SafeCare®: An Evidence-Based Approach to Prevent Child Neglect

Debra B. Hecht, PhD, Jane F. Silovsky, PhD, Mark Chaffin, PhD, John R. Lutzker, PhD

Services within the child welfare system have been described as based primarily on practice ideologies and practitioner experience rather than on scientific evidence of efficacy (Chadwick Center on Children and Families, 2004). This issue is hardly unique to child maltreatment or child welfare practice, and over the past decade there has been a shift in favor of an evidence-based practice philosophy. Randomized clinical trials have demonstrated efficacy of treatments for children affected by sexual abuse and physical abuse, as well as for physically abusive parents (e.g., trauma-focused cognitive behavior therapy (TF-CBT), parent child interaction therapy (PCIT), physical abuse focused cognitive behavior therapy, and a variety of parent training models for disruptive behavior disorders in children). Services for child neglect, by far the most prevalent form of child maltreatment, have seen fewer developments (see Chaffin, Bonner, & Hill, 2001; Littell & Schuerman, 2002; and USDHHS, 2002). Promising models exist, although none have been classified as well supported. In this paper, we briefly describe one model, SafeCare®, and its promise for preventing child neglect.

Overview of the SafeCare® /12-Ways Model

SafeCare® is a derivation of the original Project 12-Ways model developed by Lutzker and colleagues (Lutzker, 1984; Lutzker & Bigelow, 2002). This model has been used and evaluated in university-based projects in rural Illinois since 1979, in university-based projects in Los Angeles (Lutzker, 1984; Lutzker, Tymchuk, & Bigelow, 2001), and currently in Kansas, Michigan, Georgia, and in two field trials in Oklahoma. The model has been described in over 60 publications, covering the model itself, research, and outcome evaluations, and in more than 100 presentations.

The SafeCare® model is designed for use with multiproblem families involved in the child welfare system or who are at high risk for child welfare involvement due to neglect, physical abuse, or both, with the main goal of reducing subsequent maltreatment. It focuses directly on behaviors constituting child neglect, particularly neglect of young children, and is designed as a home-based service that can be delivered by paraprofessional staff. The name, Project 12-Ways, stemmed from the original twelve services offered to prevent or treat child maltreatment. Initial research and practice indicated that many involved families did not have needs in all areas, and it was difficult for paraprofessional staff to achieve competency, and/or efficient delivery in all twelve areas. The service was streamlined by selecting the three most prevalent parental behaviors associated with child neglect, when a foundation grant was funded to systematically replicate the model in California. This derivation became SafeCare® (SC). The components of SC are home safety and organization skills, child health and nutrition management skills, and child behavior management skills (Lutzker, Wesch, & Rice, 1984).

SC is based on the ecobehavioral model (Lutzker, 1984). The *eco* prefix refers to intervention targets at different levels within the concentric ecological model of maltreatment. The behavioral component reflects which targets are emphasized (proximal skills and behaviors), as well as technical aspects of how change is pursued (ongoing measurement of observable behaviors, skill modeling, practice and feedback, and training of skills to criterion; Lutzker, Wesch, & Rice, 1984; Lutzker & Bigelow, 2002). The model is rooted in the behavior analysis field. Behavioral theory conceptualizes child neglect in terms of skill deficits, particularly those skills that are most proximal to neglect and that form the objective basis of the family's involvement in the child protection system—failing to provide a safe and healthy home environment; inadequate parent-child involvement, bonding or supervision; and inappropriate parenting or child-management skills. In other words, the model focuses on neglectful behaviors directly, rather than on presumed underlying factors. This perspective does not preclude addressing possibly contributory, underlying, or co-morbid disorders such as parental substance abuse or depression, nor does it preclude recognizing the role of poverty and the need many neglecting families have for concrete supportive services (e.g., WIC, TANF, housing, etc.). However, these co-morbid or contributory areas are addressed by identification and referral to specialized services or benefits on a case-by-case basis, and they are not direct service components of the model beyond identification, referral, and support of service utilization to address them.

The SC model is structured, manualized, and prescribed. All SC components involve three structured processes—baseline assessment, intervention, and follow-up assessments to monitor change. Home visitors conduct observations of parents' knowledge and skills for each component, using a set of observation checklists. Parents are trained using a general 7-step format: (1) describe desired target behaviors; (2) explain the rationale for each behavior; (3) model or demonstrate desired behaviors; (4) ask the parent to practice the behavior during the visit; (5) provide positive feedback (point out positive aspects of performance); (6) provide constructive feedback (point out aspects of performance needing improvement); (7) review parents' performance, have them practice areas that need improvement, and set goals for the week. Using this format, parents are trained so that skills are generalizable across time, behaviors, and settings. In the Los Angeles replication, each component was implemented in approximately five sessions and was followed by a social validation questionnaire to assess parents' satisfaction with their training. Staff worked with parents until they met a set of skill-based criteria that were established for each component.

Content Modules of SafeCare®

Infant and Child Health

The goals of the infant and child health care module are to train parents to use health reference materials, prevent illness, identify symptoms of childhood illnesses or injuries, and provide or seek appropriate treatment by following steps of a task analysis (Bigelow & Lutzker, 2000). Parents role-play medical scenarios and decide whether to treat the child at home, call a medical provider, or seek emergency treatment. Parents are provided with a validated health manual that includes a symptom guide, information about planning and prevention, caring for a child at home, calling a physician, and emergency care. Parents are also provided with health recording charts and basic health supplies (e.g., thermometer).

Home Safety

The home safety component involves the identification and reduction or elimination of accessible hazards, dangerous and unhealthy filth, and clutter by making them inaccessible to children. The parent and home visitor jointly assess each room in the home using a detailed checklist, and then skill training is delivered to help the parent reduce the number of hazards by making them inaccessible. Safety latches are supplied to the families. This includes working with parents on specific household management and cleaning practices.

Parent-Child Bonding

The parent-child bonding component consists of parent-infant interaction training (birth to 8–10 months) and parent-child interaction training (8–10 months to 5 years). The purpose of this component is to teach parents to provide engaging and stimulating activities, increase positive interactions between parents and their children, and prevent troublesome child behavior (Lutzker, Bigelow, Doctor, & Kessler, 1998). Parents learn skills to structure play and daily living activities and increase bonding and attachment opportunities with their child. The primary method used is planned activities training (PAT) (Sanders & Dadds, 1982). Positive behaviors are reinforced and coached, and problematic behaviors are addressed and modified. Home visitors teach parents to use PAT checklists to help structure the child's activities and day, encourage time for positive parent-child interactions, and encourage selective use of positive reinforcement to manage child behavior.

©PHOTOGRAPHER: YANIK CHAUVIN, AGENCY: DREAMSTIMES.COM

SafeCare® Evidence Base

A number of lines of research support the efficacy of the model. These are summarized by category of methodology.

Single Case Studies of Behavior Change

Given the roots of the model in behavior analysis, there have been a number of multiple-baseline and single-subject repeated measure design studies examining changes in coded observed behaviors and home environment criteria related to the initiation and sequencing of particular skill training modules. In these designs, measures were taken for several baseline periods, during training periods, and at follow-up. Lutzker and colleagues have reported patterns of changes in appropriate and inappropriate parent-child interaction skills, child behavior, percentage of correct steps in role plays of emergency health situations, and changes in home safety and organization as a function of module sequence among a range of families from at-risk parents to parents who have been referred for neglect related child fatalities (Bigelow & Lutzker, 1998; Lutzker, Bigelow, Rice, & Kessler, 1998; Lutzker, Bigelow, Doctor, Gershater, & Greene, 1998; Rosenfield-Schlichter, Sarber, Bueno, Greene, Lutzker, 1983; Tertinger, Greene, & Lutzker, 1984). High levels of correspondence have been reported between initiation of focused modules and expected changes in corresponding behaviors.

Within-Subjects Group Studies of Behavior Change

In these studies, group within-subject changes on observed and coded behaviors corresponding to the same target areas used in single-subject designs were compared from baseline to posttreatment. Improvements have been noted consistently and have been reported across a range of provider types (i.e., research assistants, nurses, caseworkers) (Campbell, Lutzker, & Cuvo, 1982; Campbell, O'Brien, Bickett, Lutzker, 1983; Lutzker, Bigelow, Doctor, Gershater, & Greene, 1998; Tertinger, et al., 1984). Within-subjects group findings support a conclusion that the changes in observed parent behaviors noted in the single-subject studies are not limited to a small number of individual cases but are broad, aggregate effects.

Quasi-Experimental Recidivism Studies

These studies have compared recidivism outcomes of 12-Ways/SafeCare participants with those of families who received alternative services. Gershater-Molko, Lutzker, and Wesch (2002) compared recidivism rates for families receiving SC services with rates of families receiving standard in-home family preservation services in Los Angeles. At 24-month follow-up, there was a significant difference between the groups, with SC completers having a 15% cumulative failure rate compared with 44% for family preservation services as usual.

In Illinois, Lutzker and Rice (1984) randomly selected 50 families with active child welfare cases enrolled in 12-Ways, and matched them to a comparison sample of families drawn from active cases at the same child welfare field offices. Child maltreatment recidivism was found in 10% of 12-Ways cases versus 21% of comparison cases. In an extension of this research, Lutzker and Rice (1987) compared 5-year recidivism results for families receiving 12-Ways and a matched comparison group. For each of the follow-up years, the 12-Ways group had lower rates of recidivism than the comparison group, with the greatest differences occurring immediately after service completion, and differences diminishing, but not to insignificance, over follow-up. Also in Illinois, Wesch and Lutzker (1991) compared families served by 12-Ways with a field-office matched group of families receiving services as usual. The 12-Ways families had fewer re-reports (42% vs. 56%) and fewer child placements (13% vs. 25%) than the arguably less severe comparison cases, as suggested by data that the 12-Ways families prior to treatment had significantly more contacts with the CPS than the comparison families prior to their treatment.

Cont'd on page 16

Randomized Trials of Behavior Change

Lutzker, Tymchuk, and Bigelow (2001) reported outcomes for the SC model among a group of primarily young parents with intellectual disabilities who were identified as high risk for child neglect in the UCLA Wellness Project. Families (N = 160) were randomly assigned to either modified SC or a comparison condition in which they received only didactic materials from the modified SC model, without the home visitor. Participants receiving the SC model showed significantly more improvement in the usual SC target skills and behaviors than those who received materials only.

Studies in Progress

SafeCare® high-risk prevention trial. Now entering its fourth year, this study is a randomized field trial comparing SafeCare® delivered by bachelor's-level home visitors with home-based mental health services delivered by licensed master's-level therapists. Both conditions are operated within a large community-based family preservation services provider agency, which is also a community mental health center in Oklahoma. The study population involves families who are considered to be at very high risk of imminent child welfare involvement and who have a young child and at least one of the following: parental substance abuse, serious parental depression or mental illness, domestic violence, or intellectual disabilities. Results suggest that compared with usual in-home mental health services, caregivers who were randomized to SC were less depressed, had greater reduction in child abuse potential scores, self-reported greater improvement in social support, and were engaged with a broader variety of community support services. A second randomized trial is also underway to examine implementation issues in rural populations.

SafeCare® statewide trial for neglect. This study is a large field trial involving the migration of a statewide family preservation system to the SafeCare® model. Regions of the state were assigned to deliver SC versus usual care (unstructured case management and social support model). In addition, provider teams were randomly assigned to receive either a live-coached implementation approach (having a consultant/coach accompany the home visitor to directly coach practice techniques) or the more customary didactic training plus post hoc consultation. Thus, the study uses a 2 x 2 (model by implementation approach) design. Preliminary examination of downstream child welfare recidivism outcomes suggests that the coached SC teams are obtaining positive results. Preliminary results suggest that simply providing SC training without subsequent in vivo coaching results in very little or no downstream maltreatment reduction relative to usual care.

©PHOTOGRAPHER:NORIKO COOPER, AGENCY: DREAMSTIMES.COM

Additional studies. The Centers for Disease Control (CDC) has funded two research studies examining the potential efficacy of technological enhancements to the SC model. In Kansas, cell phones are being used to increase dosage (i.e., more frequent contact with therapists) with the parent-child training component of SC. In Michigan, computer-assisted SC training is being evaluated.

Summary of Research Evidence

There is a pattern of evidence to support a conclusion that SC produces in situ behavior changes in behavioral domains directly proximal to child neglect (i.e., the same behaviors that occasion child neglect reports). The effect of the program and associated behavior changes on reducing subsequent recidivism of child maltreatment is supported by a pattern of findings, including both liberal and, more important, conservatively biased quasi-experimental comparison studies. Improved benefits have been documented compared with services as usual delivered by paraprofessional staff and compared with usual services delivered by more highly credentialed mental health professional staff. There are two published trial studies supporting efficacy, and there are encouraging preliminary findings in two other randomized studies. Preliminary data are available that support feasibility in large-scale real-world settings using usual field provider staff. Success of the model probably relates also to its in situ nature, and as is true with other evidence-based models, the focus on structured skills training. Improvements in parents is predictable because generalization of skills is known to be enhanced by frequent practice and training in real-life situations.

Lessons Learned in Implementing SafeCare®

Our experience conducting the two Oklahoma field trials has yielded some initial lessons about the keys to implementing SafeCare®, and possibly other evidence-based models for child neglect, within the context of the large family preservation or family reunification service networks that service these cases. First, we believe it is critical that there is strong organizational leadership and commitment to bringing in and adopting the evidence-based practice, both financially and structurally. Second, our experience and emerging data have led us to reformulate traditional training approaches (workshop training and *post hoc* consultation), which we have found, and which a variety of evidence suggests, are largely ineffective. We believe uptake is far more effective when the initial training is done in small, intact practitioner teams (3–5 home visitors at a time), focuses on clear and specific skills, is broken up into manageable doses rather than massed, and is followed by periodic live modeling and direct observation of in situ practice. Adopting this sort of implementation approach requires a radical rethinking of how service systems conduct training. Finally, we believe it is important to understand that introduction of a new evidence-based model is likely to be met with mixed responses from front-line providers, even when they have been involved as stakeholders in the implementation process. Some will embrace the new model. Others will find it at odds with deeply held practice ideologies and habits. New staff members, who have fewer preexisting ideologies or habits, may find uptake easier than some more experienced staff. We believe that key next steps with research into SafeCare®, or any other evidence-based models relevant to child welfare, is to learn not only what works or how to improve the model itself but also how to transport these models into the unique systems serving child welfare clients.

References

Bigelow, K. M., & Lutzker, J. R. (1998). Using video to teach planned activities to parents reported for child abuse. *Child & Family Behavior Therapy, 20*, 1-14.

Bigelow, K. M., & Lutzker, J. R. (2000). Training parents reported for or at risk for child abuse and neglect to identify and treat their children's illnesses. *Journal of Family Violence, 15*(4), 311-330.

Campbell, R. V., Lutzker, J. R., & Cuvo, A. J. (1982, May). *Comparision study of affection in low socioeconomic families across status of abuse, neglect, and non-abuse neglect*. Paper presented at the 8th annual convention of the Association for Behavior Analysis, Milwaukee, Wisconsin.

Campbell, R. V., O'Brien, S., Bickett, A., & Lutzker, J. R. (1983). In-home parent training, treatment of migraine headaches, and marital counseling as an ecobehavioral approach to prevent child abuse. *Journal of Behavior Therapy and Experimental Psychiatry, 14*, 147-154.

Chadwick Center on Children and Families. (2004). *Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices.* San Diego, CA: Author.

Chaffin, M., Bonner, B. L., & Hill, R. (2001). Family preservation and family support programs: Child maltreatment outcomes across client risk levels and program types. *Child Abuse & Neglect, 25,* 1269-1289.

Cordon, I. M., Lutzker, J. R., Bigelow, K. M., & Doctor, R. M. (1998). Evaluating Spanish protocols for teaching bonding, home safety, and health care skills to a mother reported for child abuse. *Journal of Behavior Therapy and Experimental Psychiatry, 29,* 41-54.

Gershater-Molko, R. M., Lutzker, J. R., & Wesch, D. (2002). Using recidivism data to evaluate Project SafeCare: An ecobehavioral approach to teach 'bonding,' safety, and health care skills. *Child Maltreatment, 7*(3), 277-285.

Littell, J. H, & Schuerman, J. R. (2002). What works best for whom? A closer look at intensive family preservation services. *Children & Youth Services Review, 24*(9-10), 673-699.

Lutzker, J. R. (1984). Project 12-Ways: Treating child abuse and neglect from an ecobehavioral perspective. In R. F. Dangel & R. A. Polster (Eds.), *Parent training: Foundations of research and practice* (pp. 260-297). New York: Guilford.

Lutzker, J. R., & Bigelow, K. M. (2002). *Reducing child maltreatment: A guidebook for parent services.* New York: Guilford.

Lutzker, J. R., Bigelow, K. M., Doctor, R. M., Gershater, R. M., & Greene, B. F. (1998). An ecobehavioral model for the prevention and treatment of child abuse and neglect. In J. R. Lutzker (Ed.), *Handbook of child abuse research and treatment* (pp. 239-266). New York: Plenum.

Lutzker, J. R., & Rice, J. M. (1984). Project 12-Ways: Measuring outcome of a large-scale in-home service for the treatment and prevention of child abuse and neglect. *Child Abuse & Neglect, 8,* 519-524.

Lutzker, J. R., & Rice, J. M. (1987). Using recidivism data to evaluate Project 12-Ways: An ecobehavioral approach to the treatment and prevention of child abuse and neglect. *Journal of Family Violence, 2,* 283-290.

Lutzker, J. R., Tymchuk, A. J., & Bigelow, K. M. (2001). Applied research in child maltreatment: Practicalities and pitfalls. *Children's Services: Social Policy, Research, and Practice, 4,* 141-156.

Lutzker, J. R., Wesch, D., & Rice, J. M. (1984). A review of Project 12-Ways: An ecobehavioral approach to the treatment and prevention of child abuse and neglect. *Advances in Behavior Research and Therapy, 6,* 63-73. Indexed in the *Inventory of Marriage and Family Literature* (1985), XI, Family Resource Center.

Rosenfeld-Schlichter, M. D., Sarber, R. E., Bueno, G., Greene, B. V., & Lutzker, J. R. (1983). Maintaining accountability for an ecobehavioral treatment of one aspect of child neglect: Personal cleanliness. *Education and Treatment of Children, 6,* 153-164.

Sanders, M. R., & Dadds, M. A. (1982). The effects of planned activities training and child management procedures in parent training: An analysis of setting generality. *Behavior Therapy, 13*, 452-461.

Tertinger, D., Greene, B., & Lutzker, J. R. (1984). Home safety: Development and validation of one component of an ecobehavioral treatment program for abused and neglected children. *Journal of Applied Behavior Analysis, 17,* 159-174.

U.S. Department of Health and Human Services (USDHHS). (2002). *Evaluation of family preservation and reunification programs: Final report.* (http://aspe.hhs.gov/hsp/evalfampres94/Final)

Wesch, D., & Lutzker, J. R. (1991). A comprehensive 5-year evaluation of Project 12-Ways: An ecobehavioral program for treating and preventing child abuse and neglect. *Journal of Family Violence, 6,* 17-35.

About the Authors

Debra B. Hecht, PhD, is Assistant Professor of Research in clinical child psychology at the Center on Child Abuse and Neglect, Department of Pediatrics, University of Oklahoma Health Sciences Center, with focus on the development and evaluation of appropriate assessment and treatment programs for children who have been abused and neglected and their families (debra-hecht@ouhsc.edu).

Jane F. Silovsky, PhD, is a clinical child psychologist and co-Associate Director of the Center on Child Abuse and Neglect. Currently, she is Associate Professor in the Department of Pediatrics at the University of Oklahoma Health Sciences Center. Her research is in the area of prevention and intervention outcome and program evaluation of services for children affected by child maltreatment (jane-silovsky@ouhsc.edu).

Mark J. Chaffin, PhD, is a psychologist and Professor of Pediatrics and Clinical Associate Professor of Psychiatry and Behavioral Sciences at the University of Oklahoma Health Sciences. He currently serves as Director of Research for Developmental and Behavioral Pediatrics (mark-chaffin@ouhsc.edu).

John R. Lutzker, PhD, is Executive Director of the Marcus Institute, specializing in work with children who have developmental disabilities and their families. He is also Professor of Pediatrics at the Emory University School of Medicine in Atlanta, Georgia (lutzkerj@marcus.org).

Acknowledgements

The authors would like to acknowledge the support provided for the SafeCare research, which has been funded by grants from the National Institute of Mental Health (5RO1 MH065667), Centers for Disease Control and Prevention (R49 CE000449-03), the Office of Juvenile Justice and Delinquency Prevention (2006-JP-FX-0067), and the Oklahoma Department of Human Services.