Pacific islander mothers were reported to CPS as compared to White mothers, and children with American Indian mothers were more likely to have a diagnostic code specific (rather than suggestive) for maltreatment as comparted to all other groups. The authors interpreted these findings of disproportionality to indicate that children and families of lower socioeconomic status (SES) may be more closely scrutinized for maltreatment than those of higher SES, and that race and ethnicity is also a likely factor in CPS reporting and diagnosing abuse. The authors speculate that clinician implicit bias was a key driver behind the disproportionalities. They conclude that programs and policies are needed to prevent the inequitable way children receive protective interventions so that race and poverty "do not impact these crucial decision points regarding the intervention of child maltreatment."

Whether race and ethnicity or SES biases (implicit or otherwise) were the drivers behind the disproportionality cannot be ascertained directly from this data set because of key limitations. As stated by the authors, "it is difficult to ascertain from the available data whether the decision to assign a specific maltreatment code had more to do with the characteristics of the presenting medical problem or with racial bias." It is highly likely, however, that biases are at play on many levels. Other studies support that underresourced families are disproportionality evaluated for maltreatment and that biased decision-making results in overinvestigations and reporting of abuse in children from Black, Hispanic, and American Indian families.[2–7] Thus, efforts to tackle the impact of implicit and explicit biases on diagnosis and reporting of maltreatment are critical to decrease disparities that are adding to these disproportionalities.

However, the impact of social factors on outcomes is not limited to bias at the time of diagnosis or decision-making to refer to CPS. Interacting social determinants of health such as racism, poverty, and classism, may cause some groups to be more structurally vulnerable to adverse health outcomes, including child maltreatment.[8,9] Evidence indicates

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that the higher rates of identified and reported maltreatment among impoverished children in this study are likely influenced by real differences in rates of occurrence.[3,10–15] Poverty is a known risk factor for child maltreatment,[10–15] particularly in combination with other risk factors such as parental depression, substance use, and social isolation that are known to cotravel with poverty.[13,16] Other low-resource factors also place children at increased risk. For example, for lower-income single parents to work, the parent may sometimes be forced to resort to less-than-optimal child care, which increases their children's risk for maltreatment.[11,13,17–19] Evidence shows that financial and social supports mitigate the increased risks of maltreatment for children in poverty.[19–23] Conversely, decreased supports (ie, welfare benefits) are associated with increased rates of foster care placement (a proxy for maltreatment).[24] This highlights why solutions to address maltreatment must also target economic inequities that deepen the problem.

The disproportionalities of maltreatment diagnoses and reporting to CPS found in this study serve as a sentinel and likely reflect a combination of biases and true increased risk of maltreatment associated with poverty. It is critical that medical decision-makers do not conflate lower SES status or race and ethnicity with assumptions of maltreatment, because this implicit conflation is causing direct harm and further deepening existing disproportionalities as well as disparities. We must also recognize that underresourced and distressed families may have needs and stressors that contribute to a child's increased risk of negative outcomes, including maltreatment. The effects of compounded bias, oppression, injustice, and resource scarcity for certain communities are, unfortunately, enduring problems. A public health approach is required to address these injustices at the community-level, along with simultaneous work toward behavior change at the individual level to mitigate impacts of bias, and policy change at the institutional level to reduce the harms of unjust systems. Strategies for opening our eyes to our own biases, while not turning a blind eye to the risk to children that poverty brings, are critical to achieve equitable care for all.[9,25]

ABBREVIATIONS

SES: socioeconomic status
CPS: child protective services

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