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Research article

Service needs of adolescent parents in child welfare: Is an evidence-based, structured, in-home behavioral parent training protocol effective?☆

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ABSTRACT

SafeCare is an evidence-based behavioral parent training intervention that has been successfully implemented in multiple state child welfare systems. A statewide implementation in Oklahoma established the effectiveness of SafeCare with a diverse group of parents, which included adolescent parents under 21 years of age, a particularly at-risk group. The current study examined whether SafeCare is also effective for this subsample of 294 adolescent parents with regard to child welfare recidivism, depression and child abuse potential, and attainment of service goals. Post-treatment adolescent parent ratings of program engagement and satisfaction were also examined. Among the subsample of adolescent parents, the SafeCare intervention did not result in significantly improved outcomes in terms of preventing recidivism or reduction in risk factors associated with child abuse and neglect as compared to child welfare services as usual. Further, no significant differences in program engagement and satisfaction between SafeCare and services as usual were detected. These findings shed light on the potential differences in program effectiveness between adolescent and adult parents, and the need for future research to rigorously evaluate the effectiveness of behavioral parenting programs with adolescent parents.

1. Introduction

When targeting adolescents in the child welfare system, research and practice often focus on adolescents who experience abuse or neglect at the hands of their caregivers. However, adolescents also receive child welfare services as parents. The rate of adolescent pregnancy in the U.S. has reached a historic low: 22.3 out of every 1000 U.S. adolescents gave birth during 2015, a rate that has fallen 64% since 1991 (Martin, Hamilton, Osterman, Driscoll, & Mathews, 2017). Still, rates of adolescent pregnancy in the U.S. are the highest when compared to the world's 29 most advanced countries (UNICEF, 2013).

Pregnancy continues to put an adolescent at risk for physical health problems, economic hardships (e.g., receipt of welfare), and low educational attainment (Elfenbein & Felice, 2003). Unfortunately, adolescent parents often grow up in conditions of poverty, are exposed to abuse and neglect, and frequently lack the skills and resources necessary to create safe, stable, and nurturing early care

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environments for their children (Sidebotham, Heron, & ALSPAC Study Team, 2006). These skill and resource constraints increase the likelihood that their own children will be exposed to harsh parenting practices, abusive forms of physical discipline, lack of access to basic needs, and low levels of parental monitoring and stimulation in their care environments (Bartlett & Easterbrooks, 2012; Lee, 2009; Lounds, Borkowsji, & Whitman, 2006). Further, children born to adolescent parents are more likely to become adolescent parents themselves, thus continuing the cycle of risk (Hoffman & Maynard, 2008).

The prevalence of this cycle of risk was demonstrated in a recent population-level, longitudinal study of the relationship between adolescent pregnancy, maternal history of maltreatment, and intergenerational abuse and neglect (Putnam-Hornstein, Cederbaum, King, Eastman, & Trickett, 2015). Among 85,084 births to adolescents (aged 15–19) in California during 2006 and 2007, 28% were to a mother who had been maltreated between 10 years of age and her conception date (this figure included both unsubstantiated and substantiated reports). Further, among adolescent mothers who had prior unsubstantiated reports of maltreatment themselves, 35.9% of their children were reported to have been maltreated by age 5, compared to 44.1% of adolescents who had previously been substantiated as victims of abuse or neglect. The prevalence of abuse and neglect for children of mothers who had previously been maltreated was significantly higher than the rate of abuse and neglect for children of mothers who had not been previously maltreated. Thus, the mother's experience of maltreatment was a strong predictor of maltreatment within the next generation (Putnam-Hornstein et al., 2015). To decrease the likelihood of intergenerational cycles of child abuse and neglect and associated risk factors, it is critical for child welfare services to address the needs of adolescent parents in order to prevent recidivism and improve parenting skills among referred adolescent-led families.

SafeCare (SC) is an evidence-based behavioral parent training intervention that has demonstrated effectiveness in reducing child maltreatment recidivism (Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012b). Specifically, SC was developed to reduce the occurrence of risk factors for child maltreatment by improving parent-child/infant relationships, parent knowledge and skills, and other contextual environmental factors (Lutzker & Bigelow, 2002). The efficacy of the SC model in reducing child maltreatment was demonstrated among multiple populations of at-risk parents, including parents referred from child protective services, substance abuse treatment programs, and agencies that serve disadvantaged families (Carta, Lefever, Bigelow, Borkowski, & Warren, 2013; Chaffin et al., 2012b; Silovsky et al., 2011).

A considerable number of adolescent parents have participated in SC due to many factors, including involvement in child welfare and having at-risk home environments. For instance, in an earlier trial of SC, families were referred to the program after being identified as 'at-risk' by a local hospital due to the parents' age, lack of a social support network, and a low level of education (Gershater-Molko, Lutzker, & Wesch, 2003). While many adolescents have participated in SC, recruitment has not targeted adolescents, the intervention does not specifically address issues pertaining to adolescents, and research has not investigated intervention effectiveness among adolescents.

Given the high risk of maltreatment in adolescent-led families, it is important to examine whether SC is effective for use with this specific population. Importantly, the manualized SC intervention was developed in the 1980s and 1990s, and although the curriculum has been revised to include new research and technology (Guastaferro, Lutzker, Graham, Shanley, & Whitaker, 2012; Self-Brown, C. Osborne, Rostad, & Feil, 2017), it has not been revised to include research on adolescent development and adolescent parenting. Developmental-ecological theory, which postulates that adolescent parenting is influenced by interactive relationships between characteristics of the adolescent, characteristics of the adolescent-led family, and broader contextual factors, is helpful in informing speculation about how SC may or may not meet the needs of adolescent parents (Bartlett, Raskin, Kotake, Nearing, & Easterbrooks, 2014; Belsky, 1993; Bronfenbrenner & Morris, 2006).

In terms of characteristics of adolescents, the most obvious and consistently present difference between adolescents and adult participants in SC is parental age. Recent research that has illuminated how the developing brain impacts emotion, cognition, and behavior is particularly important to understanding how being young impacts adolescent parents. Evidence has accumulated demonstrating that neurological maturational processes once thought to be completed by the end of childhood continue into late adolescence and the period of emerging adulthood (e.g., Giedd et al., 1999). We now know that brain development in regions key to the regulation of behavior and emotion and to weighing risks and rewards are biologically underdeveloped in adolescents when compared to adults (Steinberg et al., 2009). These brain regions are essential for the psychological and social characteristics and skills that behavioral parent training programs intend to promote, such as modulating one's affect to increase the level of positive expressions towards infants. Thus, knowledge of how adolescent brain development makes adolescents characteristically different from adults is particularly important to understanding adolescent parenting and informing potential adaptations of SC for use with adolescents (Barrett & Fleming, 2011).

Despite not being developed specifically for use with adolescent parents, there are several compelling reasons why SC may be well-suited to meet the needs of this population. Importantly, the intervention addresses risk factors for maltreatment that are often characteristics of adolescent-led families. SC provides skills-based training in ways to interact verbally with infants, display positive and affectionate behavior towards infants and children, respond to infant and child behavior, and respond to infant and child health care needs, each of which are elements of interactional patterns that research demonstrates adolescents lack skill in when compared to adult mothers (Koniak-Griffin et al., 2002; Rafferty, Griffin, & Lodise, 2011). Importantly, the intervention also addresses some of the unique challenges that exist within interactions between the individual adolescent parent and the context of important systems, such as the family. Home-based intervention is ecologically valid by design, minimizing generalization issues that may occur in clinic settings (Guastaferro et al., 2012). This is especially important when delivering services to adolescent parents, as they often live with their children's grandparents, so applying skills from therapy in the home environment can be complicated by tensions or disagreements related to caregiving responsibilities in a multigenerational family (Black & Nitz, 1996; Black, Siegel, Abel, & Bentley, 2001). SC is an inclusive intervention and includes all caregivers (including grandparents) in the home if they agree to participate in