The Prevention of Child Maltreatment: Using SafeCare® to Highlight Successes and Needs for Improvement in Prevention Efforts

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Abstract

Child maltreatment is a public health problem of considerable magnitude. Though substantial progress has been made in the prevention of child maltreatment, one incident of maltreatment is one too many. Intervention and/or prevention efforts must always be dynamic. In this commentary, we highlight recent prevention and policy efforts in the United States, using SafeCare, an evidence-based parent support program with a focus on the prevention of neglect, as an example. We describe broad-scale implementation efforts and offer a vision for what the field must do to realize public heath impact, highlighting recent advances of parent support models in policy, advocacy, and programs. Strategies that might improve current efforts are suggested to ensure the field not become static.

Keywords Prevention · SafeCare · Home visiting

For nearly 60 years, since Kempe and colleagues' eye-opening article on the battered child syndrome (1962), child maltreatment has been an important area of social concern and scientific inquiry. Particularly since the 1980s, there has been considerable success in the United States (U.S.) in raising awareness, enacting mandated reporting policies, and the proliferation of various prevention programs. A marked declining trend in most forms of child maltreatment has been documented by Finkelhor and colleagues since the 1990s (2021). In this time, sexual abuse and physical abuse declined 62% and 56%, respectively, whereas neglect declined only 13%. Despite hopeful reductions in prevalence, *one* instance of maltreatment is one too many. In

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short, there is more to be accomplished. In this commentary, we describe successes in prevention and policy efforts, using the SafeCare® model, an evidence-based parent support program as a representative of the increasing number of evidence-based parent support programs. We share our vision for what more the field should do to realize public heath impact on the prevention of child maltreatment more generally, highlighting the advances of parent education models.

Prevention Programming and Policy Efforts

Early childhood home visiting (i.e., parent education, training, or support) programs promote child development, early literacy, school readiness, and parenting behaviors (Duffee et al., 2017) and have been the prevailing strategy for the prevention of child maltreatment for nearly two decades. Meta-analyses of studies on the effectiveness of these parent support programs show mixed results (Chen & Chan, 2016; Filene et al., 2015). Federal support remains strong, however, as evidenced by significant funding to support their implementation. For example, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, administered by the Health Resources and Services Administration (HRSA) and the Administration for Children and Families, funds the implementation of 19 home-based parent education programs with a high standard of evidence (Avellar & Supplee, 2013). In 2018, the MIECHV Program received $400 million per year through fiscal year 2022. Additionally, the Family First Prevention Services Act (FFPSA), enacted in 2018 as part of Public Law 115–123, authorized the use of Title IV-E funds for prevention services including evidence-based, in-home parent skill-based programs.

SafeCare, a parent support program developed using principles of applied behavior analysis, rated favorably by both the Title IV-E Prevention Services Clearinghouse and the Home Visiting Evidence of Effectiveness (HomeVEE) review. It remains the only parent education program designed to impact the risk factors for neglect specifically. SafeCare focuses on parents' skills in three specific areas: creating positive parent–child relationships, improving home safety to prevent unintentional injuries, and keeping children healthy (https://safecare.publichealth.gsu.edu/). The curriculum, delivered in approximately 18 weekly sessions, is designed for parents or caregivers of children under 5 years old. Several reviews of SafeCare have been published previously (see Cowart-Osborne et al., 2014; Guastaferro & Lutzker, 2017, 2019; Guastaferro et al., 2012; Rostad et al., 2016). What follows is a brief review, and glimpse "behind the curtain" to showcase the development of the SafeCare model as it is known as today.

SafeCare: A Retrospective of Model Development

New program development often combines a good idea, planning, and some fortuitous events. This was certainly the case with SafeCare. In 1979, there were nascent efforts aimed at developing and implementing prevention and intervention programs. These efforts stemmed from the first passage by the U.S. Congress

in 1974 of the Child Abuse Prevention Act (CAPTA). A federal Title XX program distributed in Illinois by the Governor's Donated Funds Initiative which issued a call for proposals for new prevention/intervention programs in 1979. At this time, the second author had been considering developing a prevention or intervention program based on providing skills to high-risk parents that they were lacking as suggested by the literature of the day. Such a program would be offered in-home based upon logistical difficulties of trying to attract parents to clinic sites to which they might be reticent to go, and that it could be difficult or impossible for them to go because of distance in rural areas, transportation, and other logistical issues. Also, a skills-based program would be offered through well-tested behavioral teaching strategies based on learning theory which also had demonstrated that the most effective teaching/training occurs in natural settings in which the skills are to be implemented (i.e., ecobehavioral; Lutzker et al., 1982). In 1979, there were a mere handful of case studies and clinical descriptions in the literature of attempts to offer treatment to individual parents who had been referred for child abuse or neglect. Though the oldest evidence-based program, Nurse Family Partnership (Olds et al., 1999), an enduring well-respected prenatal program for high-risk mothers, had begun in 1977, there were no published research articles on the model in the literature in 1979.

Thus, timing could not have been better when the southern region of the Illinois Department of Children and Family Services (DCFS) proactively contacted the second author, apprised him of the availability of funding opportunities, and asked what he might propose (the fortuitous aspect of Project 12-Ways). When Lutzker described his ideas of what he labeled an ecobehavioral approach to a prevention/intervention, the regional office worked in concert with him to submit a proposal to the state. What would be the precursor to SafeCare, Project 12-Ways was funded on July 1, 1979, and has been continuously funded ever since.

The original Project 12-Ways was so named because it offered a menu of 12 different skills training modules to families in the region either referred for child abuse or neglect or referred as high-risk. They were: (1) parent–child training; (2) stress reduction and assertiveness training; (3) self-management training for parents; (4) basic skills training for children, such as toilet training; (5) marital counseling and leisure time counseling; (6) alcohol abuse treatment or referral; (7) social support groups; (8) job-finding training; (9) money management training; (10) health maintenance and nutrition; (11) home safety training; and (12) parent-infant training. Project 12-Ways was delivered by graduate student providers to families referred by DCFS with children under 8. Three outcome evaluations within the first 7 years of Project 12-Ways showed that families who received Project 12-Ways services had a significantly lower risk of repeated investigation and referral by DCFS than a comparison group of matched families who received services as usual (Lutzker & Rice, 1984; Lutzker et al., 1984). One study showed that the Project 12-Ways families could be described as higher-risk because they had more pre-intervention reports of child maltreatment than the comparison group families (Lutzker & Rice, 1987). Though Project 12-Ways was efficacious, it was too cumbersome to disseminate on a widescale. Project 12-Ways continues to be implemented in southern Illinois by graduate students to this day.

Lutzker left southern Illinois in 1985 for California where he received a grant from the California Department of Developmental Services to replicate the Project 12-Ways model in a voluntary program adapted and tailored for parents of children with developmental and intellectual disabilities (Lutzker & Campbell, 1994). In 1993, the California Wellness Foundation proactively contacted Lutzker, having seen numerous Project 12-Ways published main outcome studies and many other studies documenting the effectiveness of the individual modules (see Dachman et al., 1984; Delgado & Lutzker, 1988; Lutzker et al., 1998; Tertinger et al., 1984; Watson-Perczel, et al., 1998). The California Wellness Foundation asked if he would be interested in developing a proposal that would replicate Project 12-Ways, but make it more streamlined, replicable, and able to be disseminated. An application was submitted, and an award was made in 1994 for a 4-year research grant comparing the new model, SafeCare (Gershater-Molko et al., 2003), to services as usual in the San Fernando Valley of Los Angeles. This also addressed another concern of the California Wellness Foundation that the new model should serve a densely populated, highly diverse community. The Foundation also wanted a demonstration that SafeCare could be delivered by a diverse, college-educated staff who resembled in DCFS caseworkers in Los Angeles.

SafeCare Modules

The three most utilized components (i.e., modules) of Project 12-Ways were chosen as the components of SafeCare: Parent–child (ages 2–5)/parent-infant (ages birth-2); home safety and cleanliness; and child health training for parents (Guastaferro et al., 2012). Most evidence-based parent support programs provide some form of parent training (Kaye et al., 2018; van der Put et al., 2018). Skill deficits in parenting can be a precursor to abuse and/or neglect, and deficits in health care skills and dangerously unsafe homes with hazards accessible to young children and highly cluttered homes are often a sign of neglect (the mode reason for referral for child maltreatment in the U.S.). The original skills targeted for parent–child and parent-infant training for Project 12-Ways were validated through surveys to early childhood educators and child behavior therapy professionals (Lutzker et al., 1985). The health care skills were validated by primary care physician residents (Bigelow & Lutzker, 2000). The home safety skills were validated by experts in home safety and DCFS workers (Tertinger et al., 1984). Over the years, SafeCare modules have been validated three different times by similar professionals (see Guastaferro et al., 2012). After each validation, skills are modified, new ones are added, and some are dropped.

Parent–Child Training

The parent-infant interaction module focuses primarily on engagement with babies and stimulation, especially talking very often to the baby. Thus, parents are taught skills such as cuddling, holding them so mother and baby can be eye-to-eye, and engagement in activities such as stretching arms and legs. The parent–child module also focuses on positive interactions between parent and child through daily

activities (i.e., bath time, bedtime, or mealtime) or when the child is playing. There is a strong focus on language, specifically incidental teaching wherein the parent is asked to always be teaching by extending language and informing the child. For example, the parent might ask the child to identify a ball. If the child says, "ball," the parent might say, "what color is the ball" and then, "is the ball big or small?" This component also focuses on having parents plan and explain activities and what the child can expect from the activity as well as providing feedback to the child.

Home Safety

This module involves the removal of accessible hazards in the home and the removal of filth and clutter. Hazards represent the most common causes of unintentional injury in the home such as choking or poisoning. Providers use the Home Accident Inventory-Revised to count the number of accessible hazards and guide the parent through identifying and removing them or using child-proofing hardware to make them inaccessible, as well as helping parents identify and clean filth and clutter. Emphasized in this module is the importance of parental supervision to prevent unintentional injuries.

Child Health Care

Targeting the risk for medical neglect, the health module teaches parents a step-by-step process to identify symptoms and illnesses and how to decide the appropriate course of care. Parents receive a validated health care manual describing common symptoms and illnesses for children under five. The provider uses scenarios to teach parents to determine if the symptoms or illnesses they observe may be treated at home, require a call to the physician's office, or a visit to an emergency department.

Model Evidence

The first trial of SafeCare in the San Fernando Valley was a 4-year follow-up matched comparison group study in which there was dramatically higher survival rates (no reports of child abuse or neglect) for families who received SafeCare to services as usual families (Gershater-Molko et al., 2002). However, the evidence-base for SafeCare was established by the landmark statewide trial in Oklahoma led by Chaffin. In an unprecedented 7-year follow-up, it was demonstrated that parents who received SafeCare had a 26% decrease in reports of subsequent child maltreatment compared to families who received services as usual (Chaffin et al., 2012). The most recent randomized trial comparing SafeCare to services as usual (i.e., unstructured support, crisis management, referrals, and parent education) among parents referred to child welfare systems indicates that SafeCare significantly improved parenting outcomes related to positive child behaviors ($d = 0.46$), proactive parenting ($d = 0.25$), and parenting stress ($d = 0.28 - 0.30$; Whitaker et al., 2020). In a secondary data analysis of behavior change among 493 families who received SafeCare across 64 agencies, there was a significant increase in health care ($d = 1.74$) and

parent–child interaction (d = 2.10) skills as well as a significant decrease in home hazards (d = 3.0; Rogers-Brown et al., 2020). However, an evidence-based program is only as effective as its dissemination and implementation efforts.

Model Dissemination

In October 2007, the Doris Duke Charitable Foundation awarded Lutzker a program grant to create the National SafeCare Training and Research Center (NSTRC), housed in the School of Public Health at Georgia State University since 2008 (www.safecarecenter.org). With the NSTRC in place, a system for implementation and dissemination has produced a SafeCare footprint in over 30 states and 8 other countries. In the U.S., the state of Colorado implements SafeCare across 41 counties and served over 2,600 families between 2014 and 2017 (Beachy-Quick et al., 2018). Though not a randomized trial, program evaluation data from the Colorado implementation indicate a replication of behavioral findings reported in prior research (e.g., reduction in hazards in the home, improved parent–child interactions, and increased health care skills), suggesting the replicability of the model when implemented on a wide scale. In Canada, SafeCare was well received by parents (Gallitto et al., 2018) and significant decrease in neglectful parenting was observed 3 months post-intervention (Gallitto et al., 2021) as well as a reduction in parents' reported depressive and anxious symptoms (Romano et al., 2020).

Without question, the international dissemination and implementation of Safe-Care is no small undertaking. As noted by Albers et al. (2020), the geographical distance from an overseas model purveyor amplifies implementation challenges. Even when well resourced, the implementation process can be fragile and tenuous. Critical to the success of implementation efforts is a clear understanding of implementation capacity and infrastructure. Shanley et al. (2021) conducted a mixed method study to assess the capacity of preparedness in Kenya to implement the prevention program. Qualitative data revealed important contextual factors such as informal, formal, and institutionalized sources of support and advice that could in equal parts facilitate or hinder implementation efforts. For example, the informal advice of trusted maternal family members is often sought, but may contrast with the usual approach offered by any given evidence-based program, thereby possibly putting a successful implementation at-risk. Thus, international implementation often requires adaptations related to content (e.g., language), but also procedural adaptations (e.g., how to recruit, engage, evaluation; Self-Brown et al., 2011).

To maintain the evidence-base of the model, it is important to consider pilot testing with an eye towards acceptability and feasibility in any new implementation context. For example, in Israel, the curriculum was adapted to be delivered in Hebrew but also had to be adapted to operate within the social welfare system which functions markedly different from the child welfare systems in the U.S. (e.g., prolonged, multi-year contact with the social worker), which has implications for evaluation of effectiveness (Oppenheim-Weller & Zeira, 2018). The adapted program was subsequently pilot tested with 46 mothers identified to be at-risk for neglect and found improved competencies and a reduction in maternal depressive symptoms

(Oppenheim-Weller et al., 2020). Similarly in Spain, SafeCare was piloted among 46 parents who not only reported high levels of satisfaction with the program, but also demonstrated improved parenting skills and reduced child abuse potential (Arruabarrena et al., 2019). Future (and ongoing) work should seek to replicate the effectiveness of any model in varied settings using rigorous experimental designs.

Evolution of Child Maltreatment Prevention Programs

The field of child maltreatment prevention has changed in the past four decades since the seminal Kempe paper. Federal efforts have encouraged collaboration among evidence-based models to help solve cross-model problems such as engagement (Guastaferro et al., 2020), and the development of national organizations working to improve the precision of programs (Duggan et al., 2013). There has also been private funding for an effort known as the National Home Visiting Model Alliance to foster increased collaboration. However, the COVID-19 pandemic spotlighted the importance of these programs, particularly among the most vulnerable children and families. A silver lining was the accelerated adoption (and/or development) of innovative approaches including, most notably, the delivery of home-based parent support programs through a virtual platform, such as telehealth.

Before the COVID-19 pandemic, Traube et al. (2020) adapted the Parents as Teachers model for virtual delivery, demonstrating high levels of effectiveness and fidelity in the telehealth platform. However, the parent support field was resistant to this delivery modality and federal funders withheld reimbursement of virtually delivered services. The COVID-19 pandemic forced the field-wide transition to virtual services and the development of the Rapid-Response Virtual Home Visiting collaborative, led by Parents as Teachers, as well as the reimbursement of services delivered virtually. Many SafeCare providers delivered the model virtually during this time, some of whom indicated that the delivery of portions of the model were the same if not easier to deliver virtually compared to in-person (Self-Brown et al., 2020). Anecdotally, we have heard stories from parent education providers across models indicating a higher rate of retention and participation in virtual services. Delivery of services virtually beyond the COVID-19 pandemic may have far reaching impact on the field of child maltreatment prevention.

What More Should Be Accomplished?

In 1983, Lutzker and colleagues suggested that the parent support field not become complacent, but instead adapt and develop new innovative strategies to improve the field of parent education and support (Lutzker et al., 1983). The past several decades have shown many advancements in policy, advocacy, and programs, but more work is still needed. Strategies to improve current efforts might include:

- Using known parenting protective factors in intervention programs. This might be accomplished by more research into parent–child interactions of families who have risk factors for child maltreatment but have never been reported and appear to be successful in their parenting and adjustment to their social ecology and incorporating any of those strategies into extant parent support models.
- Given that poverty and limited childcare availability are known risk factors for child maltreatment, it is promising that federal funding and policy changes might be forthcoming to improve these concerns.
- Community activities and an enriched environment are also known protective factors in child maltreatment and youth violence. More youth programs and child development programs could extend protective factors to families most in need.
- Finally, more research is very much needed on how to best match families to evidence-based programs. No one program will ever offer a panacea. Algorithms need to be developed for a matching process that would likely increase engagement and retention when the best fit model is chosen for any given family.

Our field prides itself on the use of evidence-based programs; thus, the science supporting parent support models must also not become static. Though several programs have demonstrated effectiveness and have been rated as evidence-based, it is important to consider the magnitude of effect. For example, the Chen and Chan (2016) meta-analysis of 24 studies claiming to prevent child maltreatment estimated an effect size of 0.198 — significant, yes, but also small. Additionally, the number of children who experience maltreatment, and specifically neglect, annually is not inconsequential. Thus, as a field, we must examine mechanisms to improve engagement (i.e., recruitment, participation, and retention) in services including, but not limited to, the provision of programs in virtual settings. Related, there needs to be examinations of ways to make programs and models more affordable to implement such that a greater number of children and families in need can be accessed. Incorporation of innovative methods such as the engineering-inspired multiphase optimization strategy (MOST) framework could maximize the effectiveness, efficiency, affordability, and scalability of parent education programs (Guastaferro & Collins, 2019; Guastaferro et al., 2021). It remains as urgent as it was in 1983 that as a field, we not become static.

Declarations

Conflict of Interest John R. Lutzker is the developer of the SafeCare model. There are no other conflicts of interest to disclose.

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