

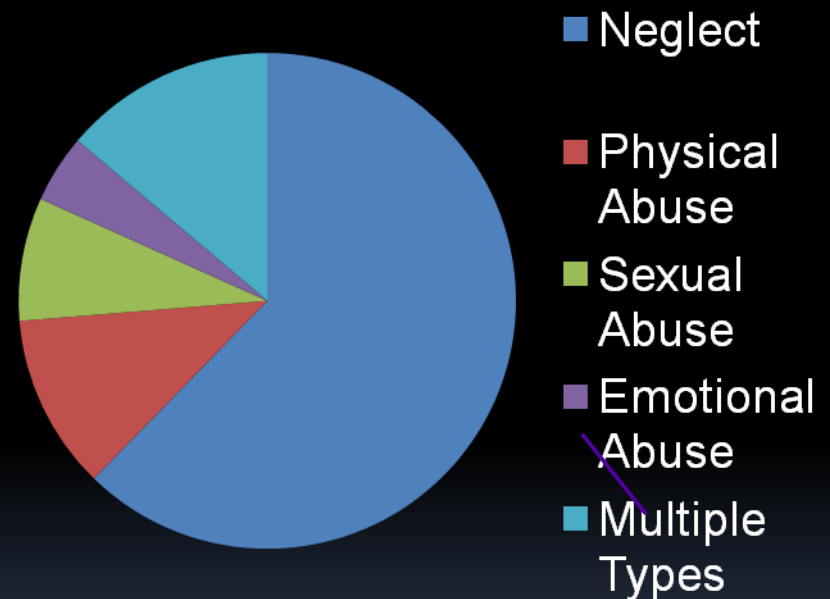
CHILD MALTREATMENT PREVENTION: OVERVIEW AND BARRIERS TO IMPLEMENTATION OF EVIDENCE-BASED PREVENTION PROGRAMS

THE SAFECARE PROGRAM

Child Maltreatment

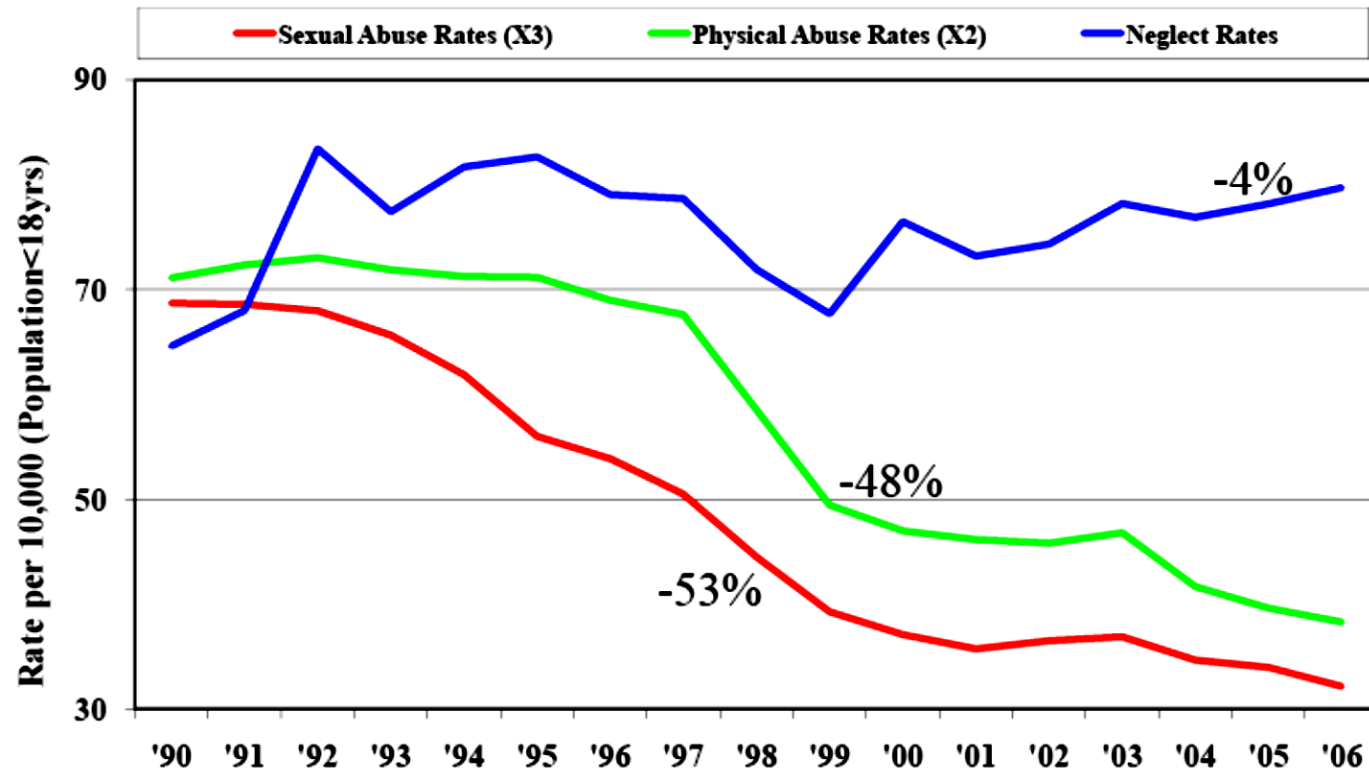
- ⦿ In 2007, an estimated 753,000 children suffered from maltreatment
- ⦿ Around 1,586 children died from maltreatment in 2007
- ⦿ Nearly 60% of maltreatment is from neglect
- ⦿ We have less data on neglect and how to prevent it than on other forms of abuse

Child Maltreatment Rates By Type



*United States Department of Health and Human Services Administration for Children and Families

Trends in Child Maltreatment in the U.S.



Source: NCANDS

Sexual abuse rates have been multiplied by 3 and physical abuse rates by 2 to graph them on the same scale as neglect; The overall % change is for the period 1992-2006.

Consequences of Child Maltreatment



Child Maltreatment

Health-risk behaviors

Sexual promiscuity

Sexual perpetration

Alcohol abuse

Illicit/injected drug use

Smoking

Behavior problems

Mental/Social Problems

PTSD

Depression

Anxiety

Eating disorders

Neurobiological

Academic achievement

Unwanted pregnancy

Obesity

Revictimization

Ischemic heart disease

Diabetes

Stroke

Cancer

Suicide

Skeletal fractures

Chronic bronchitis/
emphysema

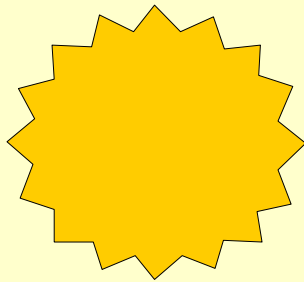
STDs (e.g., HIV)

Hepatitis

Official License

This official license certifies individual
as an EXPERT in

PARENTING?

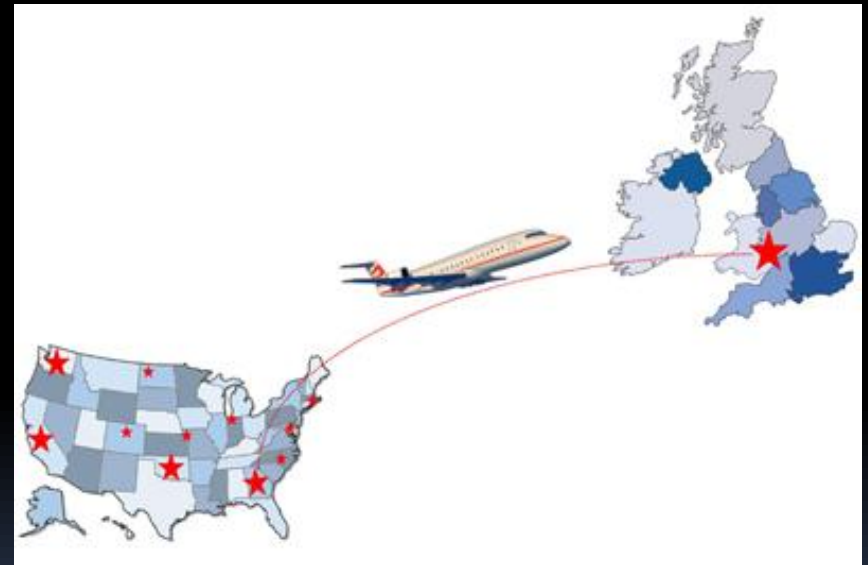


SafeCare History

- Project 12-Ways (1979)
- SafeCare (early '90's)
 - Began in California
 - Effort to make 12-Ways more disseminable
 - Safety, Health, Parenting
 - Oklahoma adopts SafeCare, 2001

National SafeCare Training & Research Center (NSTRC)

- Established in 2007
 - Demand for training began to rise
 - Oklahoma implementations (2001 - 2011)
- Housed in Institute of Public Health at Georgia State University
- 70+ sites in 12 states
- 3 countries
- www.nstrc.org



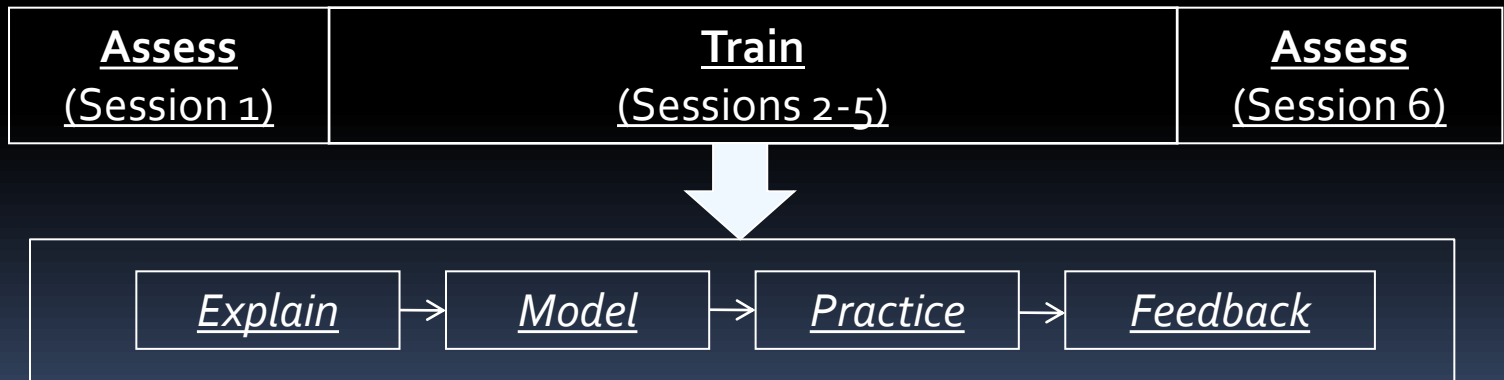
SafeCare Program Components

- In-home behavioral, skill-based model
- Targets at-risk parents with children 0-5
- Three targeted areas:
 - *Parenting* (Parent-child or parent-infant interaction)
 - *Home Safety*
 - *Child Health*
- Also includes:
 - Structured problem solving taught
 - Emphasis on good communication skills



SafeCare Modules Overview

- Each module is conducted over 6(±) sessions
 - Typically once a week
- Each module has the same process
 - Assess → Train → Assess
- Each module uses the same structured teaching sequence
 - Explain, Model, Practice, Feedback
- SafeCare relies on behavioral principles
 - Reinforcement, modeling, shaping, skill practice, etc.



Common Barriers to Prevention Programs



- Inherent difficulties associated with neglect
- Parents acquiring new skills
 - Good medical decisions
 - Preventing unintended injuries
 - Improving quality and quantity of parent-child interactions
- Preventing recidivism (future reoccurrence)
- Engaging families
- Populations that are difficult to reach
 - Low resource
 - Mental health or substance abuse difficulties
 - Dads

How can research help overcome these barriers?



- Research answers important questions, like:
 - Does intervention lead to the expected behavioral change for families? If so, what behaviors changed?
 - Do families who participate in the intervention have different trajectories over time than those families who do not participate? Did the reoccurrence of child maltreatment decline?
 - Do families like the intervention?
 - What are the most effective ways to deliver the intervention to families?

SafeCare Evidence

- Research supports SafeCare efficacy/effectiveness
 - Expert validation studies
 - Single case studies of behavior change
 - Non-experimental group studies of behavior change
 - Quasi-experimental comparison studies
 - Randomized trial
- Populations included in research
 - Parents at high-risk for maltreatment
 - Parents involved with CPS
 - Parents of children with autism and related disabilities
 - Adult parents with intellectual disabilities
 - Variety of racial/ethnic groups

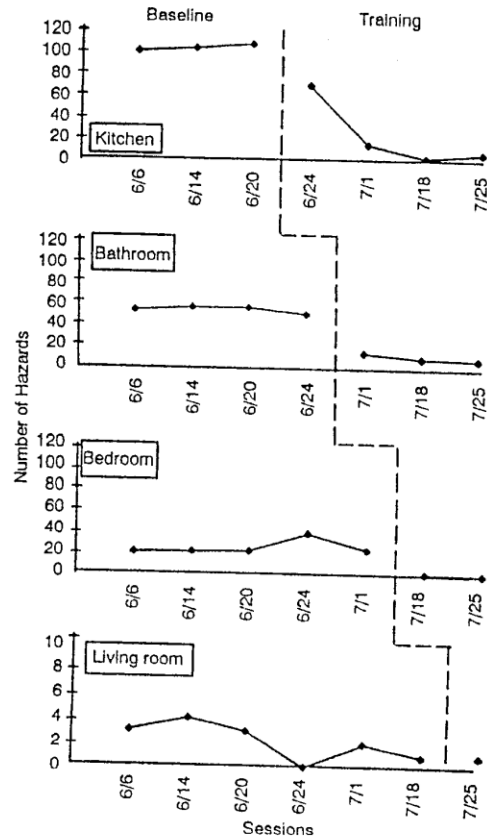


Does SafeCare lead to behavioral
change for parents?

Answer: YES

Single Case Study on Home Safety

FIGURE 3. Total number of hazards across rooms in Diane's home.



Single Case Study on Health

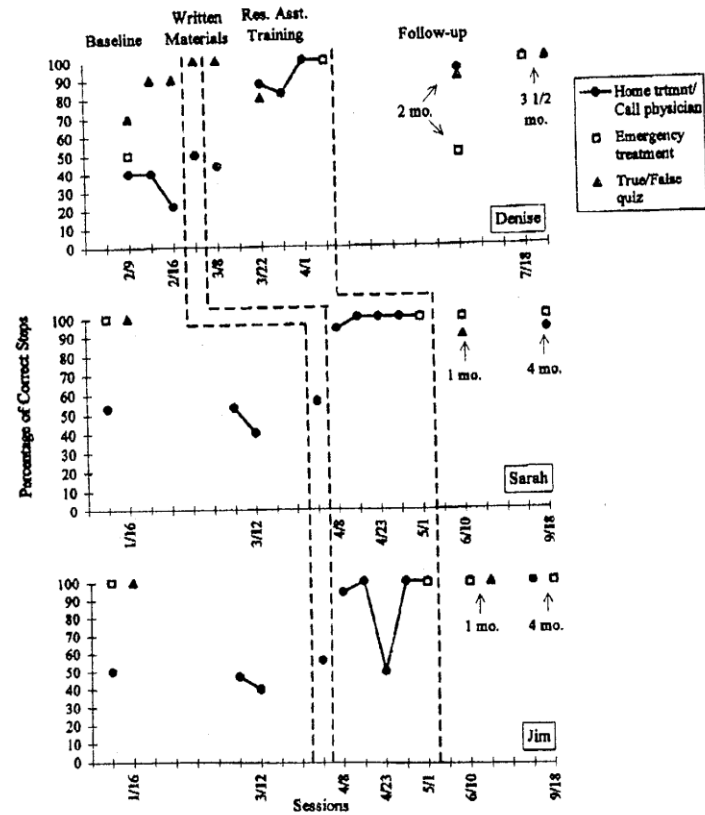


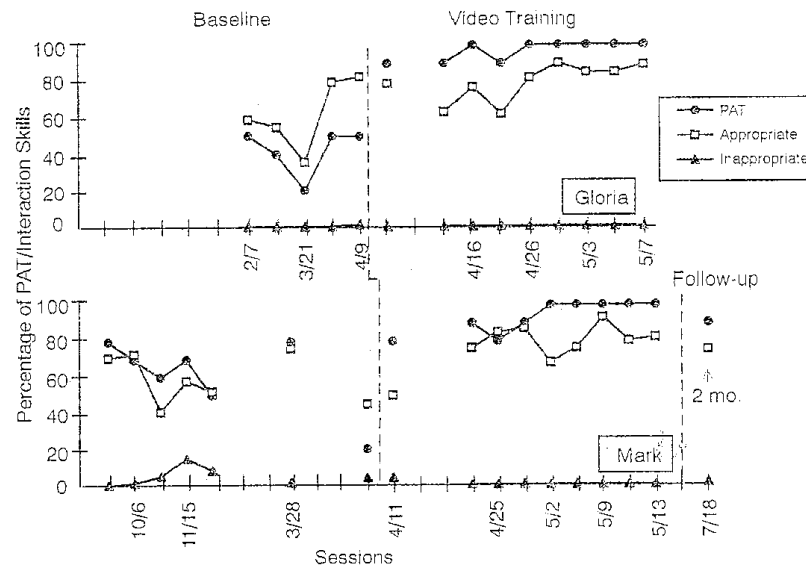
Fig. 1. Percentage of steps completed correctly during role-play scenarios and percentage correct on true/false quizzes for parents participating in training provided by a research assistant.

Single case studies: Parent Child Interaction

Kathryn M. Bigelow and John R. Lutzker

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FIGURE 1. Percentage of parent use of Planned Activities Training, appropriate, and inappropriate interaction skills for Gloria and Mark



Do families who participate in the intervention have different trajectories over time than those families who do not participate?

More specifically, does the intervention prevent abuse?

Answer: YES

Oklahoma: High-Risk Prevention project



(Silovsky et al.)

- Targeted at-risk moms with 2+ risk factors and no more than 1 existing CPS referrals
 - Substance use
 - Partner violence
 - Mental health
 - Physical disability
- Referrals
 - Hospitals
 - TANF
 - Schools
 - Child welfare
- Randomly assigned mothers to SafeCare or Services as Usual

Oklahoma Prevention Project: Results

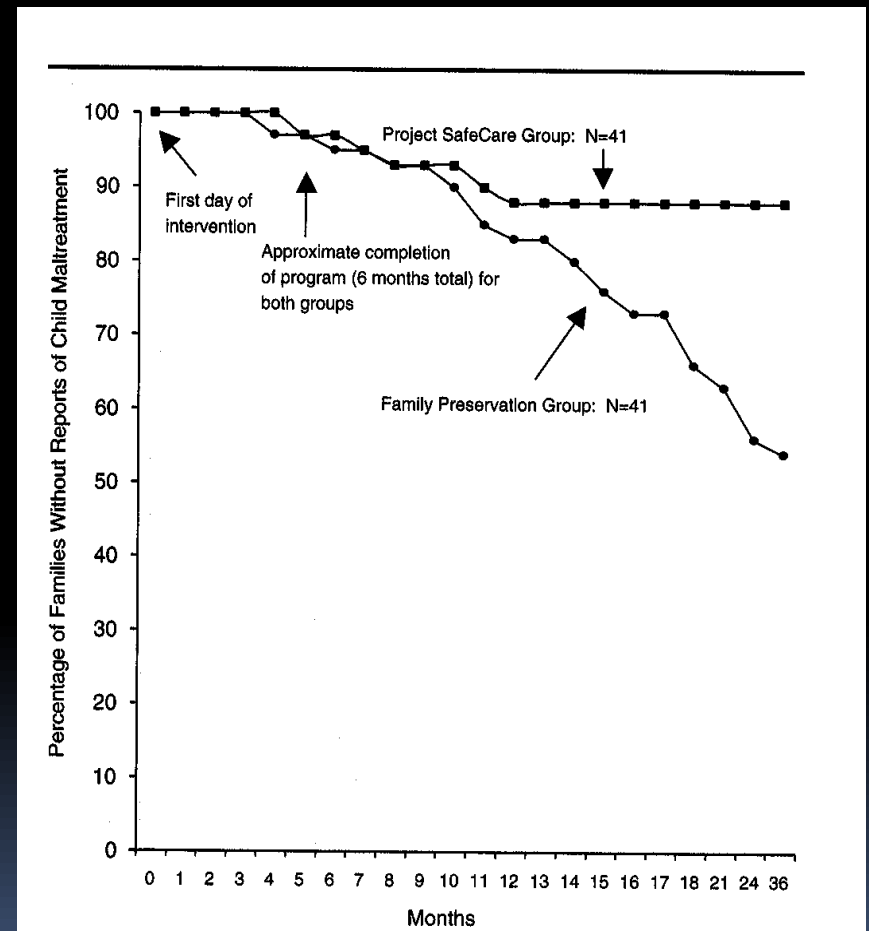


SafeCare families Had fewer child welfare reports related to DV compared to Services as Usual Families

SafeCare California

(Gershater-Molko, Lutzker, et al.)

- 82 families with current involvement in child protection services
- Top line is SafeCare families and bottom line is families that participated in family preservation
- Recidivism after 36-months
 - SafeCare: 15%
 - Family Preservation: 44%
- What does this mean?
 - 75% reduction in future reports to CPS for maltreatment in families that participate in SafeCare



Oklahoma: Statewide trial

(Chaffin)



- 6 service regions in OK assigned to SafeCare (SC) or Services As Usual (SAU)
- Providers receive SC training or do SAU
- Half of each get “fidelity monitoring” or coaching
- OUHSC researchers did evaluation to see the impact on future child maltreatment reports
- Economic evaluation

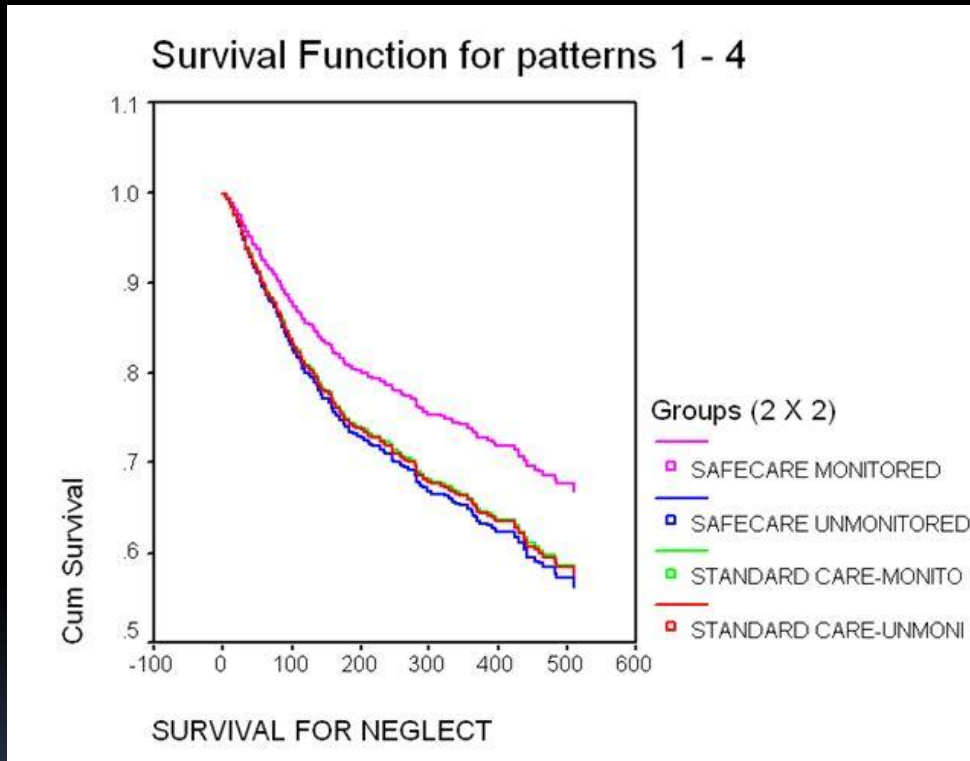
SAU

SafeCare

Monitored	Monitored
Not Monitored	Not Monitored

OK statewide trial: Outcomes

(Chaffin, Pediatrics, In press)



Reduction in neglect for SafeCare group, but only when fidelity was monitored through coaching



Also, turnover among SafeCare caseworkers was half (16%) of non-SafeCare caseworkers (31%)



Do families like SafeCare?

Answer: YES

SafeCare: Family Satisfaction

(Silovsky et al.)

- In the aforementioned Prevention Study that randomly assigned mothers to SafeCare or Services as Usual
- Mothers that participated in SafeCare compared to Services as Usual reported:
 - More satisfaction with services
 - Services to be more culturally relevant



What are the best ways to deliver SafeCare to families? How do we reach more families?

Answer: Under Investigation

Technology: Kansas Cell Phone Study

(Carta & Bigelow)

- Investigators at KU have developed a cell phone enhancement to the PCI component of SafeCare
- Why technology and cell phones?



Technology and cell phone use is pervasive and it's an inexpensive way to keep in touch...



Kansas Cell Phone Study: Preliminary Results (N=371)



- ▶ Mothers in CPAT were more likely to demonstrate improved parenting behaviors as a result of the intervention.
- ▶ Mothers in CPAT were less likely to drop out of treatment as compared to PAT mothers
- ▶ Mothers are very positive about the use of cell phones for intervention in satisfaction survey.
- ▶ Mothers rarely abused the telephones.

SafeCare with Technology for Fathers

(Self-Brown)



- Adapts SafeCare for use with at-risk fathers
 - Young
 - Low SES
 - Low education attainment
 - African American
- First year- development phase:
 - Augment SafeCare with Motivational Interviewing (MI) delivered with computer
 - Adapt SafeCare PCI module to be delivered with computer
 - Validate utilizing single-case design methodology
- Once validated, will randomly assign 120 fathers to MI-PCI or wait-list control
- Primary outcomes of interest:
 - father parenting behaviors, maltreatment risk, and child behavior outcomes
-



Implementation at NSTRC

NSTRC: two related focal areas

- Training
 - National reach
 - Rigorous implementation process that allows for sustainable implementation at each implementation site
- Research
 - Understand various aspects of the training model
 - How can we develop a practical and efficient training model?
 - Can we use technology to make aspects of the model more efficient
 - How does SafeCare fit with other evidenced based practices
 - What additional services are needed?

SafeCare Implementation

- Implementation is “A set of activities designed to put a program of known dimension into practice” (Fixsen et al 2005)
 - Or “Doing what your trying to do”
- Implementation matters for outcomes
 - Durlak (2008) reviewed 500+ studies
 - Found that greater implementation = better outcomes
 - Incomplete implementation will not yield the desired outcomes
- Our goal in training is to have sites be able to implement SafeCare with fidelity and sustain that implementation
 - Not paper implementation

SafeCare Training



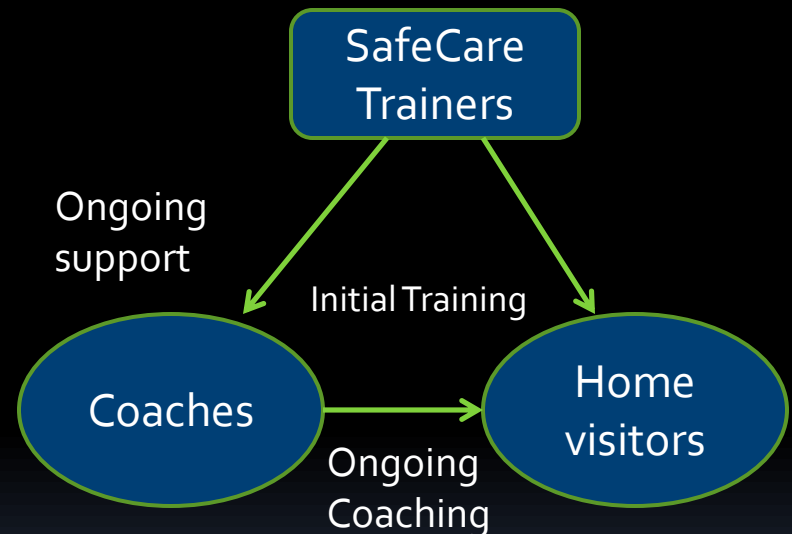
SafeCare Training Model

- Home visitor – provides SafeCare services
- Coach – provides ongoing coaching for HV to ensure fidelity to the model
 - Coaching required for SafeCare implementation
- Trainer – trains new HV and coaches
 - Trainers must practice SafeCare and coaching
 - Trainers support coaches who monitor the fidelity of home visitors

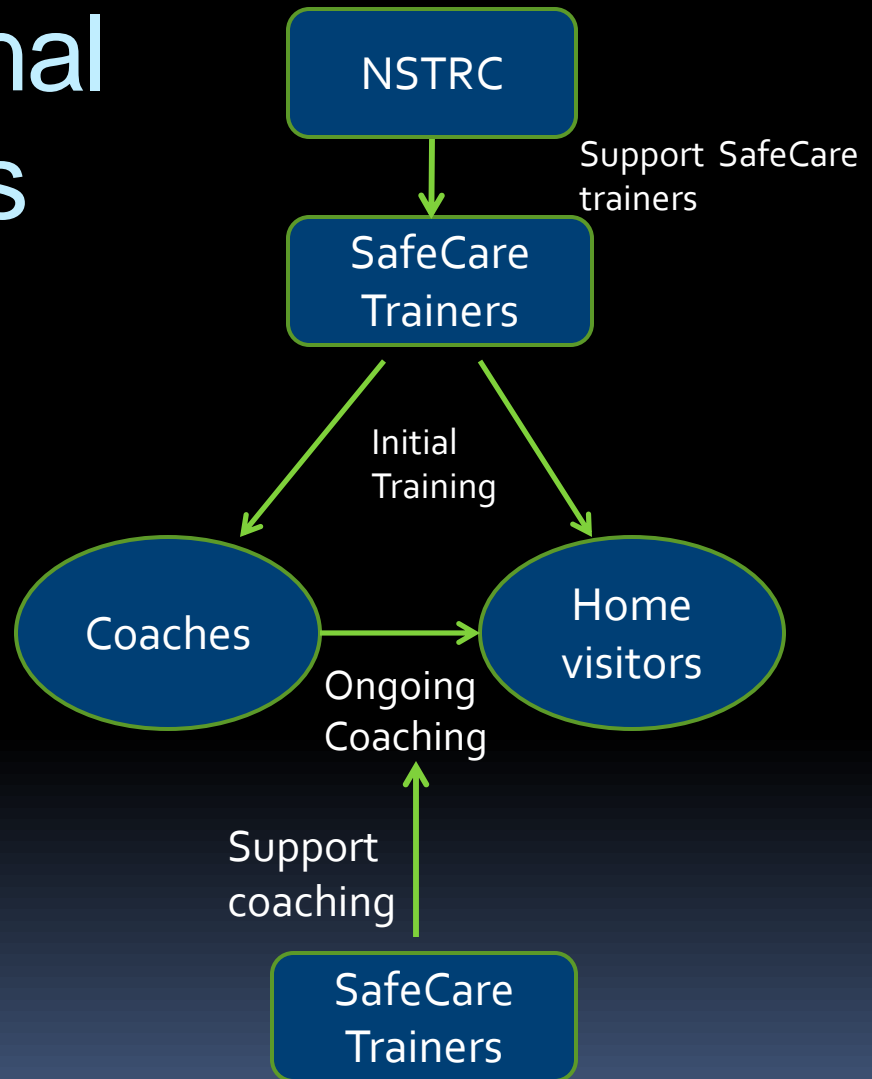


Promoting fidelity through coaching

- Coaching (fidelity monitoring) is needed for implementation with fidelity
- Coaching is meant to be collaborative & supportive
- Coaches can be supervisors or not
 - NSTRC can do direct coaching, but capacity is limited
- Coaches are supported by their SafeCare Trainers
 - SafeCare trainers can be NSTRC or external



SafeCare training model with external SafeCare trainers



SafeCare Implementation Research

- Primary focal points:
 - Testing aspects of the training model
 - Using of technology to make training more efficient and implementation stronger
 - Combining SafeCare with other evidence-based programs
 - Expanding SafeCare to new populations and/or to address new content issues

Implementation Research: GA study of training models

(Whitaker et al.)

- Funded by the CDC under translation research RFA
- Goals:
 1. Compare two training models for trainers and coaches: standard vs. enhanced
 2. Assess incremental cost and benefit of enhanced training model
 3. Understand how individual and organizational variables affect fidelity/competence for trainers, coaches, and home visitors?

SafeCare Research: Testing coaching models

(Whitaker)

- Proposed study to examine “local” vs. purveyor coaching
 - Local = training local staff to coach
 - Purveyor = NSTRC coaches
- Goals
 - Examine how coaching models affect implementation and fidelity
 - Test cost-effectiveness of the two models
 - Examine trajectories of local coaching quality

Other research proposals

- Building a module to prevent intimate partner violence (ACF; Silovsky)
- Developing a behavior management module for older children (NIH; Hecht)
- Tailoring SafeCare for adults with intellectual disabilities (Lutzker)
- Facebook-enhanced SafeCare (Edwards; proposed NIH)
- SafeCare for parents with a history of substance abuse (Whitaker, proposed NIH)

SafeCare Center: Future directions

- Refine training model
 - Research grants to test aspects of model
- Use technology to make training & implementation cheaper
 - Technology-based training, coaching, and fidelity monitoring
 - Health economics work to understand the cost/benefit ratio of
- Understand fit of SafeCare with other EBP
- Understand policy aspects of increasing EBP in child welfare settings
- Understand adaptations for cultural groups, including international implementation
- Enhance engagement in services

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