STRATEGY BRIEF

STRONG FAMILIES

How does SafeCare support parents of young children?

Most parents have wished for support at some point along their parenting journey.[1] For some, home visiting programs provide the tools, knowledge, and confidence they need to successfully navigate the challenges of parenting. While the details of home visiting programs can vary — such as services, intensity, and who is being served — all include regular visits from a professional or paraprofessional focused on building parenting skills. Home visiting programs have a strong evidence base for increasing positive outcomes for families and have been shown to support healthy child development, increase family economic independence, increase positive parenting practices, and decrease child maltreatment.

SafeCare® is one home visiting program that has been found to be effective in supporting parents of children from birth to age 5 by teaching parents positive parent-child interaction, how to respond to common childhood behaviors, how to improve the home environment by minimizing safety hazards, and how to recognize signs of child illness and injury. The goals of SafeCare are for parents to increase their positive parent-child interactions, improve home safety, improve their ability to care for their child's health, and reduce incidents of maltreatment.

SafeCare is offered once a week for 18 to 20 weeks, with each visit lasting 60 to 90 minutes and including an explanation of skills followed by modeling and role modeling, an assessment of skill achievement, fidelity monitoring, and booster training, if needed. In response to the COVID-19 pandemic, the National

casey family programs

SafeCare Training and Research Center at Georgia State University engaged families through virtual, technology-based delivery of SafeCare, developing guidance for home visitors and resources to support parents through the pandemic. SafeCare materials are available in English, Spanish, French, and Hebrew,[2] and the provider curriculum is offered in both Spanish and English.

Evidence of impact

There have been more than 60 studies examining varying elements of the SafeCare model.[3] In general, SafeCare has been shown to have a positive impact on the behaviors targeted by the model. For example, one study found an increase of 84% in parenting skills and a 78% decrease in the number of home hazards.[4] When compared to families that received services as usual, families that received SafeCare were less likely to have a recurrence of child maltreatment over the subsequent three years (15% vs. 44%),[5] exhibited improved parenting behaviors, and reported reduced parent stress.[6]

Research suggests that SafeCare works well with American Indian and Latinx families. Results of one study indicate that SafeCare was well received by American Indian parents, who felt it was culturally competent and resulted in strong partnership with their home visitor. SafeCare also has been adapted to engage Latinx families without altering adherence to the core components of the model.[7] A program developer and university researchers, in partnership with parents from the local Latinx community, designed the adaptations, targeting areas of language, extended family, acculturation, traditional beliefs, relationship development, learning style, and racism, stereotypes and discrimination. Latinx families that received this adapted SafeCare model indicated they were highly satisfied and felt the approach was culturally compatible. The adapted model has obtained national certification.[8]

NEW BEGINNINGS

Lubov Glover saw a booth for SafeCare at a baby expo. Pregnant with her second child, she was desperate for advice on how to manage her toddler's behavior. Glover's home visitor —she refers to her as "super nanny" — helped her set goals and realize that her expectation for her toddler "not to act like a toddler" was unrealistic, resulting in inconsistent parenting. Through regular sessions, Glover came to realize that she was in a mentally and emotionally abusive marriage and had underlying depression, both of which impacted her interactions with her child. Her home visitor helped her get the mental health services she needed. As a result, Glover gained the confidence to file for divorce, allowing her to build a healthy life for herself and her children, now 6 and 9. Eventually, Glover began a new career path and now is employed by the same mental health service provider where she first sought help.

With so many studies on SafeCare, varying criteria has been used to determine levels of evidence, and that has lead to different ratings for the model. While an independent technical review of SafeCare proposed that the model should be considered "well-supported," the Title IV-E Prevention Services Clearinghouse currently rates SafeCare as "supported" for in-home parent skill-based programs and services.

Upstream support to families

In the early 2000s, **Oklahoma Human Services** (OKDHS) formed a workgroup dedicated to improving outcomes for families. The workgroup examined available research from across the country and discovered that, except for SafeCare and one other program, there were no programs designed for

> I can literally say SafeCare turned my life around completely.
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> — **LUBOV GLOVER,** PARENT

populations needing extra support that showed positive outcomes. OKDHS decided to implement SafeCare because the model appeared to be the most promising, and it presented the state with an opportunity to help build an evidence base. The agency began to implement SafeCare in 2002, and in 2003 obtained federal funding to begin an evaluation.

In 2016, the **Arkansas Department of Human Services** (ADHS) found itself in a similar situation. The agency was looking to address a statewide increase in the foster care population — attributed to increases among children from birth to age 5 and substance-exposed infants — and concerns about child deaths connected to unsafe sleep practices. ADHS decided to implement SafeCare because it was a home visiting program designed for the age range the agency was looking to serve and, more importantly, it was designed for — and had been used in — a child protection context.

While OKDHS and ADHS' SafeCare implementation efforts were separated by almost 15 years, both jurisdictions' experiences offer insights and lessons for other jurisdictions considering SafeCare as part of Title IV-E Prevention Plan under the Family First Prevention Services Act. One important similarity was that both jurisdictions chose to contract with providers already experienced in delivering home visiting services and working with local community agencies.

Arkansas

In Arkansas, SafeCare is still relatively new. The rollout began gradually in 2017 and was available statewide in mid-2020. One key lesson from early implementation was the need for frequent, clear communication between all partners. ADHS contracted with Arkansas Children's Hospital as the primary provider of SafeCare since the hospital was already operating the Arkansas Home Visiting Network (AHVN). AHVN subcontracts with local community providers that have established community connections and experience with home visiting, and holds regular meetings between directors and evaluators from the provider agency and the implementing county to coordinate implementation efforts. Carefully laying the groundwork was critical. For example, clear communication to child protection staff was paired with establishing a local subcontract and training home visitors so that caseworkers did not send referrals without a SafeCare home visitor prepared to respond, and home visitors were not waiting for referrals instead of serving families. After the initial launch in the state's largest county, the implementation team continued to meet to review data that was then used to drive decisions regarding the next implementation site.

Early on, AHVN learned valuable lessons about how best to assign SafeCare cases, considering travel time, the "fit" between the family and the home visitor, and the supply and demand in a certain area. SafeCare Arkansas (SC AR) quickly learned that it was much more efficient to assign one home visitor to a general area, while maintaining flexibility for exceptions to ensure a good fit between a family and its home visitor.

LIFELONG CHANGE

As a nurse at an alternative school, Betty Hawkins-Emery initially was interested in SafeCare to support her students who also were teen parents. At the time, Hawkins-Emery was a new mother to a 3-year-old with Down syndrome and decided that while she was exploring the program on behalf of her students, she could benefit from SafeCare as well. She signed up and has been involved in the program ever since. The information she gained from her initial interactions with her home visitor allowed her to set goals and gain the knowledge she needed to care for her family. Her home visitor introduced her to resources and programs that support children with Down syndrome, allowing her to become a vocal advocate for her son's care. In addition to being the proud parent of a thriving 13-year-old, Hawkins-Emery's involvement in SafeCare has affected her life in ways she never thought possible. Thanks to her increased confidence and advocacy efforts, she has been invited to be part of multiple committees and has completed a master's degree in public administration.

In addition, it was critical that the diversity of the home visiting team reflected the diversity of the community. For example, SC AR discovered some families felt more comfortable working with a home visitor of the same race. Fidelity to SafeCare also required that the home visitor offer services directly and not through an interpreter, so it was important to know the languages prevalent in a community and to recruit home visitors fluent in those languages. To better attend to the unique needs of each community, SC AR spent time during team meetings exploring cultural differences and discussing ways to make families most comfortable. SC AR also employed an enrollment coordinator who was knowledgeable about the local community and could spend time getting to know each family in order to best match families with home visitors.

Since Arkansas still is in the early stages of implementing SafeCare, AHVN is focusing on collecting fidelity data and ensuring adherence to the model, before evaluating outcomes. Initial data indicates satisfaction with SafeCare, as evidenced by an approximately 70% retention rate for participants. Anecdotally, home visitors are reporting positive feedback.

Oklahoma

SafeCare is a voluntary service offered through contracts with provider agencies across Oklahoma, and is well established as a core part of how OKDHS works with families. OKDHS began implementing SafeCare almost 20 years ago, but the road to statewide implementation — achieved in 2008 — was not without challenges. During the initial rollout, SafeCare training was delivered over a five-day period. Because OKDHS contracted with providers already offering home-based services, feedback revealed that some home visitors were resistant to using a manualized intervention with families when they had already been delivering services without a manual. Administrators wanted to demonstrate that SafeCare could be flexible and was effective, so they modified the training, offering it in modules. By allowing time between the learning modules, home visitors were able to test the new skills with families. They observed that families were receptive to the SafeCare approach and they were able to see families' progress, which reduced their concerns.

Feedback from the first training cohort of SafeCare home visitors was beneficial as OKDHS continued to expand the program. The information allowed providers to develop an interview protocol that increased the likelihood they were hiring home visitors who would embrace the SafeCare model. For example, SafeCare learning does not stop with training. To support fidelity and continuous quality improvement, a coach will periodically observe a home visit, which is welcomed by some staff but can be uncomfortable for others.

From the beginning, OKDHS included collaboration with the University of Oklahoma Health Sciences Center in the provider contracts. The university oversees implementation and evaluation efforts, provides guidance, and serves as a source of accountability. OKDHS is accountable to the university for meeting the fidelity benchmarks of SafeCare. If benchmarks are not being met, the university and OKDHS develop a plan to address the challenges and move forward. Meeting and maintaining fidelity are important components of OKDHS' SafeCare sustainability efforts. The university also facilitates two SafeCare Parent Partnership Boards, one for mothers and one for fathers, to learn from parents who have experienced SafeCare first-hand.

As the site of one of the largest randomized controlled trials of SafeCare, OKDHS found that when delivered as part of family preservation services, it reduced maltreatment recidivism by about 26% (in the subsequent seven years) when compared to services as usual. OKDHS leadership reports that because SafeCare is "real and practical," it makes a difference in how families respond. In one study, when compared to services as

> My life just seemed to open up after being in the program. It gave me more confidence in myself and in my abilities."
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> — BETTY HAWKINS-EMERY, PARENT

usual, OKDHS found that families that participated in SafeCare achieved more of their goals, were more satisfied with services, and felt their culture was more likely to be respected.

OKDHS also has experimented with delivery and conducted pilot projects to explore how to better meet the needs of families, including:

- Partnering with multiple communities to make SafeCare more culturally responsive. Under a grant from the Children's Bureau, OKDHS adapted SafeCare for Latinx families, which led to the addition of information about natural healing strategies, cultural healing knowledge, and demonstrating respect to the core model. OKDHS also added information for home visitors on how to build stronger and more respectful relationships with American Indian families, in partnership with the Cherokee Nation and a Native American coach.
- Piloting additional content, including motivational interviewing, safety planning, behavioral parent training, healthy relationships, and building a meaningful life.
- Implementing a pilot program that provides SafeCare to families starting to engage in reunification services, to determine if it is equally effective in supporting reunification. As part of this pilot, OKDHS developed a mini-course called the "Spirit of SafeCare." It provides caseworkers with an overview of the program and a foundational understanding of what families are learning through SafeCare so that they can reinforce and support the home visitors' efforts. If these efforts are successful, SafeCare could be used to support families throughout the child welfare continuum.

To learn more, visit Questions from the field at Casey.org.

1 Unless otherwise noted, the information on parental experience of SafeCare in Arkansas was gleaned from phone interviews with: LeCole White at SafeCare® Arkansas State Office Arkansas, Children's Home Visiting Network, on November 10, 2020; Latisha Young at Arkansas Department of Human Services, Division of Children and Family Services, In-Home Program Manager, on October 21, 2020; and Lubov Glover, SafeCare® participant, on December 18, 2020.

Unless otherwise noted, the information on SafeCare in Oklahoma was gleaned from phone interviews with: Deborah Shropshire, Debra Knecht, and Keitha Wilson at Oklahoma Human Services, Child Welfare Services; Ashley Smith and Dwan McDonald at Northcare; and Debra Hecht at the University of Oklahoma Health Science Center, on November 13, 2020; and with Betty Emery-Hawkins, SafeCare® participant, on January 26, 2021.

2 Title IV-E Prevention Services Clearinghouse. (2020). SafeCare. Retrieved from https://preventionservices.abtsites.com/programs/221/show

3 Georgia State University. (2021). *National SafeCare Training and Research Center: SafeCare Research*. Retrieved from https://safecare.publichealth.gsu.edu/evidence-based-model/

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7 Finno, M., Hurlburt, M., Fettes, D., & Aarons, G. A. (2014). Cultural adaptation of an evidence-based home visitation program: Latino clients' experiences of service delivery during implementation and sustainment. *Journal of Children's Services, 9*(4), 280-294.

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