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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.

> "I can literally say SafeCare turned my life around completely."
>
> —Lubov Glover, Parent, Oklahoma

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 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]

With so many studies on SafeCare, varying criteria has been used to determine levels of evidence, and that has led 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.

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.

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 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.

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.

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 over 20 years ago, but the road to statewide implementation — achieved in 2008 — had its challenges. During the initial rollout, SafeCare training was delivered over five days. Since OKDHS contracted with providers already offering home-based services, feedback revealed that some home visitors were resistant to using a structured intervention with families when they already had 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 approaches and they observed families' progress, which reduced their concerns.

OKDHS continued to expand the program, informed by the feedback from the first training cohort of SafeCare home visitors. The information led to the development of an interview protocol that increased the likelihood of hiring home visitors who would embrace the SafeCare model, including its oversight element. To support fidelity and continuous quality improvement, a SafeCare coach periodically will observe a home visit to support staff and ensure families are receiving the services as intended.

OKDHS collaborated with the University of Oklahoma Health Sciences Center in the model's implementation, including training, consultation with provider agencies, and evaluation. The collaboration helps to ensure the fidelity benchmarks of SafeCare are met. If benchmarks are not being met, the university and OKDHS develop a plan to address the challenges and chart a path forward. 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 SafeCare reduced maltreatment recidivism by about 26% (in the subsequent seven years) when compared to services as usual. OKDHS leadership reports that families perceive SafeCare as "real and practical," and therefore makes a difference in their responding positively to the service. In one study, when compared to services as usual, OKDHS found that the families participating in SafeCare achieved more of their goals, were more satisfied with services, and felt their culture was more likely to be respected.

OKDHS has supported various pilots over the years to enhance SafeCare and explore how to better meet the needs of families, including:

- Partnering with multiple communities to make SafeCare more culturally responsive. Through a federal grant from the Children's Bureau, OKDHS adapted SafeCare for Latino families, which led to information about natural healing strategies, cultural healing knowledge, and demonstrating respect to the core model. In partnership with the Cherokee Nation, OKDHS also trained home visitors to build stronger and more respectful relationships with American Indian families.
- Adding evidence-based practices to enhance SafeCare, including motivational interviewing, safety planning, behavioral parent training, healthy relationships, and building a meaningful life.
- Providing SafeCare to families that are starting to engage in reunification services to determine if it is equally effective in supporting reunification.

Oklahoma's SafeCare model is offered through the Comprehensive Home Based Services provision of the state's Children's Services Program, and supports families throughout the child welfare continuum. In 2021, Oklahoma included SafeCare in its Title IV-E Prevention Services plan.

> "My life just seemed to open up after being in the program. It gave me more confidence in myself and in my abilities."
>
> —Betty Hawkins-Emery, Parent, Oklahoma

Arkansas

In Arkansas, SafeCare began rolling out gradually in 2017, expanded across the state in 2020, and now is provided in all counties. 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 already was operating the Arkansas Home Visiting Network (AHVN). AHVN subcontracts with local community providers that have well-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, which included establishing a local subcontract and training support to ensure home visitors were prepared to respond when a caseworker sent a referral. After the initial launch, the implementation team continued to review data that then was 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. Arkansas quickly learned it was much more efficient to assign one SafeCare home visitor to a general area, while maintaining flexibility for exceptions to ensure a good fit between family and visitor.

In addition, it was critical that the diversity of the home visiting team reflected the diversity of the community. For example, Arkansas 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 recruit home visitors fluent in those languages. To better attend to the unique needs of each community, Arkansas devoted time during team meetings to explore cultural differences and discuss ways to make families most comfortable. The state 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. In August 2023, the racial makeup of the 50 individuals in Arkansas who provide SafeCare

services was 64% white, 32% Black, and 4% multiracial, while the 3,657 caregivers served through the program between 2017 to 2023 were 62% white, 30% Black, and 5% Latino.

Arkansas contracted with the University of Arkansas for Medical Sciences (UAMS) to conduct an outcome evaluation, which suggests SafeCare, as implemented in Arkansas, has promising long-term impacts on child safety and family well-being. Findings demonstrate that among families with caregivers who successfully completed SafeCare, fewer children were in out-of-home placements up to 18 months after the end of service, versus a comparison group. Findings also show that families that successfully completed SafeCare reported more positive changes over time than the comparison group in youth status, caregiver status, caregiver advocacy status, and family relations. Additionally, UAMS found that SafeCare enrollees experienced increases in supporting positive child behaviors, proactive parenting, and reducing parenting stress.

Between October 1, 2019, and August 1, 2022, 2,380 families enrolled in SafeCare. Overall, 57% of participants completed the program, with the first module being the most common time for participants to leave or unenroll. About 72% of enrollees completed at least one of the three SafeCare modules. Home visitors have reported positive anecdotal feedback.

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[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. Updates were provided via email correspondence with Caitlin Sammons at the Arkansas Division of Children and Family Services, in October 2024.
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 Hawkins-Emery, SafeCare participant, on January 26, 2021. Updates were provided by Keitha Wilson, Oklahoma Children's Services, in November 2024.

[2] Title IV-E Prevention Services Clearinghouse. (2020). SafeCare. Retrieved from https://preventionservices.acf.hhs.gov/programs/613/show

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

[4] Gershater-Molko, R.M., Lutzker, J.R., Wesch, D. (2003). Project SafeCare: Improving health, safety, and parenting skills in families reported for, and at risk for child maltreatment. *Journal of Family Violence, 18*, 377-386.

[5] Gershater-Molko. R.M., Lutzker, J.R., & Wesch, D. (2002) Using recidivism data to evaluate Project SafeCare: Teaching "bonding", safety, and health care skills to parents. *Child Maltreatment, 7*, 277-285.

[6] Whitaker, D. J., Self-Brown, S., Hayat, M. J., Osborne, M. C., Weeks, E. A., Reidy, D. E., & Lyons, M. (2020). Effect of the SafeCare intervention on parenting outcomes among parents in child welfare systems: A cluster randomized trial. *Preventive Medicine, 138*, 106167.

[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.

[8] Beasley, L. O., Silovsky, J. F., Owora, A., Burris, L., Hecht, D., DeMoraes-Huffine, P., Cruz, I., & Tolma, E. (2014). Mixed-methods feasibility study on the cultural adaptation of a child abuse prevention model. *Child Abuse & Neglect, 38*(9), 1496-1507.

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