
Using Recidivism Data to Evaluate Project SafeCare: Teaching Bonding, Safety, and Health Care Skills to Parents

Ronit M. Gershater-Molko
University of Kansas

John R. Lutzker
University of Judaism

David Wesch
Behavioral Ecology Consulting

Project SafeCare was an in-home research and intervention, grant-funded program designed to teach parents who were reported for child abuse and neglect. Parents who participated in Project SafeCare received training in three aspects of child care: treating illnesses and maximizing their health-care skills (health), positive and effective parent-child interaction skills (bonding), and maintaining hazard-free homes (safety) for their children. Postcontact (after initial intake was made and the program began) incidents of child abuse and neglect for maltreating parents who participated in and completed Project SafeCare were compared to a comparison group of maltreating families from the point of initial intake through a 24-month follow-up period. The comparison group (referred to as the Family Preservation group) received intervention from Family Preservation programs. Families who participated in Project SafeCare had significantly lower reports of child abuse and neglect than families in the comparison group.

Child abuse and neglect is one of the most serious social problems in the United States today (U.S. Department of Health and Human Services, 1998). Its growth has been alarming. According to the findings of the *Third National Incidence Study (NIS-3)*, which was conducted between 1993 and 1995, there have been substantial and significant increases in the incidence of child abuse and neglect since the last national inci-

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dence study in 1986 (Sedlack & Broadhurst, 1996). In 1993, a total of 1,553,800 children of the nation's 63.6 million children (ages birth to 18) (U.S. Department of Commerce, 1990) were maltreated, as compared to 931,000 in 1986 and 625,100 in 1980 (Sedlack & Broadhurst, 1996). The most recent incidence studies, based on data from 44 states, report that approximately 984,000 children were maltreated in 1997 (U.S. Department of Health and Human Services, 1999).

There have been many efforts to intervene with and prevent child abuse and neglect, yet an increasing number of children become victims of child maltreatment each year. Some researchers have suggested that the increasing numbers of child abuse and neglect reports reflect a greater awareness of the problem and therefore a higher probability that an incident will be reported rather than an increase in actual incidents of abuse and neglect (Zellman & Faller, 1996). Others posit that the level of empirical assessment and evaluation of intervention programs has not matched the enthusiasm of the field for this type

Authors' Note: John R. Lutzker, Ph.D., is now at the Centers for Disease Control and Prevention. Reprints are available from John R. Lutzker, Ph.D., Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 4770 Buford Highway, N.E., Mail Stop K-60, Atlanta, GA 30341. Project SafeCare was supported by a grant from the California Wellness Foundation. We are grateful for the assistance of Seth Arkin, Kathryn M. Bigelow, and Sheryl Solomon.

of research and intervention (Saunders & Williams, 1996). Of those programs that have been evaluated, the significant methodological shortcomings and the weak quality of child abuse and neglect research have further handicapped the progress in this area (Ammerman, 1998). Therefore, the scientific knowledge about the outcome of treatment for maltreated children lags far behind the high volume of services being delivered. Nevertheless, the number of reports of child abuse and neglect, as well as the number of substantiated reports, indicate a clear need for effective intervention and prevention services (Wolfe & Wekerle, 1993).

Two major intervention approaches have been successful with abusive and neglectful parents: cognitive-behavioral strategies and social support. These approaches have also been adapted within the context of home visitation and multiple-component programs (Wolfe & Wekerle, 1993). These current intervention approaches take into account the multiple factors that parents face (e.g., lack of resources, stress, poverty, marital discord, lack of social support) that are associated with child abuse and neglect (Azar, Povilaitis, Lauretti, & Pouquette, 1998; Belsky, 1984). They focus on preventing the removal of children from their homes by improving parental knowledge of child development, changing parental attitudes toward their children, improvement of the home environment, and linking parents to available community-based resources. Examples of services offered by such programs include basic skills training, stress reduction, assertiveness training, money management, home safety, drug and alcohol abuse referrals, job training, and parent-child interaction training (Lutzker, 1994; Schellenbach, 1998). Project SafeCare was based on this model of in-home intervention.

Program evaluations of interventions designed to reduce child abuse and neglect have used recidivism as a dependent measure of efficacy (English, Marshall, Brummel, & Orme, 1999). These studies suggest that interventions in child abuse and neglect can be moderately successful at reducing future rates. Some intervention approaches appear to be more successful than others. For example, programs that showed the greatest reduction in posttraining recidivism (Kolko, 1996; Lutzker, & Rice, 1987) incorporated specific parent-training components that used modeling, practice, and feedback of parenting skills in addition to traditional parent education. Conversely, the programs that have not shown significant changes in posttraining incidents of child abuse and neglect (Blythe, Patterson, Salley, & Jayaratne, 1994; Cohn & Daro, 1987) offered only general community services

such as support groups, lay therapies, and parent education classes, without specific focus on parent training in specific skills.

Very few studies have used survival analysis to determine the maintenance of intervention gains before a family experiences a recidivistic incident of child abuse and/or neglect (Marshall & English, 1999). Zuravin and DePanfilis (1996) reviewed the recidivism literature, locating only eight that plotted recurrence of child abuse and neglect over time. This type of analysis is extremely useful in assessing the risk factors associated with recidivism.

Marshall and English (1999) conducted a survival analysis of multiple referrals to Child Protective Services (CPS), showing that a variety of risk factors, including ethnicity, gender, type of abuse, substantiation, risk level, placement, and prior referrals, resulted in different survival curves. The risk factors resulted in different postintervention times at which recidivism occurred. In addition, families with zero prior referrals to CPS had markedly different survival curves than families with multiple prior referrals. The authors concluded that this result indicates that there are "different driving forces" for families referred to CPS for the first time who are brought back into the system as compared to families with more than one prior CPS referral (Marshall & English, 1999). Marshall and English demonstrated that the percentage of families who remained free of formal CAN incidents was markedly different given prior experiences with CPS. Families with no prior services showed a suppression of further maltreatment for at least some period of time after CPS involvement, after which the percentage of families maltreating their children increased. Families with some history of CPS involvement prior to receiving CPS support showed no suppression of maltreatment in spite of ongoing CPS contact, and these families had a high proportion of maltreatment. It might be concluded that families with no prior history of CPS involvement were generally responsive to the coercive effects of their first CPS contact; families who were not responsive to this first contact and who had additional maltreatment were also not responsive to further contact with CPS.

Family Preservation is a nationwide program, the primary goal of which is to prevent the placement of abused and neglected children in substitute care (Schuerman, Rzepnicki, & Littell, 1994). These programs have been implemented in almost every state/province across North America. Although many of the Family Preservation programs vary in the type of services they provide, the philosophy remains constant. The hallmarks of family preservation programs are that the services are time limited, family centered,

home based, and crisis orientated; services are available 24 hours a day, 7 days a week; and the programs are designed to empower families by developing in them the ability to solve their own problems (Family Preservation Services Committee, 1992, p. 11; Schuerman et al., 1994). The Family Preservation approach focuses on the individual needs of each family; therefore, families receive different types of services with different objectives such as Head Start, Workfare, Child Development, and a home-based model, which provides 90 days of service focusing on improving family functioning and communication, child safety, health services, money management, and assistance with job finding and housing.

Despite the widespread existence of Family Preservation programs, there remains limited evidence to suggest that there are substantial reductions in posttrauma placement of children outside the home (Schuerman et al., 1994). The results of many family preservation studies, including the study conducted by Meezan and McCroskey (1993), suggest that difficulties in targeting services to families at risk of placement contribute to the lack of program effects on placement. In addition, in most of the family preservation studies, few control-group families have experienced placement out of the home, which suggests that the groups were generally not composed of the families who are most at risk of placement (Schuerman et al., 1994; Yuan & Rivest, 1990).

Few studies have examined the effects of Family Preservation programs on the recidivism rates of participating families. Jones (1985) conducted a 5-year follow-up study that showed that 21% (21) of 98 families in the experimental group experienced recidivism versus 25% (11) of 44 comparison-group families. This difference was not statistically significant. Other studies have had similar outcomes, with approximately 25% of experimental and comparison groups experiencing posttreatment recidivism (McDonald & Associates, 1992). Schuerman et al. (1994) suggested that the major problem in attaining the prevention objective of family preservation services is targeting the correct families. As a result, the evaluation studies show that the overall effects of family preservation services are generally limited.

Project SafeCare, an in-home, 4-year, research and treatment program for parents reported for child abuse and/or neglect, was a systematic replication of Project 12-Ways, an ecobehavioral approach to intervention/prevention in child abuse and neglect (Lutzker, Van Hasselt, Bigelow, Greene, & Kessler, 1998). Like Project 12-Ways, Project SafeCare provided in-home services. Project SafeCare, however,

only provided teaching in 3 of the 12 intervention components provided by Project 12-Ways. These were child health care (referred to as "health"), parent-child interactions (referred to as "bonding"), and home safety and accident prevention (referred to as "safety"). These interventions were selected because they at once fit the mission of the funding source and were three salient components of Project 12-Ways that were the most amenable to being "packaged" into succinct and reasonably standardized protocols that could be relatively easily disseminated. The treatment goals of Project SafeCare were to improve parenting skills and reduce future occurrences of abuse and neglect. The purpose of the current research was to assess the extent to which Project SafeCare achieved these goals with families who had abused and/or neglected their children. We thus posited that if families completed all three of these sets of protocols, they would learn important new skills that would lower risk to their children of future abuse and neglect.

Of interest in the current research were global measures of intervention success (recidivism) as determined by recidivism rates of Project SafeCare families who completed all three training components compared to the rates of a comparison group. Recidivism was defined as the recurrence of child abuse and/or neglect as indicated by a report to the county after participation in an intervention program had begun (Maltz, 1984). For the purposes of this research, the report had to be substantiated after investigation by the Department of Child and Family Services (DCFS) to be considered a recidivistic incident.

METHOD

Participants

Project SafeCare group. Families were referred to Project SafeCare by the DCFS. These families had current involvement with DCFS due to recent substantiated reports of child abuse and/or neglect. The families were included in the analyses in this study if they had completed all three training components and posttrauma data collection (the posttrauma measures on the Beck Depression Inventory, Beck & Steer, 1993; the Child Abuse Potential Inventory, Milner, 1986, 1994; and the Parenting Stress Index, Abidin, 1990, 1995). These criteria were chosen based on the belief that families would need to complete the entire program to derive maximum benefit from the services. Project SafeCare was designed for brief intervention. The entire program from the first day of face-

to-face contact, during which baseline data collection began, until the completion of training in all three components was designed to last approximately 24 weeks. The three training components of Project SafeCare were generally taught sequentially, beginning with health training, followed by safety training, and then parenting skills, unless the family presented with severe safety hazards in the home, in which case safety was trained first. Each of the intervention components was taught over the course of five sessions. If the family was unable to meet the training criterion of each component in this period, one additional training session in that component was provided, resulting in a maximum of six training sessions per component. The parents' performance in achieving the goals of each of the three teaching components was assessed individually using direct observation in role-play situations. Forty-one families completed all three training components and sufficient posttraining data to be included in the analyses.

Comparison group. The Family Preservation group served as the comparison group in this analysis. The families in this group were selected by Project SafeCare from lists provided by DCFS of families who had current substantiated reports of child abuse and/or neglect and had been referred by DCFS to Family Preservation for intervention. These lists were provided to Project SafeCare on a yearly basis from 1994 to 1997 and included only families with children aged 0 to 5 years of age living in the same geographical location as Project SafeCare families. The age range was specific so that individual matches could be made based on the birth month of the children in the Project SafeCare training group and the birth month of the children in the comparison group. For each year between 1994 and 1997, equal numbers of families from the Family Preservation group were matched with Project SafeCare families. A total of 41 families were selected for the Family Preservation group.

Recidivism Measures

A longitudinal design within a constructed control group was used for this evaluation (Rossi & Freeman, 1993). The dependent variable for this analysis was the postcontact (after initial contact was made and program began) recidivism rates of abuse and neglect of the Project SafeCare group compared to the comparison group.

Data Collection

Data regarding reports of child abuse and neglect were provided by DCFS every 6 months for the 4 years that Project SafeCare was operative for all Project

SafeCare families and all comparison-group families. DCFS was provided with updated lists (including the names and DCFS identification numbers) of all the families in the Project SafeCare training group and in the comparison group. These names were entered into the DCFS database and matched with any reports of child abuse and neglect. The DCFS reports returned to Project SafeCare listed the family's last name, the first name of the parent (usually the mother), the mother's date of birth, the name of the children in the home, the children's dates of birth, the reason for the report, and the resulting action (substantiation of report, dismissal of report, referral for treatment, removal from home, death of child). Project SafeCare received data on all child abuse and neglect reports for each target child (from birth to current reports). These reports were requested twice yearly until the collection of follow-up data by Project SafeCare was terminated. A minimum of 24 months of postcontact recidivism data were collected for each family.

Information was compiled regarding substantiated abuse and neglect incidents from the reports. Substantiated reports were defined as investigations of reports of child abuse and neglect where the outcome of the investigation was the substantiation of the reported incident by the DCFS caseworker. When reviewing these documents, the experimenter first determined the date of the report, the nature of the report (physical abuse, sexual abuse, general neglect, severe neglect), and the outcome of that report.

Reliability

The experimenter and a second recorder compiled the recidivism data independently. Reliability observations were conducted for 100% of the data collected by comparing the recorder's data to the data collected by the experimenter. Reliability was defined in terms of the percentage agreement between the two independent observers. An agreement was noted when all of the data recorded by the recorder for each incident (regarding the date of the incident, the type of abuse and neglect, and the outcome of the report) matched those of the experimenter. If a disagreement was scored, the experimenter's data were compared to the original reports sent by DCFS, and the data were corrected for use in the analyses. Reliability was calculated by dividing the number of agreements by the total number of agreements plus disagreements and then multiplying by 100. The interobserver reliability for data compilation for this analysis was 98%.

Reliability was also calculated for the information regarding the child abuse and neglect reports provided semiannually by DCFS. Forty-one families (33%) were randomly selected from the list of 82 total families for the purposes of reliability. The experimenter visited all eight regional offices served by Project SafeCare and reviewed the files for the families from each of the three groups. The experimenter checked the names of the children and parents, the dates of birth of the children, the date for each abuse and neglect report, the reason for the report, the outcome of each report, and any information regarding participation in treatment programs. This process also provided validation that the families' files that we were reviewing were the actual families reported on the list from DCFS. The information from the files was compared to the lists of reports provided by DCFS. An agreement was noted when the information from the reliability check matched the information on the DCFS report exactly. If a disagreement was noted, the data from the DCFS report were used in the analysis. The only types of disagreements that were noted were reason for the report (for example, physical abuse versus parental drug abuse). Reliability was calculated by dividing the number of agreements by the total number of agreements plus disagreements, multiplied by 100. The cumulative average reliability score was 96%.

RESULTS

Recidivism Analyses

A survival analysis was completed to determine whether the families who participated in Project SafeCare differed in postcontact recidivism to families who participated in Family Preservation. In the first analysis, families who completed Project SafeCare services and Family Preservation were compared on frequency of postcontact recidivism reports (reports received after participation in the program had begun) using a survival function. The survival curves for these two groups are depicted in Figure 1. The difference in survival rates between the two groups becomes greater at 14 months following the beginning of intervention. The largest difference between the two groups is visible at 36 months after the beginning of intervention where 85% of the Project SafeCare families and 54% of the Family Preservation group families had no reports of child abuse and neglect.

Data from the survival analysis were compared using the Wilcoxon (Gehan) statistic, which compared the pretraining and posttraining data (number

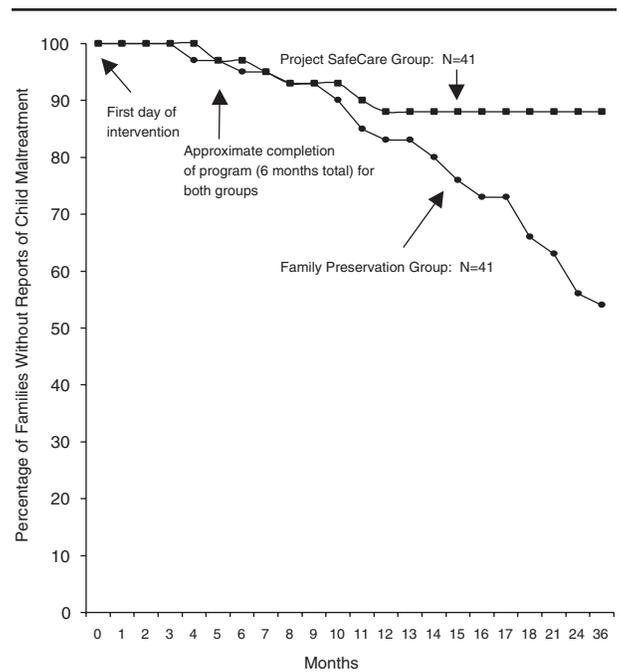


FIGURE 1: Percentage of Project SafeCare Families and Family Preservation Families Without Reports of Child Abuse and Neglect for 36 Months Following the Beginning of Intervention

of months without a report of child abuse and neglect) between the two groups (Bruning & Kintz, 1997). There was a statistically significant difference between the two groups: Wilcoxon (Gehan) = 11.41; $df = 1$; $p < .001$.

Figure 2 depicts the number of child abuse and neglect reports for the Project SafeCare group and the Family Preservation group across the 4-year period that Project SafeCare was in effect (1994-1998). This examination focused on the number of baseline reports per group and the number of reports following the beginning of intervention.

A repeated measures analysis (general linear model) was used to compare the frequency of postcontact recidivism reports for both groups. This examination focused solely on the number of reports for each group per year for a 4-year period, beginning June 1994 and ending in May 1998. The frequencies of reports for each group are depicted in Table 1. The results of the repeated measures analysis were significant for both the within-group variability, $F = 26.058$, $df = 3$, $p < .01$, and between-group variability, $F = 2.455$, $df = 6$, $p < .05$. Project SafeCare was more successful in suppressing child abuse and neglect during postcontact periods when the families entering care had high rates of child abuse and neglect than the Family Preservation program. Both SafeCare and

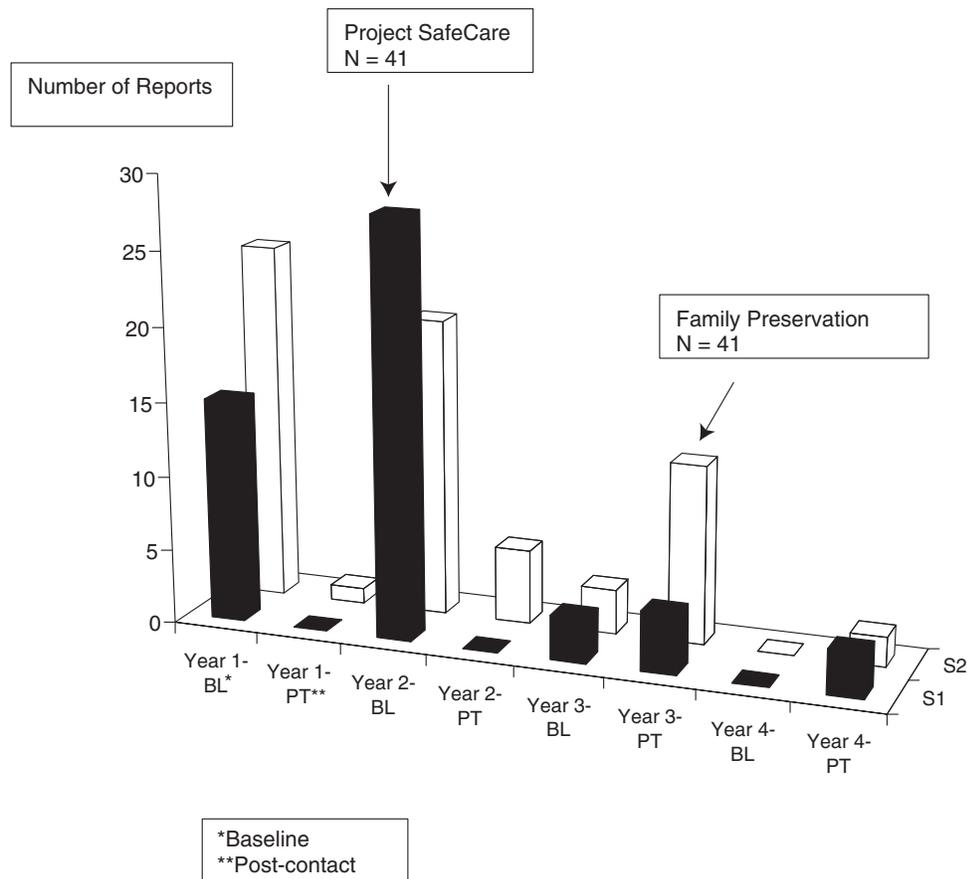


FIGURE 2: Number of Baseline and Postcontact Reports per Year for Project SafeCare and Family Preservation

TABLE 1: Number of Substantiated Reports of Child Abuse and Neglect per Group per Year

Year	Project SafeCare Group	Family Preservation Group
1	15	25
2	28	25
3	7	15
4	3	2
Total	53	67

Family Preservation had less success with families with lower rates of child abuse and neglect at baseline, but SafeCare continued to show more suppression of child abuse and neglect at postcontact than the Family Preservation Program.

DISCUSSION

We conducted an evaluation of Project SafeCare to assess the outcome of the program as measured by

survival from recidivism. We showed that maltreating families who completed all three Project SafeCare training components (health, safety, and bonding) were less likely to be involved in recidivistic child abuse and neglect than comparison-group families. Despite these encouraging results, however, there are numerous issues that warrant attention and necessitate caution when interpreting these results.

One factor that limits the results is the manner in which the comparison groups were constructed, which created some substantial differences between the samples. When families were referred to Project SafeCare, they were not randomly assigned to the intervention or the control group. In addition, the comparison group (Family Preservation group) comprised families who were assigned by DCFS to receive Family Preservation services. These factors undermine the use of a true random sampling strategy and the incorporation of equivalent comparison groups. As a result, the applicability of the results to the population as a whole is somewhat minimized.

In an attempt to create demographically equivalent groups, the comparison families in Project SafeCare were matched (constructed control groups) to the families in the Project SafeCare intervention group for geographical location, involvement with DCFS, and age of the children. Due to limitations in the accessibility of DCFS data, it was not possible to gather more detailed demographic information to establish whether the groups were, in fact, equivalent. In addition, although DCFS supplied report data and completion dates for the Family Preservation group regarding their participation in intervention programs, the inability to verify all these data is problematic. DCFS would permit reliability observations on only 33% of the cases in the comparison groups because of other intensive audits they were experiencing at that time.

An additional factor for consideration is the accuracy of the data collected from DCFS detailing the reports of child abuse and neglect. In an attempt to verify that the data reported by DCFS were accurate, reliability checks were conducted for a randomly selected 33% of the child abuse and neglect reports received from DCFS. The process of reliability involved reading all of the extensive hand-written reports on each family's entire history of involvement with DCFS because there was no specific section within these files that detailed incidents of abuse or neglect. It was often difficult to locate the information about specific incidents, and the information was often incomplete. It is also possible that families moved out of the area or that last names were changed in separations or divorces, and as a result subsequent reports of abuse and neglect were not correlated with earlier ones.

It is not likely that all the families in the Family Preservation group received similar services to the Project SafeCare group. Some of the individual family files that were reviewed reflected treatment adherence difficulties and inconsistent attendance. In addition, some of the reports that were reviewed showed that some parents completed the program without significant changes in their overall parenting, which resulted in their children being placed in foster care or eventually being adopted by other families.

Child abuse and neglect is a widespread phenomenon that affects almost all societies. The variability in the settings where abuse and neglect occurs results in subject samples that may not be representative of maltreated children in general, thereby decreasing the generalizability of findings to other populations of maltreated children (Widom, 1988). This was the case in this research.

Despite the methodological confounds, there are aspects of this research that are noteworthy. For example, questionnaires were sent to professionals to validate the content of the intervention packages. In addition, all research assistants were trained to criterion performance of the skills they were teaching parents, as well as their ability to model, train, and provide feedback. These techniques preserved the integrity of the independent variable (Greene & Kilili, 1998; Lutzker, 1998; Wolfe & Wekerle, 1993). The data collection methods used by Project SafeCare focused on parent and child behaviors to enhance the quality of family interactions and parental competence.

The literature shows that in-home, family-based, multifaceted services are effective in producing behavior change in maltreating families in rural and urban settings (Kolko, 1998; Lutzker & Rice, 1984; Lutzker, Tymchuck, & Bigelow, 2001). The strengths of this intervention approach include the reliance on behavioral definitions and direct observation of behavior. It is imperative that researchers report the sampling process in considerable detail, if possible, to enable appropriate application to the general population where possible.

Future research should focus on ameliorating the systemic and methodological weaknesses that plague research in this field. Standardized definitions of child abuse and neglect and agreements between researchers regarding adequate versus inadequate parenting skills are necessary (Greene & Kilili, 1998). Standardized procedures for gathering, analyzing, and reporting data would greatly enhance the consistency of research across studies and the applicability of research findings to larger populations (Ammerman, 1998).

Improvements in the use and application of empirical research designs, assessment strategies, sampling strategies, measurement, and outcome studies are necessary (Kolko, 1998). For example, the comparison group used by Project SafeCare was selected and matched to Project SafeCare families at the end of the program. Instead, a comparison family could have been matched as each new referral was made to Project SafeCare. This would have enabled matching of families on more significant variables such as abuse type and demographic factors. In addition, assessment strategies could have been modified to allow for more time to build rapport between staff and parents and to lessen the invasive nature of the assessment process. It nonetheless appears that the direct training strategies used by Project SafeCare to teach health, safety, and bonding produced significantly lower risk to the children in these families than the

children in the comparison group. The differences appear too large to be random.

In summary, this research offers another example of using recidivism data (through survival analysis) to evaluate short- and longer-term outcomes of a skill-based training program aimed at reducing children's risk of abuse and neglect. Although random assignment to an intervention group and a control group would be preferable, having comparisons between groups allows us an important empirical analysis. The current research shows that it is possible to identify a comparison group in this type of applied research, even if it has to be constructed. There seems little reason not to do at least a modified form of a control group. In addition, it is important to recognize that different types of services need to be, and can be, compared to one another. For these purposes, centralized registries can be extremely useful to identify comparison groups and compare their outcomes against those of the research participants. The data show a very hopeful trend and suggest that direct, skill-based intervention strategies do, in fact, reduce risk.

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Ronit M. Gershater-Molko, Ph.D. (University of Kansas), is the full-time codirector of autism spectrum therapies. She is a certified behavior analyst specializing in the treatment of children with autism and related disorders. She holds a master's degree in applied developmental psychology and a doctorate in human development and family life with a focus on children with developmental disabilities. Dr. Molko completed a postdoctoral fellowship at UCLA where she specialized in behavioral assessment and intervention, treatment planning, and individual and group therapy for children and adults with autism and genetic disorders. She teaches courses at the graduate level to teachers and administrators on classroom-based positive behavioral support and comprehensive planning.

John R. Lutzker, Ph.D. (University of Kansas), is a distinguished consultant and chief in the Prevention Development and

Education Branch for the Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. From 1988 to 2001, he was the Florence and Louis Ross Distinguished Professor and Chair of the Department of Psychology and director of graduate training in behavioral psychology at the University of Judaism in Bel Air, California. He previously served as acting provost at the University of Judaism. Also, he is an adjunct professor of human development at the University of Kansas and was president of Behavior Change Associates. Dr. Lutzker has published more than 100 professional articles and chapters and has presented more than 300 professional papers. He is a fellow of the American Psychological Association and is a clinical fellow of the Behavior Therapy and Research Society. His current major research interests are in intervention and prevention of child maltreatment and other forms of violence.

David Wesch, Ph.D. (Southern Illinois University), is a consultant to nonprofit agencies in New Mexico. He provides program evaluation, organizational behavior management, grant writing, and staff development support in this part of the Southwest. He is particularly interested in collaborative service agreements across agencies in rural communities. Dr. Wesch received his bachelor's degree from Fort Lewis College in 1975, his master's from Drake University in 1978, and his doctorate in rehabilitation from Southern Illinois University in 1990.