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CHILD WELFARE PERFORMANCE POINTERS

Preventing the Recurrence of Maltreatment

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In the context of the federal child welfare performance measurement system, recurrence of maltreatment refers to circumstances in which children that have previously been substantiated as victims of abuse or neglect experience another incident of substantiated maltreatment. Multiple episodes of maltreatment can lead to: (1) more serious short and long term negative consequences, (2) entry into the juvenile justice system, and (3) juvenile delinquency. In this literature review the authors summarize the research on child, family, and systemic factors related to maltreatment recurrence and promising practices for improving performance. Promising practices aimed at preventing recurrence of maltreatment include interventions at multiple levels (e.g., the child, caregiver, family, and agency) and include a range of service modalities.

Keywords: Child welfare, maltreatment, recurrence, outcome, policy

INTRODUCTION TO RECURRENCE

In the context of the federal child welfare performance measurement system, *recurrence of maltreatment* refers to circumstances in which children that have previously been substantiated as victims of abuse or neglect experience another incident of substantiated maltreatment. Maltreatment recurrence relates directly to the outcome goal of child safety, one of the three federal priorities for the child welfare system, along with permanency and well-being.

The frequency of recurrence of maltreatment varies widely depending on the time from initial incident, the population studied, and the number of recurrences measured. Recurrence has multiple and significant negative effects on child victims of maltreatment. In searching for correlates of early childhood experiences of maltreatment, Wiggins, Fenichel, and Mann (2007) identified

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health problems, developmental delays, cognitive disturbances, social-emotional problems, and psychopathology. Multiple episodes of maltreatment can lead to: (1) more serious short and long-term negative consequences (DePanfilis & Zuravin, 1999b), (2) entry into the juvenile justice system (Jonson-Reid & Barth, 2000), and (3) juvenile delinquency (Lemon, 2006). In addition, recurrence of maltreatment may result from ineffective child protective services, raising questions about agency performance related to ensuring child safety (Fluke, Shusterman, Hollinshead, & Yuan, 2008). The recurrence of maltreatment also adds a significant burden to agency caseloads (Bae, Solomon, & Gelles, 2009).

As Bae, Solomon, and Gelles (2009) note, there are at least four possible ways to categorize recurrence, based on victim/perpetrator relationships: (1) recurrence involving one child and one perpetrator, (2) recurrence involving multiple children by one perpetrator, (3) recurrence involving one child by more than one perpetrator, and (4) recurrence involving multiple children by more than one perpetrator. The designation of recurrence is further complicated by the time frame used for determining when a maltreatment episode constitutes recurrence.

RECURRENCE OF MALTREATMENT MEASURE

In this literature review the authors include the research on child, family, and systemic factors related to maltreatment recurrence and the promising practices for improving performance. In the federal Child and Family Service Review (CFSR) process, recurrence of maltreatment is a measure under the broad outcome goal of child safety and is a stand-alone measure defined as follows:

Measure SI.1: Of all children who were victims of substantiated or indicated abuse or neglect during the first 6 months of the reporting year, what percent did not experience another incident of substantiated or indicated abuse or neglect within a 6-month period?

This definition of recurrence focuses on the recurrent maltreatment of child victims by any perpetrator (i.e., the definition does not limit recurrence to abuse by the same perpetrator as the previous case) and restricts the definition of recurrence to substantiated episodes that occur within 6–12 months following the initial episode. It is important to note that abuse and neglect reports that are referred for alternative/differential response are not reported as incidences of abuse and not counted in this measure because they are not officially recorded as incidents of maltreatment (U.S. DHHS-ACF, 2007).

The current method of measuring the *absence* of recurrent maltreatment represents a change from the previous measure of recurrence utilized in Round 1 of the CFSR, where the measure focused on the *recurrence* of maltreatment (U.S. DHHS-ACF, 2007). According to the U.S. DHHS-ACF (2007), this change was made to match the positive perspective used in all the other CFSR measures in which higher scores indicate better performance.

FACTORS ASSOCIATED WITH RECURRENCE OF MALTREATMENT

In attempting to find ways to prevent and/or intervene in situations in which recurrence is likely to occur, there are a series of risk factors associated with recurrence of maltreatment that need to be taken into account in order to develop appropriate case plans and service goals (Connell et al., 2009; DePanfilis & Zuravin, 1999a; Fluke et al., 2008; Fuller, Wells, & Cotton, 2001). These include characteristics related to the child, the caregiver or family, and the service system. It is important to recognize however, that the presence of risk factors does not conclusively indicate that maltreatment will occur.

Child Characteristics

The recurrence of maltreatment risk factors related to the child include the child's age, special needs, ethnicity, and gender.

Age and special needs. Children who experience a recurrence of maltreatment tend to be young (under the age of six), with younger children at greater risk for multiple recurrences as well (Bae et al., 2009; Connell et al., 2009; Drake, Jonson-Reid, & Sapokaite, 2006; Fluke, Shusterman, Hollinshead, & Yuan, 2005; Lipien & Forthofer, 2004). A greater risk for recurrence of maltreatment has been found for children with a range of special needs, including behavior problems, mental health issues, disability/health problems, substance abuse, special education involvement, and development delays (DePanfilis & Zuravin, 1999a; Drake et al., 2006; Marshall & English, 1999).

Ethnicity. Although ethnicity has been studied as a predictor of recurrence, results are mixed. In some studies researchers have found that a child identified as Caucasian/White is at a higher risk for recurrence (Drake et al., 2006; Lipien & Forthofer, 2004), while in other studies they found no difference across a range of socio-demographic variables for predicting recurrence of maltreatment (Drake, Jonson-Reid, Way, & Chung, 2003; Fuller et al., 2001). Lipien and Forthofer (2004) explain that this could be due to the way race was operationalized in the study, differences among racial groups in severity and type of maltreatment, cultural bias/competence of the reporter, or other factors that may differ across racial/ethnic groups (Ards, Chung, & Meyers, 1998; Terao, Borrego, & Urquiza, 2001).

Gender. Gender has been identified as a potential risk factor, but findings are also mixed. Some studies have found that females experience recurrence less frequently (Bae et al., 2009; Drake et al., 2006), while others have found that females experience recurrence of maltreatment more frequently (Rittner, 2002) or have found no difference in frequency of recurrence (Lipien & Fothofer, 2004). Jonson-Reid, Drake, Chung, and Way (2003) found that females are at a higher risk for recurrence of sexual abuse.

Caregiver/Family Characteristics

Mental health and substance abuse. The most commonly identified risk factors among caregivers are mental health issues, alcohol, and substance abuse. For families involved with other public services (mental health, substance abuse, Medicaid, TANF), the risk of re-reporting to child welfare services goes up (Drake et al., 2006). Caregivers present a greater risk of recurrence when there are mental health problems (Rittner, 2002), a large number of problems (drugs, mental health, domestic violence, and/or unemployment: Fuller et al., 2001), a previous history of mental health/substance abuse treatment (Drake et al., 2006), or abuse of alcohol and other substances (Fluke et al., 2005; Fuller & Wells, 2003; Wolock & Magura, 1996). Fuller & Wells (2003) find that among alcohol and substance abusing caregivers, risk of recurrence increases where there is criminal behavior, no police involvement during the investigation, and in households headed by single African American females. Additional risk factors associated with caregivers include those who were: young at the birth of their first child (less than 19 years-of-age; Drake et al., 2006); have been victims of abuse (Marshall & English, 1999; Rittner, 2002); were foster children themselves; and did not complete high school (Drake et al., 2006)

Income level and family composition. Poverty and low income have been repeatedly associated with recurrence of abuse in families (Drake et al., 2006; Wolock & Magura, 1996). Some characteristics associated with poverty are also associated with a higher rate of re-abuse, such as lower levels of social support, higher levels of family stress, and the existence of partner abuse (DePanfilis & Zuravin, 1999a). Family size and composition are also relevant factors. Families with more children (three or more) and single parents living alone with their children are at higher risk for recurrence of maltreatment (Bae et al., 2009; Drake et al., 2006). Families with a child in the home under the age of two have been associated with an elevated risk of re-abuse (Fuller et al., 2001). Single parents, large families, and families with stepparents are also at higher risk for multiple recurrences (Bae et al., 2009). Finally, Marshall and English (1999) found that the presence of multiple victims in a family was also associated with risk of re-abuse.

Case/Service Characteristics

Case factors. One of the most well-documented risks for recurrence of maltreatment is the type of initial maltreatment. Risk for recurrence is highest for neglect cases, followed by physical abuse and sexual abuse (Connell et al., 2009; Drake et al., 2006; Fluke et al., 2005; Fuller et al., 2001; Lipien & Forthofer, 2004; Marshall & English, 1999). This holds true for multiple episodes of maltreatment as well (Bae et al., 2009). Not surprisingly, a greater number of previously indicated reports of maltreatment on the perpetrator have been found to raise the risk of recurrence of maltreatment (Fuller et al., 2001; Marshall & English, 1999). Cases in which the parent was identified as the perpetrator of abuse have a higher likelihood of recurrence than cases in which another person was the perpetrator, and multiple victims at initial report also raise the risk of recurrence (Drake et al., 2006; Fuller et al., 2001).

Children who have a prior history of substantiated maltreatment may be at greater risk for recurrence of maltreatment (Fluke et al., 2008; Fuller & Nieto, 2009). For children who return home from foster care placements, particularly those who were placed in non-relative foster care, the risk of re-abuse is higher (Connell et al., 2009). Another important factor in assessing risk of maltreatment relates to the period of time after an incident of maltreatment is reported. Most studies have confirmed that the highest risk for recurrence is within 6 months of the initial report and as time progresses, the risk decreases (Fluke et al., 2005; Fuller & Wells, 2003; Lipien & Forthofer, 2004). For families with multiple recurrences, the time to first recurrence following reunification and the time between recurrences can be significantly shorter (Bae et al., 2009).

Service supports. In studies that examine the relationship between receipt of services and risk of recurrence researchers have produced complex and contradictory findings. Fuller et al. (2001) found that receipt of services for intact families during the first 60 days after the report lowered the risk of maltreatment compared to families that did not receive any services. Similarly, DePanfilis & Zuravin (1999b) found that of the 42.6% of families who had a recurrence during a five-year period, only a quarter of them experienced an incident of recurrence during service provision. Bae et al., (2009) found that families with a less intense relationship with CPS (contacted less frequently, low intensity investigation, and lower intensity service disposition) were more likely to re-abuse.

In contrast, some researchers have found that the receipt of services is associated with a higher risk for recurrence of maltreatment (Drake et al., 2006; Fluke et al., 2008; Lipien & Forthofer, 2004). For example, Drake et al. (2006) found that families involved in Family Preservation services were more likely to have substantiated recidivism than those receiving traditional "family centered services." They also found that families receiving the lowest intensity services had lower recurrence rates than families receiving either no services or higher intensity services.

Several explanations for these findings have been proposed, including service ineffectiveness, closer monitoring of families receiving services, and higher risk for families referred for services (Fluke et al., 1999; Lipien & Forthofer, 2004).

PROMISING PRACTICES TO PREVENT RECURRENCE OF MALTREATMENT

Promising practices aimed at preventing recurrence of maltreatment include interventions at multiple levels (e.g., the child, caregiver, family, and agency) and include a range of service modalities. It is important to note that there is very little experimental research evaluating specific prevention strategies. The practices described here have different levels of support regarding effectiveness, as the research evidence does not conclusively identify one particular strategy or set of strategies that are proven to prevent recurrence. A lack of evidence does not necessarily mean that the practice does not have an impact on recurrence stability or other outcomes, but rather that potential impact cannot be determined with the evidence available.

Risk Assessment: Structured Decision Making

While child welfare workers bring experience, compassion, and expertise to bear when exercising their judgment, their assessment of risk may be inaccurate (Dorsey, Mustillo, Farmer, & Elbogen, 2008), and decisions may vary greatly from worker to worker (Rossi, Sheurman, & Budde, 1996; Rossi, Sheurman, & Budde, 1999). The lack of structured support systems for decision making has led to an uneven service delivery system and sometimes less than optimal decisions for children and their families (Baird & Wagner, 2000). Risk assessment systems provide tools to formalize and structure the decision-making process when assessing “child’s safety, the risk of future maltreatment, parental protective capacity, and child well-being” (Baird & Wagner, 2000; CEBC, 2009b).

There are generally two types of risk assessment, consensus-based and actuarial (Shlonsky & Wagner, 2005; Baird & Wagner, 2000). Consensus-based risk assessments are based on practice experience and empirical evidence, but have not been validated empirically (Shlonsky & Wagner, 2005). Actuarial risk assessments are developed and validated by studying the outcomes of the risk assessments (Shlonsky & Wagner, 2005; Baird & Wagner, 2000). Actuarial risk assessment is not designed to replace clinical judgment, but to be a tool used in conjunction with the professional judgment of a child welfare worker (Shlonsky & Wagner, 2005). A list of risk assessments currently used in child welfare practice can be found at <http://www.cachildwelfareclearinghouse.org/assmt-intro>.

Structured Decision Making (SDM) is a risk assessment system that has been implemented in multiple states to determine how best to serve children and families in contact with the child welfare system (Baird & Wagner, 2000; California Department of Social Services, 2002b; Johnson, 2004). SDM is a tool that combines actuarial risk assessment and clinical judgment (Shlonsky & Wagner, 2005) and uses a set of definitions to standardize the decision-making process (Johnson, 2004). The California SDM model addresses several goals, including the reduction of subsequent neglect/abuse complaints and substantiations (California Department of Social Services, 2002b). The California SDM tool is comprised of a series of tools that are used at seven different stages in a Child Welfare case: (1) Response, (2) Safety Assessment, (3) Risk Assessment, (4) Family Strengths and Needs Assessment, (5) Contact Guidelines, (6) Reassessment Risks/Needs, and (7) Reunification Assessment. (California Department of Social Services, 2002b). Separate response tools are used for cases of neglect, physical abuse, sexual abuse, and emotional abuse (California

Department of Social Services, 2002b). Within this series, the Risk Assessment Tool is an actuarial assessment used to identify risk and determine intensity of services (Johnson, 2004).

Effectiveness. In a study conducted by Johnson (2004) to assess the validity of the Risk Assessment Tool used in California's SDM model, the tool was found to be valid in predicting future recurrence of maltreatment. According to Johnson (2004), the risk assessment tool used to determine future risk of maltreatment is the most valuable tool the California SDM has to offer. The Michigan Actuarial Risk Assessment tool was compared to other consensus-based risk assessments and found to outperform the other tools in new investigations and substantiations (Baird & Wagner, 2000).

Differential Response

Differential response aims to provide "a broader set of responses to reports of possible child abuse or neglect ... engaging families to address issues of safety or risk" (Casey Family Programs, 2007, p. i). It is designed to provide a more flexible and individualized strength-based approach to serving families by: (1) using multiple pathways to services; (2) avoiding unnecessary adversarial relationships (Kaplan & Merkel-Holguin, 2008); (3) collaborating with community agencies (Casey Family Programs, 2007); and (4) engaging parents in services (Schene, 2008; Casey Family Programs, 2007).

A basic characteristic of differential response is the "track" system. A "two track" system is comprised of an investigation track (traditional response) for more severe cases and an assessment track (alternative response) to identify family strengths and needs for low and moderate risk cases (Schene, 2008). A multi-track system (three or more tracks) may have the two tracks listed above, in addition to a "prevention" track for families with no evidence of abuse, but at high risk (U.S. DHHS, 2008). California's *Another Road to Safety Program* is an example of a three track system (Conley, 2007). Criteria for determining which track a family enters can differ (Kaplan & Merkel-Holguin, 2008).

In conjunction with the California Department of Social Services (CDSS, 2007a), the Break-through Series Collaborative and Casey Family programs conducted a program to develop and implement differential response in California. This model requires that counties implement the following three core elements simultaneously to successfully utilize the differential response approach: broader response, family engagement, and community partnership. The broader response involves developing three tracks or "paths": (1) community response; (2) community and child welfare services response; and (3) child welfare services response (CDSS, 2007a). Promising practices that are being used to implement broader response include:

- Tools to support path assignments (e.g., enhanced screening tools).
- Teams to conduct joint path assignments (e.g., team decision-making meetings).
- Partnerships to assess families (e.g., partnerships with family resource centers to develop an assessment tool).

Family engagement involves multiple paths to actively engage families in case planning and in designing the system of care itself (CDSS, 2007a). Promising practices that are being used to implement family engagement include:

- Respectfully engaging families early in the process (e.g., the practice of changing the terminology used with families and agencies, such as changing "investigation" to "safety assessment," or the practice of sending a letter prior to initial contact).

- Using partners to engage birth families (e.g., using a Parent Partner on the initial visit or community specialists).
- Including families in all aspects of decision making (e.g., Team Decision Making).

Community partnerships offer a way for families to receive services within their community and child welfare agencies to develop more culturally appropriate services for families in need (CDSS, 2007a). Promising practices for implementing community partnerships include:

- Building professional relationships between partners and the child welfare agency (e.g., use of outstationing social workers to co-locate child welfare staff and community partners).
- Creating effective strategies for information sharing (e.g., use of a Universal Release form).
- Jointly assessing the community's needs (e.g., the use of a Resource Specialist Team to identify community resources (CDSS, 2007a).

An alternative differential response model implemented in California is Another Road to Safety (ARS; Conley & Duerr Berrick, 2008). Highly trained paraprofessionals are employed to provide intensive home visiting services through neighborhood agencies for families who are not high risk and reside in the neighborhood (Conley, 2007; Conley & Duerr Berrick, 2008). If a family accepts services, the home visitor (with a caseload of between 7–13 families) provides weekly services for up to nine months based on developing a trusting therapeutic relationship built between the worker and the family (Conley, 2007; Conley & Duerr Berrick, 2008). The home visitor conducts an assessment of the family, develops a care plan, and may refer the family for services or provide limited funds to cover basic expenses related to preventing stressful situations from leading to another incident of maltreatment (Conley, 2007).

Effectiveness. In California, differential response has been identified as an important tool to address recurrence of maltreatment by providing services to more families and reducing the rate of recurrence of maltreatment by 1.9% (CDSS, 2007a). In a study of differential response services in Minnesota, children receiving differential response services were found to be slightly less likely to have subsequent reports of maltreatment (Loman & Siegel, 2005). In contrast, a study by Ortiz, Shusterman, and Fluke (2008) utilizing NCANDS data found that children who received differential response services were just as likely to come into contact with the child welfare system through a re-report as children who received investigation services.

Implementation. Differential response is an approach that requires system-wide implementation to make the transition from traditional to differential response: (1) belief in the intrinsic value of family voice; (2) belief that community partnership is the most effective way to protect children; and (3) committed leadership willing to take risks (CDSS, 2007a).

Family Group Decision Making

Family group decision making (FGDM) is a group-based decision-making model in child welfare designed for families in which a child is in danger or at risk of out of home placement (Berzin, Cohen, Thomas, & Dawson, 2008; California Evidence-Based Clearinghouse [CEBC], 2009b). It involves a discussion that includes an interdisciplinary team and a family regarding the reasons the child is in danger, identifies the strengths already existing in the family, and specifies the steps needed to ensure child safety (Berzin et al., 2008). FGDM allows the family to lead the decision-making process about the care of their children with respect to out of home placement as well as other matters (CEBC, 2009b).

Effectiveness. Previous studies have shown that FGDM assists in decreasing maltreatment events as well as reports of abuse and neglect (Gundersen, Cahn, & Wirth, 2003; Pennell & Burford, 2000). In addition, families participating in FGDM can experience high levels of satisfaction (Litchfield, Gatowski, & Dobbin, 2003). More recently however, the effectiveness of FGDM has been called into question by several studies. A recently published randomized control trial indicates that FGDM is no more effective than usual treatment in improving outcomes related to child safety, placement stability, and permanence (Berzin et al., 2008) and another randomized control trial indicates there is no evidence that the intervention has an effect on service utilization (number of client–worker contacts, prescribed services, and case closures; Lorentzen, 2008). It has been suggested that some components of FGDM are not consistently implemented and that this may lead to difficulties in achieving the desired outcomes (Berzin, Thomas, & Cohen, 2007). These results indicate the need for more research, especially related to the timing and prospects for success.

Implementation. The four main components involved in FGDM include: (1) referral, (2) preparation and planning, (3) the FGDM meeting, and (4) follow-up planning and events (Merkel-Holguin, 1996). In order to implement these components, the following elements are involved: (1) independent non-case carrying coordinators; (2) private family time where the family group meets independent of service providers to develop a plan; and (3) an agreement by the public agency to carry out the plan and provide necessary resources (American Humane Association, 2010; CEBC, 2009a).

The resources to implement the program include staff time, meeting place, food/materials, and funds to ensure plans can be implemented (CEBC, 2009a). More information about FGDM training and implementation can also be found at the American Humane Association, <http://www.americanhumane.org/protecting-children/programs/family-group-decision-making/>.

Respite and Crisis Care

The Child Abuse Prevention and Treatment Act, as amended by the Keeping Children and Families Safe Act of 2003, defines respite care services as:

[S]hort term care services provided in the temporary absence of the regular caregiver (parent, other relative, foster parent, adoptive parent, or guardian) to children who—(A) are in danger of abuse or neglect; (B) have experienced abuse or neglect; or (C) have disabilities, chronic, or terminal illnesses. Such services shall be provided within or outside the home of the child, be short-term care (ranging from a few hours to a few weeks of time, per year), and be intended to enable the family to stay together and to keep the child living in the home and community of the child. (U.S. DHHS, 2003, pp. 58–59)

Most respite care services view the family in an ecological context, and are therefore incorporated within an array of family support services designed to support families at risk or already cited for child maltreatment (ARCH, 2007; FRIENDS, 2006; Jerve, 2008). The family-centered service model may include counseling (individual and group), substance abuse treatment, case management, parenting classes, and more (Cowen, 1998; FRIENDS, 2006; Jerve, 2008). Services may be in-home, out-of-home, periodic, therapeutic, in summer camps, or in after school programs and may involve child care and mentors (FRIENDS, 2007; Jerve, 2008). A study of four crisis care programs (ARCH, 2007) identified the following major service components: (1) overnight care for children ages 0–5; (2) minimum 24-hour stay; (3) maximum stay of 30 days; (4) volunteers who interact with the children and provide additional supervision; (5) parent support/case management services; and (6) parent visitation.

Effectiveness. An ARCH study (2007) examining outcomes of families in four crisis care programs found that families reported lower stress after respite care was provided. Although families who had a prior history of CPS involvement were referred more often than families without previous involvement with CPS, their substantiation rate was lower. An earlier study found that counties implementing crisis care services noted a 2% reduction in the reported incidence of child maltreatment, although it was not established that crisis care was directly responsible for the reduction (Cowen, 1998).

Implementation. The Child Abuse Prevention and Treatment Act, as amended by the Keeping Children and Families Safe Act of 2003, Title II provides a federal mandate that respite care be included in grants to community based services in an effort to prevent child abuse and neglect (U.S. DHHS, 2003). The FRIENDS National Resource Center (2006) estimates that the annual cost of one episode of respite care for a family is approximately \$1,500.

Family Resource Centers

Family Resource Centers (FRCs) are designed to respond to the needs of a community by requiring collaboration across multiple stakeholders, provide integrated services, and contextualize children's needs in relation to their community and family (The California Family Resource Center Learning Circle, 2000; The Los Angeles County Children's Planning Council, 2001; Waddell, Shannon, & Durr, 2001). FRCs may be stand-alone non-profits, located within and/or linked to schools, or operated by local governments (Waddell et al., 2001; The California Family Resource Center Learning Circle, 2000). Especially important is the development of trusting, strong, reciprocal relationships between FRC staff, the community, and the individuals and families served (Armstrong & Alderson, 2005; The California Family Resource Center Learning Circle, 2000; The Los Angeles Children's Planning Council, 2001).

FRCs serve predominantly low-income, high-risk populations who are having difficulty addressing basic needs (The California Family Resource Center Learning Circle, 2000). An FRC strives to be a "one stop shop" that focuses on the whole family to promote family assets, provide a wide range of integrated services, facilitate access to resources, and provide links to other services in order to support, strengthen, and empower families and communities in a community-based context (The California Family Resource Center Learning Circle, 2000; The Los Angeles Children's Planning Council, 2001; Waddell et al., 2001). FRCs may target a wide range of issues such as child abuse and neglect, substance abuse, family violence, family instability, juvenile violence and crime, welfare to work/employment, community unity, family isolation, family and community health, and educational outcomes (The California Family Resource Center Learning Circle, 2000). Programs may take place within the center as well as in schools or in the homes of families through home visitation programs (Armstrong & Alderson, 2005).

The California Family Resource Center Learning Circle (2000) lists the following core components: (1) parent education; (2) child development activities; (3) resource and referral links; (4) drop-in availability; (5) peer to peer supports; and (6) life skills advocacy. Additional comprehensive services include: case management; child abuse/neglect treatment services; family economics and self sufficiency; family literacy and education support; substance abuse treatment; youth development; and community development activities.

Effectiveness. Traditional program evaluations for FRCs are difficult to conduct because FRCs are all slightly different where services and programs are individually tailored to meet family needs, and it is not possible to create controlled environments to isolate specific program effects (The California Family Resource Center Learning Circle, 2000; The Los Angeles Children's Planning Council, 2001). A study evaluating the Mutual Assistance Network of Del Paso

Heights' "Block Grandparent" home visiting program found that abuse and neglect recidivism rates for families enrolled in the program dropped from 53% to 28%, and that parent-child bonds increased (California Family Resource Center Learning Circle, 2000). Another study of 12 FRCs in California found that families increased parenting skills, family cohesion and adaptability, and decreased arrests and citation between intake and case closure (Susan Philliber and Associates, 1999, cited in California Family Resource Center Learning Circle, 2000).

Implementation. The Los Angeles County Children's Planning Council (2001) surveyed 17 FRCs and found operating budgets to range from just over \$100,000 to over \$4 million, depending on the range of services, proportion of paid staff to volunteers, and cost of building maintenance. The California Family Resource Center Learning Circle (2000) recommends the following approaches to implementation:

- Leadership and Staffing: FRCs should have a minimum of one full time coordinator and one administrative support person in addition to staff who provide services and supports, including social workers, child development specialists, and public health nurses. Hiring community residents can be an important addition.
- Articulation of Policies and Procedures: Clear expectations, policies, and procedures based on solid theoretical foundations are important to ensure quality service delivery.
- Facility: A facility should be well kept, designed to be integrated into the community, and should welcome community residents and families.
- Public and Private Funding Support: A FRC must be able to leverage public and private money to ensure that programming and services are continuous. Long term stability is a key to successful implementation of programs and services.

Home Visitation: Project Safecare

Home visiting is a service strategy that includes the use of paraprofessionals, nurses, social workers, and other social service professionals in providing family services and programs inside the home (CEBC, 2013b; Gomby, 2007; Gomby, Culross, & Behrman, 1999; Sweet & Applebaum, 2004). These services can be provided by FRCs (Armstrong & Alderson, 2005) and other family support organizations (Gershater-Molko, Lutzker, & Wesch, 2002). Home visitation generally targets families who have young children in order to help parents support their children, rather than targeting the children themselves. Home visitation can help practitioners: (1) understand families in their home context; (2) remove service barriers by reducing the need for childcare, transportation, or time off work; and (3) facilitate family involvement and rapport building in a comfortable environment (CEBC, 2009; Gomby, Culross, & Behrman, 1999; Sweet & Applebaum, 2004).

Project Safecare is a brief (18–20 session) home visiting program for families with young children who have been reported for child abuse and neglect (Edwards & Lutzker, 2008; Gershater-Molko et al., 2002). It uses a multi dimensional, eco-behavioral approach that takes into account individual, family, community, and societal factors that influence child maltreatment to improve parenting skills and reduce future maltreatment (Edwards & Lutzker, 2008). Home visitors use skill assessment and training, modeling, and role rehearsal strategies to help parents improve their children's health, parent-child interactions and bonding, and home safety (Edwards & Lutzker, 2008; Gershater-Molko et al., 2002). Although a variety of models of Project Safecare have been implemented, the following are the core components (CEBC, 2009a: <http://www.cachildwelfareclearinghouse.org/program/76/detailed#relevant-research>; Edwards & Lutzker, 2008):

(1) Planned activities:

- Time management training for parents
- Explanation of rules and expectations to children
- Reinforcement/rewards
- Incidental teaching
- Activity preparation
- Outcome discussions with children

(2) Home safety:

- Assess accessible home hazards
- Provide parents with door and cabinet latches
- Use graduated plan to have parents remove identified hazards and child proof doors and cabinets
- Perform healthy home assessment and training

(3) Infant and child health care:

- Use *HEALTH* checklists to assess parent skills
- Teach any skill deficits (i.e., how to take a temperature)
- Teach use of health checklists and how to determine when to self-treat illness and when to seek medical care
- Include problem solving training

Effectiveness. In a study measuring the effectiveness of Project Safecare (Gershater-Molko et al., 2002), recidivism data (subsequent contacts with CPS) were examined to compare the program with traditional family preservation services. After 36 months, 85% of Project Safecare families had no reports of child abuse or neglect, compared to 54% of families in traditional family preservation services. Further experimental research is needed however to validate these findings and establish program effectiveness.

Implementation. Project Safecare involves three levels of training, designed to be taken sequentially: home visitor, coach, and trainer. Trainings are conducted on site using a low trainer to trainee ratio, workshops, and live demonstration of skills (e.g., role plays, modeling, and feedback). Technical support for up to one year and all documents needed for coaching and training are included. Training costs vary according to the number of trainees and the type of training. For more information, see: <http://chhs.gsu.edu/safecare/index.asp>.

Triple P-Positive Parenting Program

The Triple P-Positive Parenting Program is designed for families with children 0–18 who experience behavior and conduct problems (CEBC, 2013c). It is a flexible, multi-level intervention program, with an interdisciplinary approach, that aims to “prevent severe behavioral, emotional, and developmental problems in children by enhancing the knowledge, skills, and confidence of parents” (Sanders, Markie-Dadds, & Turner, 2003, p. 2). It is based on the following set of “positive parenting” principles: (1) ensuring a safe and engaging environment; (2) using assertive discipline; (3) developing realistic expectations; (4) taking care of oneself as a parent; and (5) creating a positive learning environment (Sanders et al., 2003). The Triple P program addresses five

developmental stages in a child's life and is conducted in self-directed, individual, and group formats (Sanders et al., 2003). The program consists of five levels of intervention that range in focus from the general population to high risk groups as follows:

- Level 1—Parenting information campaigns;
- Level 2—Brief selective intervention;
- Level 3—Narrow focus parent skills training;
- Level 4—Broad focus parent skills training; and
- Level 5—Behavioral family intervention (Sanders et al., 2003).

Effectiveness. A recent 18-county study found that the Triple P program produced positive effects across the entire population of children and families (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009). Although child maltreatment increased somewhat in counties implementing the program, the increase was less than in the counties where the program was not implemented. A meta analysis of 24 studies of the Triple P program found that it was effective in reducing child conduct problems as well as enhancing parenting (Thomas & Zimmer-Gembeck, 2007).

Implementation. The Triple P program requires training and accreditation, as well as specific resources for implementation, including manuals and kits for practitioners, parent workbooks, the *Every Parent Video Series*, Single Topic DVDs, tip sheets, and parenting booklets. Ranging from \$8,000 to \$42,500 (depending on the course selected) the fees include training, accreditation, resources for practitioners, and access to the Triple P provider network website (Triple P-America, 2009). Organizations and individuals alike can be trained and accredited to implement all or some of the components of the Triple P program (Triple P-America, 2009). For more information, see: <http://www.triplep-america.com>.

The Incredible Years

The Incredible Years is a program providing child, parent, and teacher training designed to prevent and reduce conduct and behavior problems in young children, increase emotional and social competence, and promote positive parenting practices. While the program does not directly attempt to prevent recurrence of maltreatment, it aims to prevent factors that may contribute to maltreatment. The Incredible Years is used primarily in outpatient clinics, community agencies, and schools (CEBC, 2009a). Incredible Years parenting programs focus on improving parenting skills and increasing school involvement for parents of children ages 0–12. Training occurs in a series of weekly two-hour sessions (9–20, depending on the program). The BASIC program contains a home visiting component for parents mandated to enroll in the program due to child abuse or neglect. The CEBC (2009a) provides the following description of competencies for the parent components:

The Incredible Years BASIC Parent Training Program:

- How to build strong relationships with children through child-directed play interactions
- How to be a social, emotional, and academic coach for children
- How to provide praise and incentives to build social and academic competency
- How to set limits and establish household rules
- How to handle misbehavior

The Incredible Years ADVANCE Parent Training Program:

- How to handle stress, anger, and depression management issues
- How to problem solve between adults
- How to help children learn to problem solve
- How to provide and receive support
- How to effectively communicate with your children and other adults

The child training components include guides for facilitating small group therapy and for teachers in the classroom seeking to “strengthen children’s emotional, social, and academic competencies.” The CEBC (2009a) provides the following description of the competencies for the child components:

Emotion Management:

- How to talk about feelings
- How to understand and detect feelings in others
- How to self-regulate and manage upsetting feelings

Social Skills:

- How to talk to and make friends
- How to work in teams
- How to cooperate and help others
- How to effectively communicate
- How to follow rules
- How to play with others and enter groups

Classroom Behavior:

- How to listen
- How to follow school rules
- How to stop-look-think-check

Problem Solving:

- How to deal with anger
- How to solve problems step-by-step
- How to be friendly

Effectiveness. The Incredible Years program is one of the few child welfare interventions evaluated in multiple randomized control trials (Baydar, Reid, & Stratton-Webster, 2003; Reid, Webster-Stratton, & Baydar, 2004; Reid, Webster-Stratton, & Beauchaine, 2001; Webster-Stratton, Reid, & Hammond, 2001, 2004). It has been found to improve positive parenting and decrease child conduct problems at home and school (Baydar et al., 2003; Webster-Stratton et al., 2001, 2004). Effectiveness has been shown to increase as program engagement increases (Baydar et al., 2003; Reid et al., 2004); and has been demonstrated for low-income families (Reid et al., 2004). A California Department of Social Services annual report found that children whose parents completed the Incredible Years program experienced a rate of recurrence of maltreatment of 5.7%, which was two to six percentage points lower than that of children whose parents did not complete the program (California Department of Social Services, 2007b).

Implementation. Small group therapy is conducted in two hour sessions over the course of 20–22 weeks. Program materials include a therapist manual, DVDs, workbooks for home activities, problem solving books, and case vignettes (The Incredible Years, 2009). Facilitators may also purchase extra program materials (e.g., puppets and magnets; The Incredible Years, 2009). Ideally, the therapeutic version is facilitated in conjunction with the parent component.

The Incredible Years can range in cost from \$1,300 for the School Age Parent training program to \$4,795 for the entire program package (Baby/Toddler + Preschool Basic + Advance + School Age Programs). Although The Incredible Years recommends that group leaders get certified, it is not required; however, an agency must purchase the program materials. For more information, contact incredibleyears@incredibleyears.com.

Parent Child Interaction Therapy

Parent Child Interaction Therapy (PCIT) is a parent training program based on attachment and social learning theory (Chaffin et al., 2004; Herschell, Calzada, Eyberg, & McNeil, 2002). It is designed for families who experience problems with young children (2–6 years old) exhibiting emotional and behavioral problems (Herschell et al., 2002). PCIT aims to: (1) teach parents “specific skills to establish a nurturing and secure relationship with their child while increasing their child’s prosocial behavior and decreasing negative behavior” (PCIT.org); (2) impart skills in effective non-violent discipline with their children; and (3) improve parent–child interactions (Chaffin et al., 2004).

PCIT takes place in two successive phases: (1) Child-Directed Interaction (CDI) and (2) Parent-Directed Interaction (PDI). When playing with their child during the CDI phase, parents are taught to frequently use the PRIDE skills (Praise, Reflection, Imitation, Descriptions, and Enthusiasm) and to avoid questions, commands, and criticism (Herschell et al., 2002). Children choose their own toy and parents must follow their child’s lead. Parents are continuously assessed during CDI and begin PDI when they are determined to be ready. PDI helps parents to acquire skills in issuing commands appropriately, as well as providing consistent consequences for both compliant and noncompliant behavior. Treatment is completed when parents have attained the necessary skills and children achieve behavioral goals (Herschell et al., 2002).

At the beginning of each phase, the therapist explains the skills involved in the interaction and why they are used. After the initial explanation, therapists model specific interactions so that parents and children can role-play the skills and practice what they have learned. Parents and children then attend weekly coaching sessions in which the therapist uses a one-way mirror to observe parent–child interactions and speaks to parents using a radio earpiece to inform them how to “implement specific behavioral skills with their children” (Chaffin et al., 2004, p. 501).

Effectiveness. PCIT is considered by some to be an evidence-based, empirically supported program (Chaffin et al., 2004; Herschell et al., 2002), while others view it as supported by promising evidence (CEBC, 2013a). In a meta-analysis of PCIT studies, Thomas and Zimmer-Gembeck (2007) found that PCIT was effective in reducing child behavior problems and improving parenting outcomes. Chaffin et al. (2004) report that PCIT reduced recurrence of maltreatment among a population of physically abusive parents. Other studies have suggested that PCIT can reduce child conduct problems (Nixon, Sweeney, Erickson, & Touyz, 2004), mothers’ stress (Nixon et al., 2004; Bagner & Eyberg, 2007), and coercive discipline techniques (Nixon et al., 2004). Thomas and Zimmer-Gembeck (2007) report however, that findings cannot necessarily be generalized to those with low socio-economic status or those in high-risk groups.

Implementation. PCIT provides a manual that guides coaches in the training of individual parent–child dyads (Herschell et al., 2002). Although most families complete PCIT in 10–16 one-hour weekly sessions, PCIT is assessment driven and therefore has no predetermined time limit (Herschell et al., 2002). Resources needed to implement PCIT include: “(1) two connected rooms with a one-way mirror on the adjoining wall; (2) wireless communications set consisting of a head set with microphone and an ear receiver; and (3) VCR and television monitor to tape record sessions for supervision, training, and research” (CEBC, 2013a). PCIT requires a comprehensive training program; the cost of a 5 day workshop is \$3,000, which includes: (1) 40-hours of face-to-face contact with a PCIT trainer; (2) advanced live training; (3) case experience; and (4) skill review. For additional information, contact: pcit@phhp.ufl.edu.

CONCLUSION

While the research literature provides us with an overview of factors associated with maltreatment recurrence and promising practices, it does not indicate a clear evidence-based method for preventing the recurrence of maltreatment. However, the following questions emerged from the literature on maltreatment recurrence and can promote further dialogue on evidence-informed practice:

- Given the higher recurrence risk for very young children, are risk assessment tools being utilized optimally to screen these cases for safety throughout the life of the case?
- Are there opportunities for developing and improving differential response programs to provide services that might prevent future maltreatment?
- How can family group decision making be utilized to prevent maltreatment recurrence?
- Are all available support services being offered to children with special needs as a strategy for preventing recurrence?

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