SafeCare Augmented

Goals

SafeCare was developed as a more streamlined version of Project 12-Ways, which was designed to address behaviors that can lead to child abuse and neglect.

Program Features

SafeCare Augmented is an adaptation of SafeCare. As described by Silovsky et.al. (2011), SafeCare Augmented adds Motivational Interviewing to the SafeCare protocol. The augmented program also brings in training for home visitation staff that promote the identification of and response to risk factors for maltreatment. See SafeCare for more information on the core model.

SafeCare Augmented Snapshot

- **EC Profile Indicator:** FS30 - Percent of children age 0-5 with an investigated report of child abuse/neglect
- **Clearinghouse Rating:** See SafeCare
- **Research supports** use with children birth to 5 years of age who are at risk for child maltreatment
- **Related Smart Start outcomes:**
  - Increase in parent knowledge
  - Increase in positive parenting practices
- **Purveyor training required:** Yes
- **Frequency:** Weekly or bi-weekly
- **Dosage:** 18 to 20 weeks
- **Implementation Guidance:** http://safecare.publichealth.gsu.edu/

Target Audience

Families with young children (ages birth to 5) at risk for child maltreatment (which includes: young parents; parents with multiple children; parents with a history of depression or other mental health problems, substance abuse, or intellectual disabilities; foster parents; parents being reunified with their children; parents recently released from incarceration; and parents with a history of domestic violence or intimate partner violence).

Documented Outcomes

	Type of Study	Observed parent outcomes			Parent-reported family outcomes	
		Parent engagement	Referrals and connections*	Domestic violence reports	Parenting behaviors**	Risk factors such as family resources, social support, child abuse potential, depression, and nonviolent parenting strategies
Silovsky et.al. (2011)[i]	Experimental	✓	✓	✓	✓	✓

This table contains outcomes found to be associated with the program or approach. Individual studies may contain additional outcomes that were tested and not found to be associated with the program or approach.

*Aligned with Smart Start outcome *Parents increase use of services referred to in the community*
**Aligned with Smart Start outcome *Increase in positive parenting practices*

Research Evidence for SafeCare Augmented

- The program is a modified version of the SafeCare protocol. The program is differences in service provider and parent behaviors. For example, service providers working with the SafeCare Augmented protocol may experience more success in connecting with families and referring

Review of Experimental and Quasi-Experimental Studies

Citation	**Silovsky, J. F., Bard, D., Chaffin, M., Hecht, D., Burris, L., Owora, A., Beasley, L., Doughty, D., & Lutzker, J. (2011). Prevention of child maltreatment in high-risk rural families: A randomized clinical trial with child welfare outcomes. Children and Youth Services Review, 33, 1435-1444.**
Population and Sample	The study was conducted in the rural southwest and included 105 parents of young children with "identifiable risk of depression, intimate partner violence, or substance abuse." Participants were randomly assigned to either SafeCare Augmented (SC+) or standard home-based mental health services (SAU). The study team reported making attempts to recruit Native American families for the study. Participating caregivers were at least 16 years old and had at least one risk factor, which included: parental substance abuse, mental health issues, or intimate partner violence.
Methodology	Experimental with random assignment to groups
Purpose	The overarching goal of this study was to conduct a randomized clinical trial of SC+ compared to SAU to examine reductions in future child maltreatment reports, as well as risk factors and factors proximal to child maltreatment.
Measures & Assessments	• Child Abuse Potential Inventory (CAPI) • Conflict Tactics Scale-Parent Child (CTS-PC) • Family Resource Scale-Revised (FRS-R) • Social Provisions Scale (SPS) • Beck Depression Inventory 2 (BDI-2) • Diagnostic Inventory Schedule (DIS) Alcohol and Dug Modules • Child Well Being Scales-Revised (CWBS) • Overt Hostility Inventory (OHI) • Composite international Diagnostic Interview (CITI) • Client Cultural Competence Inventory (CCCI) • Client Satisfaction Survey • Monthly Service Utilization Report (MSUR) • Demographic Questionnaire • Child Welfare Referrals and Out-of-Home Placements, Child welfare report data
Study Implementation	• Data were collected at three time periods: baseline (before randomization to groups), post services, and 6 months after the end of services. • The treatment group received SafeCare Augmented services. The comparison group received standard home-based mental health services (SAU), which included individual and family therapy and case management from the state's Department of Human Services. • SafeCare Augmented was adapted for use in the study's rural setting. This included selecting providers already established in the community; these providers were considered knowledgeable about local resources. • The study team expected that study participants would receive additional services, outside of the study parameters. • SafeCare Augmented providers received training and oversight for model fidelity. Oversight was provided by staff who were certified by the program's national developers.
Staff Qualifications	• SafeCare Augmented providers had Bachelor's degrees. They also received initial and ongoing training in Motivational Interviewing, as well as annual training in coding the Child Well Being Scales-Revised. • The SafeCare Augmented team had access to local experts in intimate personal violence, substance abuse, and mental health. • Data collectors utilized Audio Computer Assisted Self Interviews (ACASI) for self-report measures. Data collectors were trained in data collection procedures, cultural sensitivity and competency, research ethics, legal child abuse reporting requirements, and managing safety concerns during home visits. Data collectors also had a data collection manual.
Key Findings	Use of Services

- The study team found that treatment providers were "significantly more likely to engage families in services and provide more services" than providers in the comparison group. More specifically, 83% of treatment participants completed service intake, compared to 33% of comparison group participants. In addition, the treatment program recorded more hours of service (36 hours for the treatment group, compared to 8 hours for the comparison group).

Referrals and Connections

- The treatment program was "significantly more likely to refer and link families to additional services," compared to the comparison group ($p<.01$). For example, treatment participants "were referred for basic needs (utilities 10%, food 29%, housing 4%), services to address mental health (15%), substance abuse (2%), domestic violence (2%), developmental disability (4%), programs for children (school 10% and assessment services 4%), and other services (e.g., clothing, 29%)."

Child Welfare Reports

- The study team reported that 20.8% of treatment and 31.5% of comparison group participants experienced a "future referral to child welfare." Among participants with at least one referral, the median length of time until first report in the treatment group was 200.5 days while the median length of time before the first report in the comparison group was 103 days. The study team reported "the large number of individuals never experiencing a report resulted in a non-statistically significant difference between event history curves."
- One treatment participant had a report beyond 300 days after study enrollment, compared to five comparison group participants.

Future Reporting

- The study team controlled for baseline risk factors that included: prior number of referrals, age of youngest child at referral, hours of service, prior involvement with prevention services, intake completed, household monthly income, total number of children in the home, married or living with a partner, White, education level, length of stay in current community, number of moves in last five years, reported concurrent treatment programs, and participant age.
- When covariates were controlled (either singly or in combination), the study team did not find a significant group effect.

Referrals for Neglect

- The study team found that, among participants with at least one referral for neglect, the median length of time until a first report for the treatment group was 200 days. The median length of time until a first report for the comparison group was 90 days. The study team reported "these differences did not produce statistically significant event time results."

Domestic Violence Reports

- The study team found that there were no domestic violence reports for the treatment group and seven reports for the comparison group. The study team reported "a statistically significant difference in survival" between treatment and comparison groups ($p<.01$).

Parent Report of Outcomes

- The study team reported that treatment participants reported greater improvements in parenting behaviors, compared to comparison group participants.
- The study team reported "within-group improvements" within the treatment group for: family resources, social support, child abuse potential, depression, and nonviolent parenting strategies.
- The study team reported that treatment participants had "short-term improvement in use of nonviolent parenting strategies," compared to the comparison group participants.
- The study team failed to find group differences in "risk and protective factors or reports to child welfare, except domestic violence reports."

Review of Descriptive and Non-Experimental Studies

None

End Notes

[i] Silovsky, J. F., Bard, D., Chaffin, M., Hecht, D., Burris, L., Owora, A., Beasley, L., Doughty, D., & Lutzker, J. (2011). Prevention of child maltreatment in high-risk rural families: A randomized clinical trial with child welfare outcomes. Children and Youth Services Review, 33, 1435-1444.

Note: Research summaries could include verbiage directly reproduced from the research literature. Quotes and italics may be used to show a direct quote but not always.

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