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The Association of Participant Characteristics and Service Delivery with Program Completion Rates for SafeCare in Georgia

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ABSTRACT

THE ASSOCIATION OF PARTICIPANT CHARACTERISTICS AND SERVICE DELIVERY WITH PROGRAM
COMPLETION RATES FOR SAFECARE® IN GEORGIA

By

MALINDA SUZANNE BOLT

JULY 28, 2015

Child maltreatment affects millions of children annually, and evidence-based home visiting

programs, such as SafeCare®, help increase parenting skills and, ultimately, the well-being of

children. Although effective at reducing maltreatment when participants complete services,

high attrition rates in home visiting services may reduce this effectiveness. Using a sample of all

clients receiving SafeCare services in Georgia (n=93) from October 2013 to February 2015, we

evaluated individual characteristics, information seeking behaviors, and programmatic factors

in order to understand the relationships, if any, with participant program completion. During

this evaluation cycle, SafeCare reports a completion rate of 43%. The race of the primary

guardian significantly relates to program completion (p=0.02). This evaluation can assist those

implementing SafeCare to anticipate the needs of their target population.

THE ASSOCIATION OF PARTICIPANT CHARACTERISTICS AND SERVICE DELIVERY WITH PROGRAM COMPLETION RATES FOR SAFECARE® IN GEORGIA

by

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B.S., THE UNIVERSITY OF GEORGIA

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APPROVAL PAGE

THE ASSOCIATION OF PARTICIPANT CHARACTERISTICS AND SERVICE DELIVERY WITH PROGRAM
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Author's Statement Page

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Introduction

Child Maltreatment Overview

Although current child health policies aim to reduce the negative impact of child maltreatment, the sexual, physical, and psychological abuse and neglect of children create a massive burden in the United States. In 2008, the CDC released a report that defines child maltreatment to be "Any act or series of acts of commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child " in an effort to create a uniform definition. Of the 74 million children in the US, 3.5 million were referred to Child Protective Services (CPS) for potential maltreatment in 2013, and 17.5% (612,500) of those cases were substantiated as maltreatment (United States Department of Health and Human Services, 2015). Estimates indicate that the actual number of maltreated children is much higher, due to underreporting of child maltreatment (Finkelhor, D. et al., 2015). In FFY 2013, an estimated 1,520 children died due to child maltreatment, and 73.9% of child fatalities were victims under the age of three (USDHHS, 2015). In 2008, the estimated total lifetime burden of fatal and non-fatal child maltreatment equaled $124 billion (Fang, Brown, Florence, & Mercy, 2012). Factors such as short-term health care costs, long-term health care costs, productivity losses, child welfare costs, criminal justice costs, and special education costs impact the overall cost of CM across the lifespan (Fang, Brown, Florence, & Mercy, 2012). At a conservative estimate, non-fatal cases in 2008 produced lifetime costs of $210,012 per case and fatal incidences totaled $1,272,900 per individual (Fang, Brown, Florence, & Mercy, 2012). In 2006, states disbursed over $25.7 billion in federal, state, and local funds to the child welfare system in an effort to reduce child abuse and neglect (Fang, Brown, Florence, & Mercy, 2012).

Additionally, Medicaid expenditures for children suspected of or identified as being victims of child abuse average $2,600 per year higher than the Medicaid expenditures of non-victims (Florence et al., 2013).

Physical Consequences.

While the financial burden is heavy, the physical, psychological, and behavioral effects of child maltreatment create adverse health outcomes that can span the lifetime for victims (US HHS, 2015). Of these impacts, the physical consequences of maltreatment may be the most visible, ranging from death, stunted growth, untreated infections and illnesses, and obesity (The Institute of Medicine & the National Research Council, 2014). Research indicates that adults who self-report experiences of maltreatment as a child face significantly lower levels of health-related quality of life in adulthood (Corso et al., 2008). Furthermore, a 2001 study of pediatric emergency room admissions by Dominguez, Chalom, and Costarino shows that of the 1,376 child (ER) admissions 17 were reported as cases of child abuse. And 6 of the 85 child deaths were the direct result of abuse (Dominguez, Chalom, & Costarino, 2001). Brown and colleagues' 2010 study suggests that a relationship between adverse childhood experiences such as maltreatment may play a significant role in an increased risk of development of and death from lung cancer.

Psychological Consequences.

CM clusters with various mental illnesses for those who experience maltreatment (Norman et al., 2012). A 2012 meta-analysis by Norman and colleagues indicated that CM doubles the likelihood of developing an adverse mental health condition throughout the lifespan for victims. The study describes a strong body of evidence indicating that adverse

psychological health outcomes such as depressive disorders, anxiety disorders, suicide

attempts, and risky sexual behaviors are linked to experience of CM (Norman et al., 2012).

Childhood maltreatment increases the likelihood of problems in socialization as well,

such as disconnectedness, which can result in difficulty transitioning in a stable adulthood

(Casanueva, Dolan, & Smith, 2014). In a nationally representative sample, the National Survey

of Child and Adolescent Well-Being (NSCAW) indicates that 15% of youths who experience

maltreatment face issues with disconnectedness during a three period after reported

maltreatment. Disconnected youth are defined as neither in school nor employed and are not

being prepared for life as an adult. Issues resulting from disconnection include early pregnancy,

poverty, social and familial disruption, and alienation. There were no significant differences by

race, gender, poverty level, or home placement setting at baseline, however, the likelihood of

disconnectedness increases with age of victim at reported maltreatment (Casanueva, Dolan, &

Smith, 2014). Approximately, 47% of youths with disconnectedness were found to have low

cognitive skills or behavioral issues (Casanueva, Dolan, & Smith, 2014).

Behavioral Consequences.

Adults who have experienced childhood maltreatment are at an increased risk for

perpetrating or being the victim of violence, smoking, obesity, high-risk sexual behaviors,

unintended pregnancy, and substance abuse (IOM & NRC, 2014). These negative behaviors

have deleterious health effects, which inflate health-related costs (World Health Organization,

2014). For children who experience maltreatment with a caregiver as the perpetrator, issues of

attachment may arise and the child may continue to experience disorganized attachment to

others throughout life further exacerbating psychological and social impacts of maltreatment (IOM & NRC, 2014).

Evidence-Based Practices and Policies

In 1993, the National Research Center released a report encouraging empirical research of CM interventions as a main objective for the future of child policy (IOM & NRC, 1993). Since that time, several behaviorally-based parenting programs have been shown to impact child maltreatment reports and recidivism, including Parent-Child Interaction Therapy (Thomas & Zimmer-Gembeck, 2012), Triple P (Prinz et al., 2009), and SafeCare (Chaffin et al., 2012).

As the movement toward evidence-based practices (EBPs) continues, the child policy sector shifts its focus to interventions that are effective in reducing rates of CM and preventing future cases (Chaffin & Friedrich, 2004). Determinations of what programs to implement are made from research evidence relying primarily on randomized trials or a quasi-experimental designs that can indicate whether an intervention is effective and thus warrants widespread implementation (Chaffin & Friedrich, 2004). EBPs are typically manualized and many have quality assurance procedures built in to implementation methods that allow for accountability and fidelity to the model.

Many home visiting models have been noted to have strong research evidence for preventing or reducing child maltreatment (Avellar, S. et al., 2014). Home visiting as an approach to treatment can reduce barriers to access for participants such as transportation and child care (Damashek, Doughty, Ware, & Silovsky, 2011). Additionally, EBPs can lessen the economic burden of child maltreatment (Covington, 2013). Many EBPs have been shown to be cost-effective, with positive cost-benefit ratios (Lee et al., 2012).

The SafeCare® Model

SafeCare® is a behaviorally based, in-home parenting model designed to prevent child maltreatment among parents of children ages 0-5. SafeCare focuses on teaching parenting skills in three key areas (or modules) related to child maltreatment: Child health, Home Safety, and Parent-Child/Infant Interaction. The teaching portion of each module follows a general seven step outline. Home visitors describe target behaviors, explain the importance for each behavior, model the behavior, request parental demonstration of behavior, provide positive feedback, indicate areas for improvement, and provide goals for the next training meeting. Each module typically requires five training sessions, an assessment, and a social validation or satisfaction questionnaire. However, if a parent does not meet the requisite criteria for module advancement, the provider will revisit problem areas and conduct additional training. During the modules, home visitors provide parents with required materials to continue the program and improve child well-being such a thermometer to check the child's temperature, child safety latches for cabinets to improve home safety, and a child health manual to encourage healthy behaviors.

The Health Module.

During the Health Module, parents learn to use child health reference materials, prevent childhood illnesses, identify symptoms, and determine the course of action for child illness. Child health knowledge is assessed through role-play health scenarios where parents determine the course of action in various child health scenarios. Along with skill building exercises, parents are supplied with thermometers, health recording charts, and a medically-

validated health manual. Parents complete this module by indicating that they can properly meet the health needs of their child or children.

The Home Safety Module.

The Home Safety Module focuses on ensuring that home safety risks are identified and eliminated, so that the child is no longer exposed to home hazards. Home visitors assess rooms in the home using the validated and reliable Home Accident Prevention Inventory (HAPI), which identifies five types of home hazards: fire and electrical, mechanical-suffocation, ingested object suffocation, firearms, and solid/liquid poisons. Decreases in hazards indicates that the Home Safety Module effectively trains parents in home injury prevention.

The Parent-Infant/Child Interaction Module.

The Parent-Infant/Child Interaction Module uses the Planned Activity Training (PAT) Checklist during play and routine activities to ensure parents understand how to engage in positive activities and prevent negative child behaviors. During in-home assessments, home visitors help parents identify areas for improvement and modify interaction behaviors in order to increase positive interactions.

SafeCare Research

The largest randomized control trial of SafeCare followed over 2100 families after a state-wide implementation in Oklahoma to determine the effectiveness of the model. SafeCare reduced child maltreatment recidivism by approximately 26% in comparison to services as usual for families with children within the age range of 0-5 years (Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012). In regards to specific skills improvements, single-case studies of SafeCare have indicated that planned activities increase positive parent-child interactions (Cordon, Lutzker,

Bigelow, & Doctor, 1998), use of the HAPI and training reduces home hazards, and the health

module improves the health skills of parents (Bigelow & Lutzker, 2000). A recent randomized

trial has demonstrated improved parent and child outcomes following receipt of SafeCare

relative to a control (Carta et al., 2013).

Because research indicates that SafeCare successfully decreases child welfare recidivism

and improves parenting behaviors, the model has been broadly implemented in 20 states

across the US as well as internationally. International implementation with cultural

modifications includes sites in Australia, Belarus, Canada, Israel, Spain, and the United Kingdom.

Agencies implementing SafeCare – or any evidence-based practice – must focus on delivering

the program correctly and engaging families in services. The latter has proved to be a

substantial challenge in child welfare-related services.

Engagement and Attrition

Engagement is one of the most important constructs of programmatic interventions as

participants must receive services in order for those services to impact behavior. Though home

visiting interventions report higher levels of engagement versus non-home visiting services,

attrition still greatly affects implementation (Olds, 2003). Researchers recommend using a

multidimensional approach to address the socio-ecological issues affecting participation (Olds,

2003). While attrition rates vary by program's target demographics, on average between 20%-

50% of participants drop out of home visiting programs (Gomby, 2007). One large program,

Parents as Teachers, which focuses primarily on young at-risk mothers, experiences almost a

60% drop out rate on average before the target child reaches two years of age (Wagner,

Cameto, & Gerlach-Downie, 1996). Thirty-eight percent of mothers dropped out of the Nurse-

Family Partnership (NFP) program and attrition occurred more commonly among younger

mothers (Brand and Jungmann, 2014). Other findings suggest that young mothers, unmarried

mothers, and African-American mothers were more likely to drop out, and that home visitors'

turnover was related to premature dropout (O'Brien et al., 2012). Hispanic mothers, those

living with a co-parent, and those employed at enrollment remained in the program longer.

Provider qualities such as flexibility correlated with higher retention rates as well (O'Brien et al,

2012).

A 2003 program evaluation by Wagner and colleagues identifies the five dimensions of

home visiting engagement: (1) "say yes" engagement (participant agrees to enroll); (2) "be

there" engagement (attends scheduled visits); (3) "be involved" (participant actively

participates in session) engagement; (4) "do the homework" engagement (participant uses

learned skills outside of sessions); and, (5) "look for more" engagement (participant ventures

outside of home visiting services for more information regarding parenting techniques).

Wagner argues that in order to effect behavior change, it is necessary to focus on each form of

participant engagement as parents can function well in one area of engagement, but not others

(Wagner, Spiker, Linn, Gerlach-Downie, & Hernandez, 2003).

Parental characteristics have been found to significantly affect the strength of various

dimensions of engagement for the PAT home visiting intervention (Wagner, Spiker, Linn,

Gerlach-Downie, & Hernandez, 2003). Participants who remained in the program were

significantly older than other participants, of higher education status, and more likely to earn a

household income of $40,000 or greater and own their own home. African Americans were

much less likely to enter into services, and those who refused services mirrored the

characteristics of the completion group rather than the drop out group. Older adult, Caucasian

mothers were most likely to be rated highly on overall engagement as were participants who

owned their own homes. Teen and Latina mothers were the only participant groups found with

significantly high "look for more" engagement, which means these mothers joined groups and

sought community support outside of program services and family members. (Wagner, Spiker,

Linn, Gerlach-Downie, & Hernandez, 2003).

Though most child maltreatment home visiting interventions are aimed toward the

mother, research indicates that the role and engagement of the direct co-parent, such as the

father, must not be underestimated (Duggan et al., 2004). A 2004 study by Duggan et al.

describes paternal engagement as low for home visiting services, even when the father resided

in the home. Fathers with a history of domestic abuse and heavy drinking were reported to

interact very little with home visitors leading the evaluation team to question whether the

program was having the intended effects; in order to reduce child maltreatment, an

intervention must address behavior modification for the high risk parent—in these cases, the

violent father. Overall, paternal engagement levels for all family types, living together,

separated, and separated with seldom visits, saw a decrease in paternal engagement overtime.

With decreasing paternal engagement, maternal relationship satisfaction decreased (Duggan et

al., 2004). Given the complex nature of child maltreatment and family dynamics, evaluations

attempting to understand engagement and attrition must also include information regarding

the co-parent, if available.

Integrated Theory of Parent Involvement.

Information regarding demographic characteristics and parenting program completion rates are readily available, and in fact, the abundance of these data have led to mixed results (Josten, Mullett, Savik, Campbell, & Vincent, 1995; Olds & Kitzman, 1993). For instance, the National Committee to Prevent Child Abuse (1995) reported high attrition rates for first-time mothers, while Olds and Kitzman's 1993 meta-analysis indicated much lower rates. Intervention scientists have begun to focusing research on determining whether specific factors can be identified to predict engagement in home visiting child maltreatment program participants (McCurdy et al., 2006). McCurdy and Daro's Integrated Theory of Parent Involvement (ITPI) posits that four domains influence engagement and attrition: individual factors such as objective program experience, provider factors such as caseload, neighborhood factors such as social cohesion, and program factors such as participant incentives. Other service-based factors such as funding, provider competence, and service delivery mode are considered primary influencers. ITPI attempts to establish a causal link between the four domains and intent to enroll, enrollment, and program retention (McCurdy & Daro, 2001).

Damashek et al. uses the ITPI framework in the 2011 evaluation of SafeCare attrition rates compared to Services as Usual (SAU). In this case, SAU was also a home visiting program, but it had programmatic differences from SafeCare. While providers offering SAU were paid by hours worked, SafeCare home visitors received a base pay allowing for more flexibility with scheduling and drop-by visits with parents. This version of SafeCare was augmented to use Motivational Interviewing, an approach to engage those with substance abuse issues and can also help reduce attrition by building rapport with weakly engaged clients. The researchers

examined the characteristics of the caregiver, their environment, the home visitor's characteristics, and programmatic factors to determine if these variables affect both enrollment and retention in services. SafeCare was found to have a much higher enrollment rate (i.e., parents entering the program), and completion rate (i.e., parents completing the program) than SAU possibly due in part by the manualized-program approach. Mothers with depressive symptoms were more likely to enroll in services than non-depressed mothers, a result also found in a review of the literature by McFarlane, Shea Crowne, Burrell, and Duggan in 2014. Victims of domestic violence were more likely to complete services than non-victims. Mothers with substance abuse issues were less likely to complete services than mothers without. Maternal age was the strongest demographic predictor of program completion (Damashek et al., 2011).

Another evaluation of home visiting programs indicates that matching participants and home visitor characteristics such as race, parenting style, and culture has been found to significantly increase sustained enrollment in home visiting services (Daro et al., 2003). Research reflects that home visitation services attempt to match home visitors and participants ethnicity regularly as well (McCurdy et al., 2003). Participants who enrolled in home visiting programs earlier in pregnancy were much more likely to continue enrollment than those who did not. African Americans and Latino participants remained in services significantly longer than Caucasian participants, and African American home visitors' participant retention rates were significantly higher than those of Caucasian home visitors. Programs with the lowest caseloads reported the lowest attrition rates as well (Daro et al., 2003).

The Current Project

While evidence indicates that the SafeCare model is effective in reducing child

maltreatment, evaluation of program completion rates would inform key decisions (Segal, Sara

Opie, & Dalziel, 2012) as policymakers shape implementation processes and funding (Willging

et al., 2014). Program evaluation is a matter of public value and the effects of child

maltreatment can be seen across all strata of society (Segal, Sara Opie, & Dalziel, 2012). Many

home visiting programs are currently being disseminated, but more information regarding the

applicability of each model for particular targeted groups is necessary for policymakers and

funders to properly choose the correct program for their target and goals (Segal, Sara Opie, &

Dalziel, 2012).

Using data from Georgia's statewide implementation of the SafeCare model, this study

examines program completion rates, demographic characteristics, and program factors that

may relate to program completion. The two questions addressed are: What proportion of

families complete SafeCare in Georgia during the October 2013-February 2015 evaluation

cycle? Do family characteristics and program factors significantly relate to program

completion/attrition?

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Methods and Procedures

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Project Overview and Data Sources

In 2008, the state of Georgia began providing funding through the Department of Family

and Child Services (DFCS) for state-wide implementation of SafeCare. Agencies conducting

family preservation services were offered training from the National SafeCare Research and

Training Center (NSTRC) and contracts to provide SafeCare services to at-risk and maltreating

families. As part of implementing SafeCare in Georgia, providers collect and provide to the state data on each family served. Data from the current contract year (2012-2014) was de-identified and sent to NSTRC for evaluation. In this evaluation data from several sources were used: the Initial Referral form (Appendix A), a Family Needs Assessment (Appendix B) collected at the first visit (prior to any SafeCare sessions), and Case Closure form.

During this evaluation cycle, from October 2013 to February 2015, 93 families with 201 children enrolled in one of the two versions of SafeCare. Families who are considered low risk for child maltreatment are offered Family Fusion, a version of SafeCare in which families receive the parenting module and either health or safety if needed. Families in need of more intensive services are asked to complete all three modules of SafeCare.

Sample

The sample consists of all families who received SafeCare or Family Fusion services between October 2013 and February 2015. In all, 93 families were served, including 23 that received SafeCare and 69 that received Family Fusion. Families were referred from a variety of sources including Horizons, Lutheran Services of Georgia, and other agencies across the state.

Data Collection Procedure

Data for this evaluation come from several forms that were either part of the referral for services or were completed by the home visitors as part of SafeCare delivery. An initial referral form contained family information and reasons for referrals. Providers conducted a needs assessment prior to initiating SafeCare sessions, and a case closure form when the case was closed (either because it was completed or not). All data was sent to the state Department

of Family and Children's Services, and de-identified data was provided to Georgia State University for coding and analysis.

Measures

Individual Characteristics.

Families in the evaluation completed demographics information questionnaires for DFCS during the referral process. For purposes of this analyses, the relevant demographics were extracted.

Primary Guardian's (PG) age.

The age of the primary guardian is grouped by years and will be presented in the results.

Number of children. Number of children was reported by caregivers, and has been grouped for analyses as one, two, or three or more children in the household.

PG Race. For analyses, race has been re-categorized as '1' or '0' for white or non-white, respectively.

Co-parent. A *co-parent* in this evaluation includes anyone who the PG listed as a secondary guardian of the child or children. Responses are coded as 'Yes' (1) or 'No' (0) for the presence of a co-parent.

PG marital status. PG marital status responses are coded as '0' or '1' for non-married or married, respectively.

DFCS history. Families were screened for DFCS history and this data will be reported as '0' or '1' for no history with DFCS versus prior/current history.

Referral reason. Service providers were provided a list of 9 options for indicating why a family was referred for services, and could check as many as applied. We examined the most

commonly checked referral sources that would allow for chi-square analyses. Those were (1) *parental capacity building*, (2) *prevention*, (3) *neglect*, and (4) *safety*. Each was coded 'Yes' or 'No' (1/0).

Total adults in the household. Total adults in the household was reported and for purposes of analyses, number of adults was categorized as one, two, or three or more.

Information Seeking and Main Concerns.

Participants completed a Needs Assessment form on which they reported whether they needed assistance or information on several areas of need. For each item, parents indicated 'Yes,' 'No,' or 'Not Sure' as to whether they needed assistance in that area. The individual items were collapsed into four conceptual domains: *parenting information*, *social issues*, *social support*, and *health, community, and social services.*

Seeking parenting information (9 items). Items in the parenting domain including discipline tips, bonding with their child, handling child behavior, child development, interacting with their child, child nutrition, helping their child learn, and how to help their child when it is sick. We tallied the number of yes responses to create the index of parenting information seeking.

Seeking social issues information (4 items). Participants indicted whether they needed information regarding four social issues (e.g., how to be more assertive, how to have healthy relationships). All 'yes' selections were coded as '1,' tallied via SAS 9.4, and labeled *seeking social issues information*.

Seeking social support information (3 items). Participants could also select social support topics such as meeting other families, having more time for oneself, and help with family

problems. All answers of 'Yes' were tallied and coded under the variable *seeking social support information.*

Seeking health, community, and social services information (7 items). If participants requested help obtaining health, community, and social services such as transportation, child care, health or dental care, or other needs, this response was coded as 'Yes' (0/1)for seeking health, community, and social services information.

Main concerns for the family. Similarly to information seeking, *main concerns* is used as a measure of initial engagement and also as a qualitative assessment of the participant's self-identified concerns. Respondents answered an open-ended question, "What are your main concerns for your family?" Three themes were identified: (a) family stability and wellbeing, (b) health and safety, and (c) self-improvement and education. Participants' responses were coded for a single main theme, thus a categorical variable was created representing *main concern*.

Program Factors.

Family Fusion or SafeCare. Participants enrolled in services were assigned to either Family Fusion (one or two modules of SafeCare), or SafeCare, all three SafeCare modules.

Time to first contact. The time to first contact is the number of days between the participant's referral date and the first time that a home visitor was able to contact a participant via telephone.

Program Completion.

Program Completion. The dependent variable of this evaluation is *program completion* a dichotomous variable coded 0 = 'No' and 1 = 'Yes'.

Data Analysis Plan

We first report the descriptive statistics for the sample for all variables. Then, bivariate

analysis, namely, chi-square and t-tests were conducted to analyze the relationship of each

variable to program completion. There were too few data to conduct multivariate analyses.

Results

Sample description

Table 1 contains descriptive information on the sample. The median age of PG at the

time of referral was 27 years old with a range of 17 to 60. Seventy-four participants (79.6%)

were single and 19 (26%) were married. About half the sample white and half was non-white

(primarily, African American), and about half reported the presence of a co-parent. Forty

percent of the sample had one child, twenty percent had two, and forty percent had three or

more. About half the sample lived as the only adult in the household and half lived with one or

more other adults. About two-thirds of the sample had a prior history with DFCS, and one third

did not. Regarding referral reasons, 31 cases were referred for *parental capacity building*

(33.3%), 15 cases for *neglect* (16.1%), 25 cases for *prevention* (26.9%), and 18 cases for *safety*

(19.4%).

Chi-Square Analyses

Table 2 describes the chi-square analyses of categorical data in this evaluation. Race of

the primary guardian was significantly related to program completion with white participants

(54.3%) being more likely to complete SafeCare services than non-white participants (30%), p =

0.02. Though the rest of variables did not statistically significantly relate to program

completion, they are reported below. Of the remaining categorical variables – marital status,

presence of a co-parent, number of children in the home number of adults in the home, DFCS

history referral reason identified concerns, or program (SafeCare vs. Family Fusion) – none were

statistically significantly related to program completion.

T-Test of Means Analyses

A t-test of means was performed in order to determine between program completers

and non-completers for continuous variables. Results and means are presented in **Table 3**.

Though no variables were found to be statistically significant, *health, community, and social*

services information seeking approached statistical significance (p = .085), with parents that did

not complete services expressing greater needs (M = 2.2) than those who did complete (M =

1.5).

Table 1			
Demographic Variables		**N**	**Percent**
PG marital status	Single	53	74.6
	Married	18	25.4
PG race	Non-White	40	46.5
	White	46	53.5
Co-parent	No Co-parent	39	44.8
	Co-parent present	48	55.2
Number of children	1	33	39.3
	2	18	21.4
	3+	33	39.3
Total adults in the household	1	34	43.1
	2+	45	56.9
DFCS History	No history	30	43.3
	Prior/current history	41	57.8

Referral Reason	Capacity building	No	62	66.7
		Yes	31	33.3
	Neglect	No	78	83.9
		Yes	15	16.1
	Safety	No	75	80.7
		Yes	18	19.4
	Prevention	No	68	73.1
		Yes	25	26.9
FF or SC	FF		69	75.0
	SC		23	25.0
Main Concerns	No identified concerns		36	38.7
	Family stability & well-being		43	46.2
	Safety		4	4.3
	Education & training		10	10.8
Parenting information seeking			63	87.5

		40	55.6
Social issues seeking		40	55.6
Social support information seeking		40	55.6
Health, community, and social services information seeking		52	72.2
Program Completion	Did not complete program	50	57.5
	Completed program	37	42.5

Table 1 Continued	N	Mean	SD	Median	Min	Max
Parent Age	82	29.6	9.14	27.16	17.7	60.65
Time to first contact	73	10.0	11	6.0	-6.0	58.0

Table 2			Program Completion		Chi-Squared (by Program Completion)	
Demographic Variables			**%**	**N**	**X^2**	**Probability**
PG marital status	Single (0)		39.6	53	1.387	0.239
	Married (1)		55.6	18		
*PG race**	Non-White (0)		30.0	40	5.17	0.022*
	White (1)		54.3	46		
Co-parent	No Co-parent (0)		33.3	39	2.45	0.118
	Co-parent present (1)		50.0	48		
Number of children	1		36.4	33	1.881	0.391
	2		55.6	18		
	3+		39.4	33		
Total adults in the household	1		43.8	34	0.0162	0.899
	2+		45.2	45		
DFCS History	No history		38.5	26	0.242	0.623
	Prior/current history		44.4	45		

Referral Reason	Capacity building	No	37.5	56	1.626	0.202
		Yes	18.4	31		
	Neglect	No	43.1	72	0.047	0.828
		Yes	40.0	15		
	Safety	No	40.6	69	0.518	0.472
		Yes	50.0	18		
	Prevention	No	41.3	63	0.148	0.700
		Yes	45.8	24		
FF or SC	FF		38.1	63	2.334	0.127
	SC		56.5	23		
Main Concerns	No identified concerns		46.7	30	0.7470	0.8621
	Family stability & well-being		41.9	43		
	Safety		25	4		
	Education & training		40.0	10		

Table 3	Completed	Did Not Complete	T-test	Probability
Parent age	31.0 (9.8)	28.5 (8.7)	-1.18	0.24
Parenting information seeking	2.9 (2.3)	3.4 (2.1)	0.99	0.32
Social issues seeking	0.81 (0.9)	1.0 (1.02)	0.82	0.42
Social support information seeking	0.87 (0.9)	0.85 (0.9)	-0.08	0.94
Health, community, and social services information seeking	1.5 (1.6)	2.2 (1.7)	1.74	0.085
Time to first contact	7.8 (8.0)	11.3 (13.8)	1.2	0.24

Discussion

Overview

The purpose of this evaluation was to determine whether significant differences in rates of program completion relate to family demographics, information seeking behaviors, or program characteristics. This information can assist each stage of implementation of SafeCare, from the decision to fund implementation by policymakers, the focus of trainers at the NSTRC as the model is disseminated, and the method of service delivery by home visitors. It is noteworthy that overall program completion rates were low with 37 of 87 participants or 42.5% completing the program.

Family Characteristics

PG race.

Race of the primary guardian was found to be the only significant family demographic characteristic, which may be an indication that continued focus on home visitor and participant race may reduce attrition in SafeCare's home visiting program. Information on home visitor characteristics and whether there was a match between home visitors and participants' race was not available, but would be of interest to examine. Previous research suggests that participants remain in home visiting services longer if the service provider closely matches the parenting style, race, and culture of the participant (Daro et al., 2003). In Georgia, over half of the non-white participants dropped out of services indicating that there is a need for a new approach to this population.

In order to better understand this retention gap, examining demographic and geographic information regarding SafeCare providers would be helpful. Though Atlanta,

Georgia is a densely populated urban center with diverse racial and cultural spread, rural areas, which make up the majority of the state, exhibit a more homogenous distribution of race, with the majority being white. Future research should focus on retention rates between the urban and rural areas of the state due to the large differences of populations.

Due to the low power of this evaluation, other interactions differentially affecting program completion rates by race could not be explored. Any discussion of race which disregards the importance of health disparities as they currently exist in the United States for minorities overlooks the complex interactions affecting behavior. So, while PG race was found to be statistically significant in this evaluation, nuanced interactions affect attrition rates overall. More research regarding these factors must continue in the future in order to understand the issues creating barriers to maintaining enrollment for minorities (Gopalan et al., 2010; McKay et al., 1998).

Motivational Interviewing

Cultural matching is not the only way to mitigate low engagement rates. Motivational Interviewing utilizes a client-centered focus to increase participant engagement for programs dealing with behavior changes (Miller, 1996). Motivational Interviewing is a therapeutic approach to engaging participants where counselors focus on four important domains affecting overall engagement. These domains are the expression of empathy by the counselor, highlighting inconsistencies in participants' priorities and current behaviors, accepting participant resistance, and promoting self-efficacy. This form of counseling was first developed by Miller in 1983 to help increase engagement in treatments for those with substance abuse addictions (Miller & Rose, 2009), and has over time been applied to many forms of treatment

such as oral health, depression, obesity, and smoking cessation (Lundahl, Kunz, Brownell, Tollefson, and Burke, 2010). Dameshek and colleagues' 2011 evaluation of SafeCare services reported higher sustained enrollment versus Services as Usual and this is thought to be related in part to the home visitors' use of Motivational Interviewing. A 2010 meta-analysis of 119 research studies by Lundahl, Kunz, Brownell, Tollefson, and Burke indicated that overall MI increases engagement. Moreover, in regards to effects on race, MI might be more effective on minorities; the empathy-based approach may appeal individuals who have experienced social rejection (Lundahl, Kunz, Brownell, Tollefson, and Burke, 2010).

Information Seeking

No significant differences were found between types of information seeking and program completion. One effect approached statistical significant, information seeking about social/community services. Interestingly, parents who dropped out expressed greater need than parents who completed. Dropout may be related to the level of need in that families with greater needs are unable to complete the program. Many parents were comfortable requesting information on more than parenting (although it was the largest group of information seeking cases, due in part because of the increased number of topics for parenting versus other groups).

Program Characteristics

No observable difference was found between program completion and program characteristics. Though few statistically significant differences were found relating specific variables to program completion, this evaluation does provide a snapshot of the participants enrolled in SafeCare services in Georgia. Many of the participants (~50%) are concerned with

independence, stability, and their family's well-being, and over half of SafeCare families are two or more adult households. On average (median), families are staying in services for 94 days before case closure due to either attrition or program completion, so perhaps, some skills acquisition occurs before dropout.

In this evaluation, program completion is used as an indicator of parental uptake of skills. We assumed that program completion is necessary for both parenting skills acquisition and behavior change. Realistically, this might not be the case, but examining the relationship between skill uptake and program completion was not possible in this data.

Limitations

A first limitation of this evaluation is the limited number of families that received SafeCare or Family Fusion services. Only 93 cases were included in the analyses from families served over a 17-month period. The challenges of recruiting families into SafeCare services in Georgia were noted by Whitaker and colleagues (2012). The small sample size limited the types of analyses that could be conducted; analyses were restricted to bivariate analyses and no multivariate analyses were conducted as only one variable was found to be significant. Moreover, the small sample limited to the extent to which statistical significance may be found. Seemingly large differences in completion rates for some variables did not emerge as statistically significant. For example, completion rates for SafeCare were almost 50% higher than for Family Fusion (56% to 38%), but this difference was not statistically significant due to the small sample size. A second limitation is that the data utilized were collected in the field by the services providers. Such data collection necessitates the use of very brief data collection forms, completed by poorly trained data collectors. As a result, much information may be

missing or incorrectly filled out. For instance, 22 cases have no information regarding the needs

assessment, and it is unclear whether this information was never collected, whether the client

refused, or whether paperwork may have been lost. Likewise, 22 participants had no

information on DFCS history, thus determinations regarding the relationship of the population

and DFCS investigations cannot be applied to the entirety of the sample.

Data collectors and coders may introduce bias into the data collection process. For

example, participants answered an opened ended question about their main concerns, and this

was hand coded by the author, which naturally lends itself to bias.

Conclusion

Though the current evaluation failed to find a large number of differences between

program completers and non-completers, the importance of understanding engagement and

program completion in real-world implementations of practices remains strong. The problems

associated with this evaluation – small sample size, limited data collection, and non-

independence of data collectors can be addressed with more rigorous methods, and by

allowing more data to accrue over time.

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Appendix A: Initial Referral Form

"SafeCare®" Initial Referral Form

SafeCare is provided in your community by **Children First**

693 North Pope Street Athens, GA 30601
p:706-613-1922x1 f:706-316-3616

Date of Referral:

Case Manager: Phone: Email Address:

Case Number: County: Select   PSSF #:

Referral Source- From Division of Family & Children Services

☐ Child Protective Services Intake   ☐ Family Support (Diversion)   ☐ Family Preservation   ☐ Foster Care

Family Characteristics

	First Name	Last Name	Gender (M/F)	Race (B, W, L, O)	DOB
Primary Parent/Guardian					
2nd Parent/Guardian					
Child 1					
Child 2					
Child 3					
Child 4					

Family Address (Street, City, Zip):

Home Phone: Cell Phone: Last 4 digits of Parent's SSN:

Relative Contact: Name: Phone Number:

If the child(ren) are in foster care, please complete the following:

Foster Parent: Address: City: Zip:

Home Phone: Cell Phone: Work Phone:

If children are with Biological Parent or Relative Placement, please complete the following re: the Parent or Relative:

DOB: Ethnicity: Last 4 Digits of SSN:

Marital Status: Select   Educational Level: Select   Estimated Annual Income: Select

Source of Income:

☐ FT Employment ☐ PT Employment ☐ Food Stamps ☐ Child Support ☐ Relative Subsidy ☐ Retirement ☐ Social Security

☐ SSI ☐ TANF ☐ Unemployment ☐ VA – Veteran's Admin ☐ Workman's Comp ☐ WIC

DFCS Screening

Was the referral screened for current or prior DFCS involvement? ☐ Yes   ☐ No

Result:

☐ No prior CPS history   /   ☐ Prior CPS history -- ☐ Substantiated or ☐ Unsubstantiated /   ☐ Current CPS/Family Support case

Comments:
What brought this family to the attention of DFCS?

"SafeCare®" Initial Referral Form (p. 2)

Case Assignment

Provider: **Children First**   County: **Clarke**   Date Assigned: ☐ / ☐ / ☐

Coach: **Akilah Thomas**   Home Visitor: **Mary-Eleanor Joyce**

Initial Family Contact

Initial Introductory Contact: 1st Call Date: ☐ / ☐ / ☐   Time: ☐   2nd Call Date: ☐ / ☐ / ☐ _ Time: ☐

3rd Call Date: ☐ / ☐ / ☐   Time: ☐   4th Call Date: ☐ / ☐ / ☐   Time: ☐

1st Home Attempt Date: ☐ / ☐ / ☐   Time: ☐

2nd Home Attempt Date: ☐ / ☐ / ☐   Time: ☐

☐ Option A: Contact Made -- ☐ Family Accepts Home Visit -- Date Home Visit Scheduled: ☐ / ☐ / ☐

☐ Family Refused Home Visit -- Reason: ☐ Family Not Interested   ☐ Family Too Busy

(If Option A, and family accepts home visit, complete information in next section. Otherwise, stop here.)

☐ Option B: Unable to Contact -- ☐ Phone disconnected/Wrong number   ☐ Wrong address/Unable to locate

(If Option B, no further information required on form)

Program Overview Visit

Program Overview Visit Date: ☐ / ☐ / ☐

☐ Option A: Family Enrolled -- Enrollment Date: ☐ / ☐ / ☐   ☐ Family Signed Consent Form

☐ Option B: Family Did Not Enroll/Refused Services --   Refusal Date: ☐ / ☐ / ☐

Reason for Refusal --Reason: ☐ Family Not Interested   ☐ Family Too Busy

SafeCare® Home Visiting Program

First Session/Baseline Visit Date: ☐ / ☐ / ☐   Starting SafeCare Module: ☐

Comments: ☐

BACK

**Family Visitation Services/SafeCare®/Family Fusion
Needs Assessment**

Family: _____

Parenting Information			
I need more information about/help with:			
Tips on discipline	☐ Yes	☐ No	☐ Not sure
How to bond with my child	☐ Yes	☐ No	☐ Not sure
How to handle my child's behavior	☐ Yes	☐ No	☐ Not sure
How children grow and develop	☐ Yes	☐ No	☐ Not sure
How to play with or talk to my child	☐ Yes	☐ No	☐ Not sure
Feeding/nutrition for children	☐ Yes	☐ No	☐ Not sure
How to help my child learn	☐ Yes	☐ No	☐ Not sure
What to do when my child is sick	☐ Yes	☐ No	☐ Not sure
Other:			

Social Issues			
I would like more information about/help with:			
How I can be more assertive	☐ Yes	☐ No	☐ Not sure
Alcohol or drug addiction	☐ Yes	☐ No	☐ Not sure
Healthy relationships	☐ Yes	☐ No	☐ Not sure
Domestic violence issues	☐ Yes	☐ No	☐ Not sure
Other:			

Support			
I would like:			
To meet and talk with other families	☐ Yes	☐ No	☐ Not sure
More time for myself	☐ Yes	☐ No	☐ Not sure
Help with family problems	☐ Yes	☐ No	☐ Not sure
Do you have anyone you can talk to about problems?	☐ Yes	☐ No	☐ Not sure

Health, Community, and Social Services			
I need help in getting:			
Transportation	☐ Yes	☐ No	☐ Not sure
Day/child care	☐ Yes	☐ No	☐ Not sure
Health or dental care	☐ Yes	☐ No	☐ Not sure
Food	☐ Yes	☐ No	☐ Not sure
Education or training	☐ Yes	☐ No	☐ Not sure
A job	☐ Yes	☐ No	☐ Not sure

Help with meeting my monthly expenses   ☐Rent   ☐Food   ☐Electric
☐Heat   ☐Child Care   ☐Other: _____

In the past two years, how many times have you moved? _____

Have you received any assistance for/with food, rent, clothing, etc. within the last year?   ☐Yes ☐No ☐Not sure

What are your main concerns for you and your family?