Children and Youth Services Review 93 (2018) 474–483

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Perspectives on the implementation of an evidence-based neglect program within child welfare

Kelly Weegar*, Jessie Moorman, Lauren Stenason, Elisa Romano

School of Psychology, University of Ottawa, Ottawa, ON, Canada

ARTICLE INFO

Keywords:
Child welfare
Child neglect
Evidence-based program
Qualitative analysis

ABSTRACT

In child welfare in Ontario (Canada), neglect is a major concern due to high incidence rates compared with other maltreatment types. This qualitative study examines child welfare service directors' and providers' experiences with implementing the SafeCare® program, an evidence-based intervention that is aimed toward the prevention of child neglect. Service directors (n = 9) and providers (n = 15) were recruited from six Ontario child welfare agencies that had been delivering SafeCare for 1.5 years. Data were gathered using semi-structured focus groups which asked about reasons for adopting SafeCare, positive experiences and challenges with implementation, and SafeCare's sustainability within agencies. Overall, service directors and providers rated SafeCare as a valuable program that contributed to positive outcomes for participants (e.g., family reunification), providers (e.g., enhanced skills), and the agency (e.g., increased value). Among the factors that contributed to a positive implementation experience were the structured and skills-based approach of SafeCare, as well as the flexibility to meet the diverse needs of families. Service directors also described SafeCare as a vehicle for changing views and increasing enthusiasm among providers and the agency toward evidence-based practices within child welfare. In terms of challenges, service directors and providers noted limited financial resources for continued training in the program as well as reluctance toward certain aspects of SafeCare (e.g., audio recording). Findings are important for purposes of refining SafeCare's implementation and better ensuring its sustainability within Ontario child welfare. Findings also provide important information about family-, provider-, and agency-level variables that play a role in successful program implementation and sustainability, as well as in changing perspectives and ensuring the engagement of child welfare toward structured evidence-based programs.

1. Introduction

1.1. Definition and scope of neglect

Child neglect has been defined as any act(s) or omission by a caregiver that denies a child basic age-appropriate needs and therefore has potential to result in harm to the child, either physically or psychologically (American Psychiatric Association [APA], 2013; Slep, Heyman, & Foran, 2015). The following types of child neglect have been identified: *physical* neglect is the absence of provision by a caregiver for a child's basic needs and/or supervision for a child's safety, including abandonment in extreme circumstances; *medical* neglect is when a caregiver does not ensure that a child is medically treated when necessary; *educational* neglect is when a caregiver fails to ensure that a child's basic learning needs are met; and *emotional* neglect is when a caregiver does not provide a child with enough nurture and stimulation (APA, 2013; Horwath, 2007). Child neglect, along with physical abuse, sexual abuse, emotional (or psychological) abuse, and exposure to intimate partner violence, are collectively referred to as child maltreatment (Fallon et al., 2015; Slep et al., 2015). Although any of these maltreatment types can occur separately, they often co-occur and are linked with other types of adversity (e.g., peer violence; Finkelhor, Ormrod, Turner, & Hamby, 2005; Turner, Finkelhor, & Ormrod, 2010). Child neglect also tends to occur within the context of events beyond caregivers' control (e.g., poverty, mental health problems, and social isolation; Wilson & Horner, 2005).

In Canada, reliable nation- or province-wide statistics on the prevalence of child neglect do not exist because of few population-based surveys for children and youth. Nationally representative surveys of childhood experiences among Canadian adults have also left out measures of childhood neglect (e.g., Afifi et al., 2014). As a result, estimates of child neglect in Canada have tended to rely on information from

* Corresponding author at: School of Psychology, University of Ottawa, Vanier Hall, 136 Jean Jacques Lussier, Ottawa, Ontario K1N 6N5, Canada.
E-mail addresses: kweeg065@uottawa.ca (K. Weegar), jmoor095@uottawa.ca (J. Moorman), lsten096@uottawa.ca (L. Stenason), eromano@uottawa.ca (E. Romano).

https://doi.org/10.1016/j.childyouth.2018.08.035
Received 19 March 2018; Received in revised form 28 August 2018; Accepted 28 August 2018
Available online 29 August 2018
0190-7409/

cases that have come to the attention of police or child welfare. For instance, the Ontario Incidence Study of Reported Child Abuse and Neglect – 2013 (OIS-2013; Fallon et al., 2015) tracked 5265 child maltreatment investigations conducted in a representative sample of 17 child welfare agencies in Ontario (Canada) across a 3-month period in 2013. Data from these investigations were then used to generate annual provincial estimates of the different maltreatment subtypes. From all of these investigations, 34% were substantiated (18.33 per 1000 children), and child neglect was the second most substantiated maltreatment type (24% or 4.42 per 1000 children) behind exposure to intimate partner violence (48% or 8.70 per 1000 children). Likewise, national incidence estimates from the most recent report of the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) found that child neglect represented 34% of substantiated cases (Trocmé, Fallon, MacLaurin, Hélie, & Turcotte, 2010).

Estimates from the OIS and CIS are likely under-estimates because many instances of child abuse and neglect do not come to the attention of authorities. This can occur for various reasons, such as children being reluctant to report their victimization to trusted individuals because of their stage of physical, mental, and cognitive development and/or fear of negative consequences. Within this context, research from other developed countries, such as the United States (Finkelhor, Turner, Shattuck, & Hamby, 2015), Australia (Australian Institute of Health and Welfare, 2016; Moore et al., 2015), and the United Kingdom (Cawson, Wattam, Brooker, & Kelly, 2000; Ratford et al., 2011), also points to the high prevalence of child neglect. For instance, U.S. prevalence data in 2014 from the National Survey of Children's Exposure to Violence on 4000 youth suggested that close to 8.6% of children under the age of 10 and 14.3% of 10–17 year olds experienced neglect (Finkelhor et al., 2015). Furthermore, results from a national sample of 6196 parents and children in the U.K. indicated that neglect was the most prevalent type of maltreatment across all age groups: 5.0% for children < 11 years; 13.3% for 11–17 year olds; and 16.0% for 18–24 year olds (Ratford et al., 2011). Collectively, these data suggest that child neglect is one of the most prevalent maltreatment types in developed countries.

1.2. Risk factors for neglect

Research has suggested that certain factors may increase a child's risk of experiencing a particular form of child maltreatment. These risks may be related to the child's characteristics or those of his/her family, the community in which he/she lives, or social policies (Chamberland et al., 2005; MacMillan, 2000). In addition, risk factors are likely to vary for different age and population groups (Stith et al., 2009). Specific risk factors that have been associated with an increased likelihood of child neglect include: caregiver psychopathology; caregiver substance use; early separation from mother; young maternal age; single-parent household; low socio-economic status; and large family size (Stith et al., 2009).

1.3. Consequences of neglect

Child neglect can bring about wide-ranging impairments in socio-emotional development, mainly as a result of disturbances to the child's attachment system. The occurrence of child neglect often compromises the development of a secure attachment between a child and primary caregiver, which is necessary for the successful progression through later developmental processes (e.g., emotion regulation, social competence; Sroufe, 2005). Thus, diverse negative outcomes can arise from neglect, including early onset of both externalizing and internalizing behaviour problems (Kim & Cicchetti, 2010; Kotch et al., 2008; Valentino, Cicchetti, Rogosch, & Toth, 2008) as well as poor executive functioning and low intellectual performance (Fishbein et al., 2009; Geoffroy, Pereira, Li, & Power, 2016). In the worst circumstances, child neglect can be fatal. Although Canadian data on neglect-related fatalities are not available, research from other developed countries are revealing, such as data from the U.S. that suggests that 72.9% of all child fatalities are linked to child neglect (U.S. Department of Health & Human Services, 2017).

1.4. SafeCare®: an evidence-based intervention for child neglect

Considering the harmful impacts of child neglect and its high occurrence, evidence-based interventions are needed to ensure the physical and psychological safety of children who have or are at risk of experiencing neglect. While a number of evidence-based parenting programs have been employed with child welfare-involved families (e.g., Triple P, Incredible Years), few have specifically targeted neglect-specific concerns. SafeCare® (Lutzker & Bigelow, 2002) is an evidence-based parenting program that directly targets risk factors for child neglect among child welfare-involved families with young children (i.e., newborn to 5 years). Trained providers implement SafeCare in the home environment over the course of 18–20 sessions, generally on a weekly basis with each session lasting 1–1.5 h. There are three modules, namely home safety, child health, and caregiver-infant/child interaction. SafeCare relies primarily on behavioural principles and as such, includes strategies such as regular data collection to monitor progress over time, behavioural rehearsal to develop skills, and behavioural observation (Guastaferro & Lutzker, 2017; Guastaferro, Lutzker, Graham, Shanley, & Whitaker, 2012; Self-Brown et al., 2014).

The health module helps caregivers identify signs of illness and injury and then assess and intervene effectively. To do so, caregivers are presented with a series of scenarios designed to characterize various childhood health issues, during which they are guided toward seeking treatment that is appropriate to each situation. Caregivers are also provided with reference materials (e.g., health recording charts, medically-validated manual) to help them assess their child's injuries and illness in order to determine the best course of action, that is whether to care for the sick or injured child at home, schedule a physician's appointment, or bring the child to the hospital emergency room (Guastaferro & Lutzker, 2017; Self-Brown et al., 2014).

The safety module is designed to help caregivers create a physically safe environment for their young child by recognizing and removing hazards in the home. Providers begin by assessing three separate rooms in the home (as chosen by caregivers to respect their privacy) and noting the number of hazards that can be accessed by the child based on height (e.g., poisonous solids and liquids, fire and electrical hazards, sharp objects). Providers then work with caregivers to help them monitor their home environment for safety risks and to demonstrate how to eliminate and reduce hazards within the home (Guastaferro & Lutzker, 2017; Self-Brown et al., 2014).

The caregiver-infant/child interaction module helps caregivers improve the relationship with their child by engaging in sensitive responding and increasing positive interactions. This module is divided by age to account for different developmental needs. Infant-specific activities (newborn to 2 years) focus more on non-verbal strategies (e.g., positive voice tone, gentle touching, and frequent eye contact), whereas strategies for older children (3–5 years) are more verbal and elaborate (e.g., activity planning, positive discipline). For both infants and young children, activities are also grouped into play (e.g., peek-a-boo, reading) and non-play (e.g., changing a diaper, preparing for bed; Guastaferro et al., 2012).

A critical component of the SafeCare implementation model involves training and coaching of providers by staff from the National SafeCare Training and Research Center (NSTRC) in Atlanta, Georgia. First, NSTRC staff deliver workshops to individuals who agree to become trained as SafeCare providers. As the new SafeCare providers begin meeting with families, coaches play a pivotal role in ensuring fidelity to the treatment model by reviewing sessions and providing guidance. The coaching of SafeCare providers is “front-loaded” so that newly-trained providers participate in weekly coaching and then the frequency of coaching is gradually reduced to a monthly basis as