Risk Management of Maltreatment of Infants and Toddlers: A Shared Case Review and Decision-Making Model

Maria Scannapieco, Ph.D., M.S.W.
Kelli Connell-Carrick, Ph.D., L.M.S.W.

Abstract

Child maltreatment is a significant social problem facing American society today. Since the second National Incidence Study of Child Abuse and Neglect, the number of seriously harmed children has increased 299%. Children under the age of five experience abuse and neglect more than any other age group, and they suffer the most devastating consequences. Young children are more likely to die from maltreatment than any other age group. To address these serious problems, first, a description of an innovative child protection model that focuses on children that are zero to four years of age is discussed. Second, a description of the families referred to the CPS risk management unit is presented. Third, the lessons learned from this risk management model are discussed, and implications for practice are presented.

Introduction

Child maltreatment is a widespread social problem in American society today. Since the second National Incidence Study of Child Abuse and Neglect (NIS-2), the number of seriously harmed children has increased 299% (Sedlak & Broadhurst, 1996). In 1999, approximately 826,000 children were victims of maltreatment in the United States. Slightly over 58% of these children suffered neglect, 22% suffered physical abuse, 11.3% were sexually abused, and 6% were emotionally maltreated (U.S. Department of Health & Human Services [USDHHS], 2001). These percentages may reflect duplicated cases in which both neglect and sexual abuse were substantiated regarding the same child, but the percentages are nonetheless tragically high.

Children nationwide continue to suffer maltreatment. Children under the age of five experience abuse and neglect more than any other age group, and they suffer the most devastating consequences (USDHHS, 2001). Children aged five and younger are more likely to die from maltreatment than any other age group (Margolin, 1990; McClain, Sacks, Froehlke & Ewigman, 1993). Nationwide in 1998, 1,100 children died as a result of maltreatment, and most fatality victims were very young (USDHHS, 2001). Approximately 38% of all fatality victims were under the age of one, and 77.5% were under the age of five (USDHHS, 2001). Overall, only 10% of child deaths occur in children over the age of four (Levine, Compaan, & Freeman, 1995); most fatality victims are under the age of two (McClain et al., 1993; Levine, Compaan, & Freeman, 1995).

The purpose of this article is threefold. First, an innovative child protection model focusing on children who are zero to four years of age is described. Second, a description of the families referred to the risk management unit of the Texas Department of Family and Protective Service (TDFPS), Child Protective Services (CPS) division, is presented. Third, the lessons learned from this risk management model are discussed and implications for practice are presented.

Infants, Toddlers, and Child Protection

Children under the age of five present unique circumstances to the child welfare system that make assessment of maltreatment difficult. Young children are inherently vulnerable, and they rely solely on their caregivers to provide for their physical and emotional growth. Whether their needs are met is determined by the opportunities provided to them by their caregivers. The limited cognitive and verbal skills of young children present an additional difficulty in assessing maltreatment. Only during toddlerhood do children begin to speak and understand language better. Because of this, it is challenging to interview a toddler and impossible to interview an infant. Instead, child welfare workers must rely on observations of the child, parent, family, home environment, and the context of the maltreatment. The assessment of young children requires the child welfare worker to pay attention to the physical, developmental, socio-emotional, and cognitive skills of the child, using observational rather than conversational means (Scannapieco & Connell-Carrick, 2002). The success of this depends on the workers' knowledge and skills and their opportunities to spend time with families and observe interactions and family functioning.

In addition to the attention needed to assess the development of the child and any current maltreatment, an assessment of the attachment relationship is necessary. Attachment theory has informed child maltreatment practice and research for the past two decades (Aber & Allen, 1987; Bolen, 1999; Brazelton, 1988; Carlson, Cicchetti, Barnett, & Braunwald, 1989; Cicchetti & Lynch, 1993; Egeland & Sroufe, 1981; Perry, 1994; 1996; Perry, Pollard, Blakley, Baker, & Vigilante, 1995), and is well established in the empirical literature. The quality of early caregiver–child interaction has crucial implications for child development (Beckwith, 1990; Belsky, Rovine, & Taylor, 1984; Brazelton, 1988; Carlson, 1998; Coates & Lewis, 1984; Erickson, Sroufe, & Egeland, 1985; Wachs & Green, 1982). In this article we will not attempt an exhaustive discussion of attachment theory, as that can be found elsewhere in the literature, but will provide an overview.

When working with infants and toddlers, an assessment of the attachment relationship can provide a foundation for evaluation of overall family functioning and the risk of child maltreatment. Attachment is the most important social relationship in an infant's life. It represents behaviors beginning at birth, and occurs naturally during the first three years of life, when the infant relies totally on the primary caregiver. In the context of this primary dependence, the caregiver's response to the dependence determines how the attachment relationship is established (Perry, 2000). To form and maintain quality attachment relationships, primary caregivers need to provide continuous, sensitive, and responsive care to the infant. In doing so, the primary caregiver establishes a quality bond with the infant.

The attachment relationship is hypothesized to be dyadic and reciprocal. The sensitive parent reacts to an infant's crying and learns to differentiate among the infant's various cries; for example, different rhythmical cries indicate hunger, anger, and pain. The infant, in turn, experiences the pleasant sensations of having its basic needs met and responds with smiles. This, in turn, is gratifying to the parent, increasing his or her attachment and increasing sensitivity to the child's needs (Bowlby, 1983). Child welfare workers can observe the attachment relationship within the home by paying special attention to the responsiveness of the caregiver and the response of the infant or toddler. Assessing attachment, however, requires a skilled worker with both knowledge of child development and ample time to spend with the family. Even in the best circumstances, assessing attachment is difficult; it is especially difficult when the assessment was initiated because of a risk of child maltreatment.

To adequately assess child maltreatment in infants and toddlers, the worker must investigate both attachment and child development, in addition to the indicators of child abuse and neglect (Scannapieco & Connell-Carrick, 2002). This inherently vulnerable age group—infants and toddlers—requires special attention, given its unique circumstances, increased risk of maltreatment (USDHHS, 2001), and increased risk of death (Margolin, 1990; Texas Department of Family and Protective Services [TDFPS], 1998).

Risk Management Units for Infants and Toddlers

Texas experienced an increase in the numbers of both child victims of maltreatment and child deaths due to maltreatment in 1998. In Texas alone, in 1998, 176 children died as a result of abuse or neglect, and 36% of these children had had prior contact with Child Protective Services (CPS) (TDFPS, 1998). Of these fatalities, 48% were due to neglect, and 44% were attributed to abuse. The victims of child fatality were the youngest and most vulnerable; children under the age of three were significantly overrepresented as fatality victims. Eighty-one percent of all Texas child-maltreatment-related fatalities in 1998 occurred to children under the age of five; 73% of victims were under the age of three; and 42% of victims were under the age of one (TDFPS, 1998). This represents a 61% increase in deaths of children under the age of three between 1997 and 1998; the number of child fatality victims under the age of one nearly doubled from 1997 to 1998.

Also during 1998, Judge F. Scott McCowan delivered a petition to the Texas legislature as a result of a 14-year analysis of the child welfare system in Texas (McCowan, 1998). The petition compared Texas trends to U.S. national trends and argued that children continued to be at risk of abuse and neglect as a result of an under-resourced system (McCowan, 1998). Specifically, the petition asserted, because CPS had too few resources, it classified too few calls as reports; it assigned too few investigations (of those classified as reports) and completed those investigations slowly; it confirmed too few cases when an investigation did take place; and, of the confirmed cases, it removed too few victims. In 1998, Texas consistently fell below the national rate of investigations, reports, and substantiations.

When one couples the fact that most children who experience fatal maltreatment are under the age of five (Margolin, 1990; TDFPS, 1998; USDHHS, 2001) with a child welfare system that is stressed by high turnover, large caseloads, and few resources, the need to establish a program targeting those most at risk becomes evident. In response to this, Dallas County

CPS responded by developing so-called high-risk units.

The Dallas Model

In 1999, in response to the increase in child deaths in the state of Texas, Dallas County, the second largest county in the state, developed three specialized, high-risk assessment units and two family-based safety services (family preservation) units to work with children from zero to four years of age. Focusing entirely on this age group within these special units, Dallas CPS's goal was to increase workers' ability to assess cases, determine risk, and to provide ongoing, family-based safety services for this vulnerable population.

In Texas, a statewide intake system is located in Austin, the state capital. All reports go through the state-run call center and are then sent directly to one of 11 regions. Reports to the three high-risk assessment units must meet the following criteria:

- The child is zero to four years of age and is the primary victim.
- The primary allegation is not an allegation of sexual abuse, abandonment, or a drug-exposed infant.

Given the previously discussed facts on the difficulty of assessing children aged zero to four, and given that 73% of all child deaths in Texas in 1998 occurred in children under the age of three (TDFPS, 1998), Dallas County CPS felt it was important to focus on this age group exclusively. The rationale behind excluding certain types of allegations is that the circumstances are either not life-threatening or are cause for automatic, immediate removal.

Each assessment unit has seven workers to one supervisor. The workers' caseloads are capped at 12 cases per month, a limit that is strictly adhered to by the supervisor. If the unit receives more cases than workers can handle, the cases are referred to other investigative units. This is in sharp contrast to other assessment units, where the caseloads are as high as 25 cases a month per worker.

Shared Decision-Making and Case Review

Central to the risk management model that Dallas established is the feature of shared decision making among the program director, supervisors, and workers. Although at first this may seem hierarchical, and adversarial from the worker perspective, the shared case review and decision-making are conducted in a collegial manner.

The model encompasses several key features. The first is the "staffing," a meeting held every morning, which lasts as long as it takes to review all cases that are ready for shared case review. Staffing occurs when the worker is ready to present a disposition or needs direction in completing an assessment. Second, the staffing team is made up of the program director, at least two risk management supervisors, the worker assigned to the case, and other workers in the units. Usually all supervisors are present for the staffing: three assessment supervisors and two family-based safety services supervisors.

Third, the team reviews every case assigned to a worker at least once and often twice. The worker must bring a social history on the children and photographs of the children to the staffing. If the team decides that more information is needed (e.g., collateral contacts, interview with another child), the worker must return to do another staffing on the family before any disposition of the case. At the conclusion of the staffing, a disposition decision is made. At least two supervisors must agree on the disposition; often the entire team comes to consensus.

In Texas, three basic types of dispositions may be made at the conclusion of an investigation: ruled out, unable to determine, and reason to believe. "Ruled out" and "unable to determine" basically describe unsubstantiated cases of maltreatment. The "reason to believe" category is where the substantiation cases fall. If the case is substantiated—the risk is determined to be high, and a parent is unable to protect—the child is removed to either foster care or kinship care. If the risk is found not to be significant enough for removal, the child may be assigned to a family-based safety unit. Additionally, if the disposition is "unable to determine" but significant risk is present, the family may be assigned to a family-based unit.

Family-Based Safety Services (FBSS) Units.

There are two family-based safety services units that have dedicated caseloads of families with children less than four years of age. In 1999, Texas changed the name of its family preservation program to "family-based safety services" to reflect its commitment to safety first for children.

The units have the following characteristics. As in the Dallas model, each unit has seven workers to one supervisor; caseloads are capped at six families per worker at any given time, and supervisors strictly observe this cap. FBSS supervisors are involved in each case before an assessment disposition and are also involved in the decision making regarding the disposition. An FBSS supervisor is always present at the group decision-making staffing if it looks as

though a case may require home-based services. If a case must be opened, an FBSS unit immediately gets the case. Within two days of the staffing and the FBSS unit's receipt of the case, the assessment worker and the FBSS worker make a joint visit to the family, based on the crisis intervention framework.

These specialized units draw on the expertise of several child welfare professionals by using a case-by-case focus. The collegial nature of the model allows open discussion concerning the assessment, with the ultimate goal being the protection, safety, and well-being of the child.

Profile of High-Risk Families and Children

A random sample of cases was obtained from the high-risk units from March 2000 to December 2000, and each family in the sample included at least one child age 0 to 47 months. Table 1 shows the profile of the 342 families included in the sample. Some information, however, was unknown or missing from the case records; therefore, some sample sizes vary as indicated.

Victim Characteristics

Four hundred and fifty-seven victims (N = 457) were identified, all of whom were between birth and 47 months of age. The mean age of the victim was 23 months. The majority of children were Black (34.3%), closely followed by White children (30.1%) and Hispanic children (27 %). The majority of victims were male (54%).

Parental Characteristics

Two hundred and sixty-nine (N = 269) mothers were identified; their mean age was 24.8 years. The range was 13 to 45 years. Similarly, 45 fathers were identified in the sample; their mean age was 28.0, slightly higher than the mothers' mean age. The range of paternal ages was 17 to 47 years. The majority of parents were single parents (54.2%). Dual-parent status included families in which another individual in the home acted as a co-parent or support for a parent, such as couples living together but not married, as well as married couples. Almost 46% of parents were identified as being in dual-parent status.

Home Characteristics

The average number of individuals living in each home was 4.35 persons, with a range of 2 to 11 adults and children. The mean number of children in a home was 2.1, ranging from 1 to 7 children in the home. Similarly, the average number of adults in each home was 2.2, ranging from 1 to 7. The overwhelming majority of families investigated by the high-risk unit were poor: almost 73% had incomes of $20,549 or below. Nonprofessionals, such as a family member, friend, or neighbor, reported the majority of families.

Table 1 Description of High-Risk Clients

Variable	Family Characteristics		
	Mean	*N*	*%*
Age			
Victim 0–47 months (months)	22.8	457	
Mother (years)	24.7	269	
Father (years)	28.0	45	
Ethnicity			
White		100	30.1
Hispanic		90	27.1
Black		114	34.3
Other		28	8.4
Gender of victim			
Male		266	53.6
Female		230	46.4

Number of children in the home	2.13		
Adults in the home	2.23		
Total individuals in the home	4.35		
Income			
0–$20,549		248	72.5
$20,550 +		94	27.5
Parenting status			
Single parent		162	54.2
Dual-parent household		137	45.8
Reporter			
Professional reporter		147	45.2
Nonprofessional reporter		178	54.8
Previous history of placement		34	10.1
Relative care		19	5.7
Foster care		15	4.5
Out-of-home care, location unknown		4	1.2
Previous history with CPS		153	45.8
Physical abuse		94	28.6
Neglectful supervision		66	20.1
Physical neglect		39	11.9
Medical neglect		21	6.4
Emotional abuse		12	3.7
Abandonment		4	1.2
Sexual abuse		36	10.5
Refusal to accept parental responsibility		2	.6

Previous Maltreatment and Placement

Approximately 10% of families had a previous history of out-of-home care, and almost 46% had previously been involved with CPS in Texas. Of those with a previous history of placement, the majority were in relative care, whether formal or informal, closely followed by foster care.

Data were available for 334 families regarding previous history of maltreatment; of those, almost 46% of families had previously been involved with CPS in Texas. For five families that had previously been involved with CPS, the specifics of the allegation and maltreatment were unknown. Thus, the specific types of maltreatment discussed below and presented in Table 1 are based on a sample of 329. The most frequently reported type of previous maltreatment was physical abuse ($N = 94$), representing 62% of those families with previous CPS history. The second most frequent type of previous maltreatment was neglectful supervision ($N = 66$), which represented 43% of families with previous history.

In sum, many families were seen by the high-risk unit, even though the victim had to be between the ages of 0 and 4 and have had significant contact with CPS, including out-of-home care and previous investigation. Families seen were large ($M = 4.35$) with incomes less than $20,549.

The uniqueness of the high-risk unit lies in the criteria under which cases are assigned to the unit, specifically age-specific and allegation-specific reports. It is also important to note that families are often the subject of reports of more than one type of alleged and investigated maltreatment. Table 2 details the allegations of the maltreatment, as well as the case determinations.

Table 2 Allegations and Determinations of Maltreatment

Allegation	N	% of sample	N substantiated	% substantiated
Physical abuse	216	88.9	44	20.4
Neglectful supervision	136	39.8	55	40.4
Physical neglect	121	35.4	38	31.4
Medical neglect	73	21.3	38	52.1
Emotional abuse	11	3.2	5	45.5
Abandonment	2	.6	1	50.0
Sexual abuse	16	1.8	3	18.8
Refusal to accept parental responsibility	2	.6	1	50.0

The three most frequently reported types of investigations were for physical abuse, neglectful supervision, and physical neglect, respectively. The overwhelming majority of cases investigated involved physical abuse ($N = 216$), which represented almost 89% of all allegations; 20% of these cases were substantiated. Although less frequently reported for families, neglectful supervision was substantiated more frequently (40%) than physical abuse. Similarly, physical neglect was also substantiated 32% of the time. Medical neglect was more likely to be substantiated than any other form of maltreatment (52%), and one could speculate that this is due to the increased support for case determination yielded by the collaborative effort of doctors, nurses, and CPS staffing. Both neglectful supervision and medical neglect were substantiated at higher rates than in other investigative units.

Lessons Learned

This discussion is based on interviews with the risk management team; observations made during participation in several group staffings, and review of case materials. Lessons learned address case process, supervision, transfer of cases, and outcomes.

Case Process

It became clear that many of the lessons fall within a scheme similar to that presented by Munro (1999): that is, they involved errors in reasoning by workers and team correction of those errors before case disposition. Munro (1999) presents six common errors in reasoning, four of which are applicable and will be used as a framework for discussion.

1. Staff assessment of risk is based on a narrow range of evidence.
    - Initially workers brought incomplete information to the team staffings. Some examples: workers often would not make critical contacts with other family members and collateral contacts. This resulted in a

limited picture of the family. The staffing addressed this error by requiring workers to collect additional information and then return to another staffing before a disposition was made on the case. Another advantage to the group decision-making staffing is that it serves as an ongoing mechanism to assure quality assessments, an important point given the personnel turnover rates in CPS.

2. Evidence was often faulty due to a lack of communication among professionals in various agencies.

    - Given the ages of the children involved, the professionals predominantly involved with the cases were medical and law enforcement personnel. The more senior members of the team were able to give direction to the workers concerning follow-up questions to be addressed with the doctors involved in each case. An example of this was the case of a failure-to-thrive child. The worker had received information about lack of weight gain, but was unable to apply this information to a determination of risk. The supervisors suggested that the worker ask additional questions concerning organic or non-organic causes of the lack of weight gain. Another example of this reasoning error was that workers did not talk directly with the law enforcement officers who reported the incidents. Without this firsthand information, workers often erred in favor of an unsubstantiated disposition. In the team decision-making process, this was pointed out and workers were asked to make contact with the primary officer, thus giving them additional valuable information.

The third and fourth errors of reasoning are grouped together, because of their similarity.

3. Past information was overlooked.

4. Written information was less likely to be noticed than oral information.

    - Although it is agency policy that workers review any history the family may have with CPS, workers often made only minimal efforts to do so, especially when a prior investigation was unsubstantiated. This is also due to a lack of agency resources for assisting workers in the search for records. Workers are required to bring a social history to the staffing, where the program director or supervisors would delve deeper into prior history than the worker. Additionally, the team would review any written material that was available on the case. Often additional risk concerns would be uncovered.

With all four of these common errors, the group decision-making staffing reduced the chances of poor reasoning. The complexities of making judgments on any CPS case are overwhelming at best, and the complexity is exacerbated when the cases involve clients who are the most difficult to assess: children zero to four years of age. Team decision making brought expertise to the cases, and tenure enhanced the quality of the decisions as well as the consistency in the case process.

Supervision

The Dallas model is based on cooperative supervision in respect to decisions concerning risk, safety, and disposition outcome. Because the team staffs every case and the agreement of at least two supervisors is required for any decision, the burden is reduced for any given supervisor. Society places an awesome responsibility on CPS, and when models are developed that share responsibility as well as providing quality case decision making, we should take notice.

The Dallas experience exemplifies the benefits of cooperative supervision. Shared case conferencing improves the quality and consistency the supervisor provides to a worker. Supervisors also gain additional support and reinforcement from their peers on a daily basis concerning their case decisions.

Another lesson learned is that group decision-making is an invaluable means of training supervisors. More senior supervisors, as well as the program director, act as role models for the newer supervisors and serve as a resource of knowledge and skill that cannot be duplicated in any training arena. The benefit for workers who participate is also obvious.

Transfer of Cases

When it is determined that there is a high degree of risk for reoccurrence of maltreatment, the child is to remain with the family, and the family has agreed to accept services, the case is transferred to the FBSS unit. The inclusion of an FBSS supervisor at the group decision-making staffing and the immediate transfer of the case to the FBSS unit, along with a joint visit within two days (as previously described), are what set this model apart.

This process allows families and children to receive services immediately during a critical time of change. The continuity provided by this model has reduced the amount of resistance families show toward CPS, which means that a more positive movement can be made toward resolving the challenges the family faces.

The FBSS units adhere to the rule of dedicated caseloads of no more than six families. FBSS workers thus have the time required to work with the caregivers and children and provide the needed concrete and social services. Workers develop positive attitudes toward their work, a result that also may reduce the amount of turnover in these units, not only in workers but in supervisors as well.

Outcomes of Shared Case Review and Decision Making

A systematic study is currently underway on this program (Scannapieco & Connell-Carrick, 2002), but the results are not yet available. The outcomes discussed here are impressions and observations from members of the decision-making team, participants, and case reviews. Previous findings were discussed in earlier sections. The following are additional outcomes:

- Workers were confident about the results of family risk and safety assessments.
- Case disposition decisions were consistent across worker, supervisor, and unit.
- Supporting documentation was thorough and consistent across cases.
- Workers and supervisors felt confident in their decisions to remove children from their homes or keep children with their families.
- Workers and supervisors felt supported in their decisions.

Overall, the approach to assessing families used in the high-risk unit model appears to be promising, pending empirical validation. Several components of the unit setup contribute to its potential, including capped caseloads, case staffing, team decision making, and coordination of services within the high-risk units.

Case staffing and a team approach to decision making can help correct errors in reasoning prior to case disposition (Munro, 1999). This is especially important when working with children aged zero to four, who are at increased risk for death (Margolin, 1990; USDHHS, 2001) and delays in reaching developmental milestones (Scannapieco & Connell-Carrick, 2002). The construction of the high-risk unit addresses several reasoning errors. First, it overcomes the error of a narrow range of evidence by mandating contacts with collaterals, family members, and professionals, to be presented at case staffing. Even the newest of workers benefits from the amount of information expected to be presented at case staffing by expanding the scope of contacts. Second, the high-risk philosophy directs workers to utilize other community professionals, such as doctors, law enforcement personnel, and child development professionals, to obtain a comprehensive picture both of the child and the family as a whole. Third (again necessary for case staffing), workers are expected to thoroughly explore families' histories with CPS in the case records, a step that otherwise is often overlooked and can lead to errors in case decisions (Munro, 1999). Although technological advances have made the process of exploring a family's history easier, the technology is still far from perfect, and often the worker must spend quite a lot of time doing computer searches. For example, families change their names; also, separate reports concerning a single family are not merged or linked. These factors mean that caseworker access to necessary information of past maltreatment is not always easy or reliable. In short, the evidence shows that the high-risk unit addresses many reasoning errors, which in turn results in reliable and sound decision making.

Although empirical outcomes from the unit are still pending, the effects of the high-risk units are already apparent. One obvious benefit of the high-risk unit is that caseworkers are assisted by more senior, experienced supervisors and are supported by a group decision-making model. Given the importance of early childhood for future development, the decision to substantiate maltreatment, as well as to remove a child when necessary, is momentous and difficult. A team approach ensures that all relevant information is explored and culminates in a well-informed and thoughtful decision that seeks to promote safety and healthy child development.

Conclusion

The increased child death rate in Texas in 1998 called for immediate action. Dallas County responded by establishing a high-risk unit that investigates life-threatening forms of maltreatment and serves children between zero and four years of age. The focus on children zero to four years was warranted by the alarming number of children in this age group who died. Abuse and neglect can be identified when they exist, because workers have capped caseloads, the ability to spend ample time with families of young alleged victims, and staffings with a team of experts. Timely case decisions avert the long-term, adverse

consequences of maltreatment on child development, and allow immediate support and assistance to be provided to the family. Once a child who has been living in an impoverished environment or has been physically abused for several years reaches school age, the consequences for the child's cognitive, social, and physical development are already apparent. Early assessment can positively alter the course of the child's early years.

An adequate assessment of maltreatment in children zero to four years of age is difficult and requires both skill and expertise. More senior individuals in service agencies often move into administrative positions after years of front-line work, and sometimes their expertise does not get translated to or tapped by the front-line staff in times of crisis. The high-risk unit was developed as a way to incorporate the experience and expertise of tenured CPS staff to improve the client service by CPS. Such experience is translated to staff through daily staffing of every case theyt investigate and serve, and the impact manifests in informed and educated decision making regarding the most vulnerable victims of all: children zero to four years of age.

References

Aber, J. L., and Allen, J. P. (1987). Effects of maltreatment on young children's socioemotional development: An attachment theory perspective. *Developmental Psychology, 23*, 406-414.

Beckwith, L. (1990). Adaptive and maladaptive parenting: Implications for intervention. In S. Meisels and J. Shonkoff (Eds)., *Handbook of early childhood interventions* (pp. 53-77). New York: Cambridge University Press.

Belsky, J., Rovine, M., and Taylor, D. G. (1984). The Pennsylvania infant and family development project, III: The origins of individual differences in infant-mother attachment: Maternal and infant contributions. *Child Development, 55*, 718-728.

Bolen, B. (1999). Development of an ecological/ transactional model of sexual abuse victimization and analysis of its nomological classification system. Doctoral dissertation, The University of Texas at Arlington.

Bowlby, J. (1983). Attachment and loss: Retrospect and prospect. *Annual Progress in Child Psychiatry and Child Development,* 52(4), 29-47.

Brazelton, T. D. (1988). Importance of early intervention. In E. Hibbs (Ed.), *Children and families: Studies in prevention and interventions* (pp. 107-120). Madison, CT: International Universities Press.

Carlson, E. (1998). A prospective longitudinal study of attachment disorganization/disorientation. *Child Development, 69*, 1107-1128.

Carlson, V., Cicchetti, D., Barnett, D., and Braunwald, K. G. (1989). Finding order in disorganization: Lessons from research on maltreated infants; attachments to their caregivers. In D. Cicchetti and V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 432-463). Cambridge, MA: Cambridge University Press.

Cicchetti, D., and Lynch, M. (1993). Toward an ecological/transactional model of community violence and child maltreatment. *Psychiatry, 56*, 96-118.

Coates, D., and Lewis, M. (1984). Early mother-infant interaction and infant cognitive predictors of school performance and cognitive behavior in six year olds. *Child Development, 55*, 1219-1230.

Egeland, B., and Sroufe, L. (1981). Developmental sequalae of maltreatment in infancy. *New Directions for Child Development, 11*, 77-92.

Erickson, M., Sroufe, A., and Egeland, B. (1985). The relationship between quality of attachment and behavior problems in preschool in a high-risk sample. In I. Bretherton and E. Waters (Eds.), *Growing points of attachment theory and research, Monographs of the Society for Research in Child Development, 50*, 147-166.

Levine, M., Compaan, C., and Freeman, J. (1995). Maltreatment-related fatalities: Issues of policy and prevention. *Law & Policy, 16*, 449-471.

Margolin, L. (1990). Fatal child neglect. *Child Welfare, 69*(4), 309-319.

McClain, P. W., Sacks, J. J., Froehlke, R. G., and Ewigman, B. G. (1993). Estimates of fatal child abuse and neglect, United States, 1979 through 1988. *Pediatrics, 91*(2), 338-343.

McCowan, F. S. (1998). A petition in behalf of the forsaken children of Texas to the Governor and the 76th Legislature. Retrieved January, 2004 from http://www.co.travis.tx.us/petition.

Munro, E. (1999). Common errors of reasoning in child protection work. *Child Abuse & Neglect, 23*(8), 745-758.

Perry, B. (2000). *The early years last forever: The importance of brain development*. Lecture materials. Corpus Christi, TX. See http://www.childtrauma.org for more information.

Perry, B. D. (1996). Incubated in terror: Neurodevelopmental factors in the "cycle of violence." In J. D. Osofsky (Ed.), *Children, youth and violence: Searching for solutions*. New York: Guilford Press.

Perry, B. D. (1994). Neurobiological sequelae of childhood trauma: PSTD in children. In M. M. Murburg (Ed.), *Catecholamine function in posttraumatic stress disorder: Emerging concepts* (pp. 233-255). Washington, DC: American Psychiatric Press.

Perry, B. D., Pollard, R. A., Blakley, T. L., Baker, W. L., and Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: How "states" become "traits." *Infant Mental Health Journal, 16*, 271-291.

Scannapieco, M., and Connell-Carrick, K. (2002). Focus on the first years: An eco-developmental assessment of child neglect for children zero to three years of age. *Children and Youth Services Review, 24*(8), 601-621. (This is the reference I located, is it correct?)

Sedlak, A., and Broadhurst, D. (1996). *The third national incidence study of child abuse and neglect (NIS-3)*. Washington, DC: U.S. Department of Health and Human Services.

Texas Department of Family and Protective Services [TDFPS]. (1998). *Child abuse and neglect deaths in Texas and the nation*. Retrieved January, 2004 from www.TDFPS.state.tx.us/psfc/chldstdy.pdf.

U.S. Department of Health & Human Services [USDHHS], Administration on Children, Youth and Families. (2001). Child maltreatment 1999: Reports from the states to the national child abuse and neglect data systems. Washington, DC: Government Printing Office.Wachs, T. D. and Green, G. E. (1982). *Early experience and human development.* New York: Plenum.

Dr. Maria Scannapieco, Ph.D., M.S.W., is Professor at the School of Social Work, University of Texas at Arlington and Director of the Center for Child Welfare. Dr. Scannapieco has been the Director of the Center for Child Welfare for nine years and is the principal investigator of two federally funded grants, renewed annually, estimated at 3.7 million dollars. Dr. Maria Scannapieco has worked in the public child welfare arena for over 25 years with direct child protection experience as well as foster care administrative experience. Since coming into academia, Maria Scannapieco has continued her commitment to the child welfare field in both teaching and scholarship. Dr. Scannapieco has over 100 publications and presentations competitively selected many in the areas of child maltreatment, out-of-home placement, independent living programs, and training and retention of child welfare workers. She has been published in such professional journals as *Child Welfare, Social Service Review, Children and Youth Services Review*, and *Social Work*. Dr. Maria Scannapieco has authored two books with Oxford University Press, *Kinship Foster Care: Practice, Policy, & Research (1999)* (with Rebecca L. Hegar) and *Understanding Child Maltreatment: An Ecological and Developmental Perspective (2005*) (with Kelli Connell-Carrick).

Dr. Kelli Connell-Carrick, Ph.D, L.M.S.W. is an Assistant Professor at the University of Houston, Graduate School of Social Work. She has worked in the child welfare arena with administrative and direct practice experience, and has continued her dedication to child welfare in academia in both teaching and scholarship. She has over 40 competitively selected publications and presentations. She has published in the areas of child maltreatment, neglect of infants and toddlers, and professional development of child welfare staff, and in journals such as *Child Welfare, Child and Adolescent Social Work,* and *The Journal of Interpersonal Violence*. Dr. Connell-Carrick has also co-authored a book with Dr. Maria Scannapieco titled *Understanding Child Maltreatment: An Ecological and Developmental Perspective,* published by Oxford University Press in 2005.