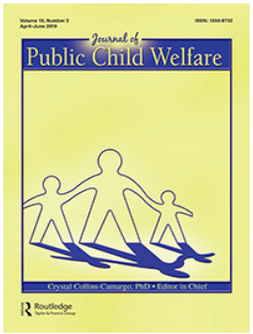

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I'm From the Government and I'm Here to Help: How Can Public Health Perspectives Improve Outreach in Child Maltreatment Prevention Programs?

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ABSTRACT

State and local governments are designing programs to prevent child maltreatment at an increasing rate. A relatively small portion of families offered these programs go on to engage in and complete services. Workers in a child maltreatment prevention program implemented across 21 sites in 1 state documented outreach efforts in logs maintained by program evaluators. Additionally, evaluators interviewed 23 outreach workers and supervisors who were developing and refining outreach strategies in this prevention program. Data from logs and responses to interviews speak to challenges in navigating prevention outreach with families to achieve engagement and buy-in, particularly when "cold-calling" about screened-out reports of child maltreatment. This paper presents a summary of barriers and facilitators of family engagement in outreach for prevention services, guidance from the public health literature on improving outreach strategies for at-risk populations, and suggested practice, policy, and research implications.

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In an address to the American people on April 12, 1986, Ronald Reagan characterized the challenge of prevention as a government service, saying "The nine most terrifying words in the English language are, 'I'm from the government and I'm here to help.'" Prevention services differ from other human services in that they focus on mitigating risk and strengthening protective factors with citizens to lessen the likelihood that a particular situation will occur. Government agencies utilize prevention strategies in areas such as disease, violence, disaster preparedness, and more recently, child maltreatment. These strategies are designed to change citizen behavior within their ecological environment, and thus, the technologies employed demand extensive relationship between the government agent and the citizen (Hasenfeld, 1983). However, the extant research indicates one of the greatest challenges to coproducing government services with citizens is developing a

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Color versions of one or more of the figures in the article can be found online at www.tandfonline.com/wpcw.

trusting relationship (Thomas, 2013). The focus of this paper illustrates and explores this dilemma, wherein increasing numbers of state and local governments are designing programs to prevent child maltreatment, but a relatively small portion of families offered these programs go on to engage in and complete services. This exploration is guided by qualitative and quantitative data from a prevention program with 21 individual sites with leadership from within a department of human services. We use a public health lens developed in injury and disease prevention to gauge opportunities for outreach improvement. We also review implications for policy and further research on outreach strategies originating from public agencies.

Theoretical and practical basis for outreach

Prevention-related interventions generally rise from ecological theory (Bronfrenbrenner & Morris, 1994). Ecological models acknowledge an interrelated connection between human behavior and environment. Further, ecological theory sets forth a nested-ness of the individual, within expanding ecologies spanning from the self to society. This understanding provides foundation for choices related to prevention programs. When considering violence prevention, for example, the World Health Organization identifies four levels for intervention and consideration: individuals, relationships (with other individuals), communities, and societies (Dahlberg & Krug, 2002). Ecological theory guides prevention program development by intentionally targeting interventions at and between certain levels, such as the family within the community or the individual within the family (Newes-Adeyi, Helitzer, Caulfield, & Bronner, 2000). Child maltreatment, as in the program reviewed in this article, is commonly understood in ecological terms, and the interplay between the individual, family, community, and society is a foundational framework for research and intervention (Belsky, 1980). Public health scholars recognize this theoretical basis in the area of prevention, and cite outreach as the first step when engaging individuals in health promotion (Sallis, Owen, & Fisher, 2015).

Outreach, or establishing a relationship between the government entity and a citizen, is one of the ways that public health professionals engage populations, particularly high-risk populations, who may be difficult to reach using other, less targeted methods (Kelller, Strohschein, Lia-Hoagberg, & Schaffer, 2004). Identifying and developing connections with the population-of-interest is an important first step to outreach (Kelller et al., 2004). Following contact, the purpose of outreach is to provide information about health and/or behavior concerns, the steps to reduce risk, and the resources available in the community (Kelller et al., 2004). Ideally, this type of outreach is tailored to the unique health needs, risk and protective factors, and resources of the community, so practitioners are encouraged to utilize available data, such as demographic characteristics and health data, and also

collect additional data from the community to understand local perspectives on the issue (Tembreull & Schaffer, 2005). Outreach also takes an ecological approach to the determinants of health, including consideration of how society, community, and interpersonal issues may be positively or negatively impacting health (Kelller et al., 2004). Finally, outreach is often informed by a health promotion approach, which is focused on fostering resiliency and addressing prevention at the primary (preventing an issue altogether), secondary (addressing early stages of issue), and tertiary (limiting further negative effects and/or preventing future issues) levels (Kelller et al., 2004). The prevention program explored in this inquiry incorporates ecological theory into practice.

Recognizing children at risk are nested within families who may be experiencing economic and social difficulty, the outreach portion of the intervention is designed to engage families in a positive helping relationship with a representative of a community resource agency. Once outreach is complete and services accepted, the outreach worker then works with families to identify and access community services to mitigate the risk to the child. Bronfrenbrenner reminds us, however, that while positive change may result from leveraging the ecological perspective, when families experience conflicts in their interactions with entities in exosystems (such as government agencies, schools, and other community institutions), this may be a barrier to achieving such change (1996). Given the stigma of child maltreatment and child protective services (CPS) in current society, this article explores both the child–family dynamic encountered by outreach workers as well as the family–government (in this case, CPS) dynamics outreach workers experienced, with an aim of highlighting areas to consider for future, similar endeavors.

Prevention of child maltreatment

The Centers for Disease Control identified child maltreatment prevention as a public health priority at the start of the millennium (Hammond, 2003). Similar to prior public health initiatives addressing violence in the general population, the emphasis of child maltreatment prevention initiatives is identifying known risk factors and indicators of child maltreatment and implementing strategies to effectively mitigate the risk of injury. In the decade that followed, considerable evidence developed related to child maltreatment prevention. In a systematic review of child maltreatment prevention interventions, Mikton & Butchart developed a typology to encompass the types of interventions explored by this burgeoning study: (1) home visiting, (2) parent education programs, (3) sexual abuse prevention, (4) abusive head trauma, (5) multi-component interventions, (6) media-based public awareness, and (7) support and mutual aid groups (2003). They

concluded that in 14 studies, home visiting was, "judged to be promising or… found to be supported by one well-designed study." During this same time, prevention strategies by state government expanded to include child maltreatment prevention programs targeted to at-risk families (Child Welfare Information Gateway, 2011). These services reflect aspects of home visiting models, but tend to be less formally structured and are more flexible in duration and scope than tested home visiting models.

Child maltreatment prevention efforts directly originating from public child welfare agencies, like the program described in this article, are typically composed of voluntary in-home services and goal setting designed to help families achieve or maintain protective parental or caregiver factors such as improved financial stability, mental health stability, knowledge of child development, and reduced substance use. Referrals for the program in this study come from one of two sources: reports of alleged child maltreatment that do not meet the legal standard for assessment (i.e. screenouts), or families who were reported for child maltreatment, received an assessment from the child welfare agency, and did not require further formal intervention or ongoing services. Typically, the latter group receives a referral as part of the assessment process, oftentimes with the family's knowledge. The former group, however, does not receive notice that the public child welfare agency received a call about their family nor are they aware the agency passed their information to a prevention services delivery agency. Two other forms of referral to child maltreatment prevention programs like these are used in other jurisdictions: (1) Community members call the prevention program out of concern for the family, and (2) Families are allowed to call the prevention program on their own behalf to request services.

In the United States, the rate at which families accept voluntary child maltreatment prevention services hovers around 50%, though it varies across jurisdictions from 20% to 80% (Loman, Shannon, Sapokaite, & Siegel, 2009; Maguire-Jack, Slack, & Berger, 2013). This substantial range in acceptance may be related to the variation among strategies and protocols for outreach between prevention programs, prevention agencies, and even among outreach workers, as noted in a national survey conducted in 2011 (Morley & Kaplan, 2011). Given the successes experienced by recipients of this type of child abuse prevention programs, the purpose of this study is to examine strategies and protocol used by workers when conducting program outreach, particularly when engaging with families who will not expect the contact.

Using qualitative methods, this paper describes outreach worker perspectives on family engagement in a prevention program implemented in several jurisdictions of one state. The program offered at-risk families voluntary case management services, which included the availability of flex funds, or direct cash resources to be spent on urgent concrete needs requested by the family. The program sought to mitigate the risk of child maltreatment by

strengthening families' protective factors, building social capital, increasing financial stability and self-sufficiency, and improving family functioning and well-being by leveraging both formal systems and informal resources to meet their self-identified needs. Quantitative analyses of outreach logs documenting outreach and service provision at the site level are triangulated with the qualitative data for validation. Further, the decision models of outreach workers are revealed with relation to outreach protocol for the two groups of families receiving outreach. Finally, the evaluation team discusses implications for practical outreach strategies, policy-makers considering similar programing, and future evaluation and research.

Methods

The context for this evaluation was a child maltreatment prevention home visiting program that was implemented across 21 counties with leadership and coordination from a division within a state department of human services. The intent of the program was to target families who either had a screened-out report of child maltreatment, or an assessment of child maltreatment that required no further formal intervention by the local CPS agency. Outreach workers from the provider agency (most often a community provider) contacted families following this referral. A small number of sites operated within a division of the local CPS agency. Outreach was conducted via phone, letter, or drop-in home visit, depending on program discretion and/or availability of contact information. It is also important to note here that the jurisdiction type was relevant to the outreach protocols utilized by each site. Many of the sites are defined as "frontier" counties, a subset of rural defined as sparsely populated rural areas with a population density of six or fewer people per square mile (Economic Research Service (n. d.). Table 1 includes a listing of sites by provider jurisdiction type (i.e. urban, rural, or frontier) and site location (i.e. DHS or community provider). Outreach workers entered efforts into logs maintained by the evaluation team documenting referrals, outreach attempts, program acceptance, and service completion. These logs were reviewed regularly by the evaluation team to check for continuity and accuracy. Logged data from all of the 21 sites were used to explore outreach protocols and provide context for the qualitative analysis.

Likewise, to provide further context for the data from the logs, a convenience sample of outreach workers and their supervisors volunteered to participate in semi-structured interviews about their practice. The interviews for outreach workers (n = 15) centered on three primary questions: (1) How do you explain the program to families? (2) What has contributed to your ability to successfully engage families to participate in the program? (3) Thinking about the families who you have outreached to, but have declined

Table 1. Referrals and acceptance/decline rates.

Site	Location type	Provider type	Eligible referrals	Actual referrals	% Eligible- > Referred	Number accepted	Acceptance rate	Number declined	Decline rate
1	Frontier	Community	108	100	93%	30	30%	63	63%
2	Urban	DHS	558	305	55%	73	24%	229	75%
3	Rural	DHS	234	187	80%	47	25%	137	73%
4	Rural	Community	206	198	96%	56	28%	133	67%
5	Rural	DHS	423	158	37%	88	56%	70	44%
6	Rural	Community	351	298	85%	52	17%	245	82%
7	Rural	Community	149	115	77%	23	20%	86	75%
8	Rural	Community	3,658	372	10%	147	40%	225	60%
9	Frontier	Community	270	166	61%	32	19%	124	75%
10	Rural	Community	2,550	812	32%	149	18%	662	81%
11	Rural	Community	204	182	89%	21	12%	146	80%
12	Rural	Community	338	242	72%	55	22%	185	76%
13	Rural	Community	332	293	88%	33	11%	249	85%
14	Frontier	Community	424	159	38%	62	39%	94	59%
15	Rural	Community	65	61	94%	23	38%	31	51%
16	Rural	Community	800	192	24%	84	43%	110	56%
17	Frontier	Community	649	476	73%	88	18%	385	81%
18	Rural	Community	133	119	89%	26	22%	92	78%
19	Rural	Community	306	269	88%	75	28%	188	70%
20	Frontier	Community	71	71	100%	35	49%	36	51%
21	Rural	DHS	334	213	64%	38	18%	172	81%
Totals			**12,163**	**4,988**	**41%**	**1,237**	**27%**	**3,662**	**70%**

to participate, what are the factors that you believe contributed to their decision? These interviews also included general portions discussing program design, staffing, use of flexible funding, and service availability. Similarly, supervisors (n = 8) were asked to discuss program design, their observations of workers, service needs and delivery strategies, and successes and challenges in outreach to families from their perspective.

An evaluation assistant trained in interviewing techniques facilitated the interviews via GoToMeeting, and recorded each hour-long interview after obtaining permission from respondents. A member of the evaluation team directly transcribed interview segments from 12 outreach workers pertaining to family engagement and outreach processes. Three interviews were not transcribed due to technical difficulties with the recording technology. The remaining portion of all interviews was organized in Excel according to common answers and distinct outliers. The evaluation team analyzed transcriptions of the engagement and outreach portion of outreach worker interviews using Constant Comparative Analysis (Corbin & Strauss, 2014) to analyze themes and outliers in the sample interviews. A member of the evaluation team delineated chunks of text from each of the three primary questions in the semi-structured worker interview and assigned codes to each chunk. *In vivo* coding was conducted to capture unique vernacular using NVivo 11 for Windows. One evaluator analyzed coding to develop emerging themes from interviews. As themes across interviews emerged, the evaluator recoded nodes to organize the content of the interviews. In an effort to check validity of this analysis, evaluation team members conducted cross-checking of all assigned chunks and codes in an effort to reconcile any differences in interpretation.

Following the Constant Comparison Analysis, evaluators employed two quasi-statistical methods to analyze data for themes related to worker description of outreach strategies. First, the evaluation team tallied frequently mentioned words, as described by Sandelowski (2001). Evaluators compared these tallies to emergent themes from the Constant Comparison Analysis to assist in triangulation of data, and to identify key words. The evaluation team then analyzed these key words in their original context using Key Words in Context analysis.

The evaluation team created a within-case display for each worker's outreach protocol that highlighted assumptions, key conditions, and associated actions, as described by Werner and Schoepfle (1987). Specifically, the display used for this analysis was a type of decision modeling, which outlines the public/outward steps taken by outreach workers through the course of the initial outreach contact, as well as the internal decision-making represented by outreach workers in each interview. Then, the project team identified the decisions articulated by the outreach workers in the sample. Evaluators grouped individual protocols by similarities to develop a decision model

Table 2. Outreach attempts and decline reasons by site.

Site	Average number of outreach attempts	Number declined/ not receiving services	Proportion active declines	Proportion unable to reach	Proportion other reason not receiving services
1	3.4	63	16%	44%	40%
2	3.0	229	38%	39%	23%
3	3.5	137	38%	50%	11%
4	3.3	133	35%	43%	23%
5	3.0	70	33%	49%	19%
6	3.8	245	29%	61%	10%
7	2.5	86	26%	51%	23%
8	2.4	225	25%	55%	20%
9	2.3	124	15%	38%	48%
10	3.5	662	36%	49%	15%
11	2.1	146	13%	84%	3%
12	3.0	185	26%	56%	17%
13	3.0	249	22%	57%	20%
14	3.3	94	25%	49%	26%
15	4.5	31	42%	45%	13%
16	2.3	110	13%	85%	3%
17	2.6	385	29%	48%	23%
18	2.4	92	14%	59%	26%
19	2.8	188	26%	29%	45%
20	1.8	36	14%	47%	39%
21	2.7	172	42%	39%	19%
Totals	**3.0**	**3,662**	**29%**	**51%**	**20%**

most commonly employed in the program. Throughout the entire evaluation of the prevention program, of which this inquiry represents a small part, evaluators solicited peer debriefs from state program staff and leadership, in an effort to interpret, contextualized, and triangulate the findings obtained in both the logs and qualitative analysis.

Findings

The findings in this section present variation among the 21 sites offering child maltreatment prevention outreach. Specifically, this section discusses summative findings from worker logs on decline rates, staffing structure, program definition, and referrals. Where applicable, evaluators triangulated these findings with data from the semi-structured interviews. Then, evaluators explored more in-depth results on outreach barriers and facilitators in general as well as in the initial phone call to families, and reported successes of the intervention.

Decline rates

Due to the sheer volume of cases that were either screened out or closed after assessment, and given that some of the 21 outreach sites were mid-to-large

sized, the number of families eligible for prevention outreach far exceeded the number of actual referrals to the prevention program. There were 12,163 families eligible to receive the prevention program (based on program and site-specific eligibility criteria), but 4,988 of those families were actually referred, for an overall referral rate of 41% (Table 1). In part, this low referral rate reflects the sites' capacity to serve only a percentage of families who are eligible to receive prevention services. Further, the majority of sites (17 of 21) were randomized control trial sites whereby the agencies received contact information for only those families randomized into the treatment group. The treatment-control ratio at each site was set based on the average numbers of eligible families (screen outs and closed assessments) experienced in that site per month as well as the site's capacity to serve families. As a result, some smaller sites had a randomization ratio up to 90:10 treatment:control, whereas the opposite was true for larger sites. The evaluation team adjusted these ratios over the life of the project to provide sites with an adequate amount of referrals while not overwhelming them beyond their ability to serve families. For the remaining four sites that opted out of the randomized control trial, the site worked directly with their county CPS partner to receive referrals and managed issues of capacity directly with their county partner, resulting in occasional waitlists. For the 4,988 referrals from November 2014 through June 2016, the overall cross-site acceptance rate was 27% with site-level acceptance rates ranging from 11% to 56%.

The cross-site decline rate was 70%, with 3% missing (Table 2).[1] When looking at reasons families did not receive services, it should be noted that there are passive and active declines. Active declines indicate situations where a caregiver told an outreach worker they were not interested in prevention services, which happened 27% of the time across sites. A passive decline indicates a situation where a caregiver was unable to be reached after multiple outreach attempts by the outreach worker or the caregiver was actually ineligible to participate in the program. The Referral Logs tracked up to six outreach attempts, and were designed to capture at least the number of outreach attempts specified by the best practice protocols outlined in the program manual: three phone calls, two letters, and one home visit attempt. Fields to track dates of outreach attempts were also included as the program manual stated that outreach should conclude within three weeks of referral receipt. In practice, there was wide variation by site in terms of how many and the types of outreach attempts a worker may attempt before designating a referral "unable to reach," in addition to the time frames over which outreach was conducted. Outreach workers made an average of three outreach attempts per referral, across sites (Table 2). Staff were unable to reach slightly over half (51%) of all referrals to offer services. In part, this is due to the unreliable and oftentimes poor or outdated contact information provided by the referral source, particularly for screened-out reports, as well as the transient nature of this population. For the

remaining 20% of referred families who did not ultimately receive prevention services, it was for other reasons including duplicate referrals (such as those where the family had already accepted or declined services from a referral generated by a prior report) and inappropriate referrals (such as those located out of service area, for whom a CPS case was already open, or for whom no child was in the home).

Staffing structure

The 15 outreach workers interviewed had an average of 11.3 years of experience working with children and families in some capacity. The eight supervisors averaged 21.8 years of experience in the field. Of the outreach workers, eight were dedicated, full-time staff. The remaining seven were part-time workers at the community agency, or had other agency and community project responsibilities aside from the outreach program. All but one of the eight supervisors had teams that included workers involved in the outreach program as well as other programs in the agency. Some supervisors also reported they were case carrying for the outreach program. There was some overrepresentation in the sample from certain sites where both the supervisor and an outreach worker participated in interviews. Some sites did not have representation in the sample.

Program definition

When the state office providing leadership began the prevention program, they proposed a service delivery model, which included short-term (12–16 weeks) case management, a comprehensive assessment of protective factors and family finances, a structured approach to goal setting, and the option to utilize flexible funding. Within these parameters, however, individual sites were allowed a great deal of leeway in their service models and the specifics of service delivery. One purpose of the interviews was to understand from a worker's perspective how these models were playing out in practice at sites, in order to supplement variants already known by the state agency.

As expected throughout the 23 interviews with outreach workers and supervisors, the site variability of prevention programing was evident. The interviewer asked respondents about a preset model for the program, and the largest group (8/23) cited Parents as Teachers as creating a guiding foundation for their work with families. Other services mentioned included Nurturing Parenting, Love and Logic, HIPPY, Strengthening Families, and Parenting Wisely. Answers to variations of the question, "What is this program?" ranged widely in outreach strategies, core elements, approaches to goal setting, length of involvement for participants, approval and use of flex funding, financial literacy programming, and utilization of community

resources. In many instances, the flexibility to allow for local control and determination of programing was cited as a strength by respondents. Local issues such as community characteristics, local economies, and even geography (proximity to an interstate highway, for example) were discussed as unique challenges by site that could be met with the flexibility of the programing.

When asked about the core elements of the prevention program, most (18/23) cited that resources and referrals for other community service were the most common and helpful part of outreach. Alongside this service, 17 respondents discussed that goal setting with families is a core element to the program. Sixteen respondents also highlighted that family development and parenting programing are core elements. While flex funds were not used with every family, six respondents reflected that flex funding for concrete services was sometimes necessary to create a foundation for goal setting or to achieve prevention program goals.

The interviewer asked workers about utilization of community resources. Eight of 15 responded that this work is eased by existing relationships with community members, instituted before the prevention program began. This connection is solidified through regular community meetings such as those centered around early childhood, local service collaboratives, or through schools and faith-based groups. Workers leveraged these relationships to assist families in making connections as part of their work on goal attainment. Workers and supervisors stated that there are shortages of community resources in some areas that made outreach more difficult to deliver. For example, the most often shortage cited was related to housing, particularly low-income accessible housing (11/23). Other service needs related were transportation (9), parenting and family supports (9), mental health services (3), legal services (3), substance abuse treatment (2), and domestic violence resources (2).

The 15 workers were asked specifically about their initial approach to goal setting with families. All respondents talked to some degree about the importance of family-driven goal planning, responding that the typical process was to ask families what they would like their families to look like in six months, or where they prioritized their main areas of need. Several workers talked about assisting families in goal setting by supplementing family goal setting with information gained from a standardized assessment of family strengths and protective factors, which was developed by the state leadership. Eight outreach workers expressed that the standardized instrument, often administered at the first meeting, was helpful in this regard, with three stating that it could sometimes feel intrusive or burdensome due to the level and type of information needed for completion of the tool.

The length of involvement of families in the prevention program varied by site, worker, and presenting family characteristics. Ten of 15 workers stated they liked the flexibility to meet with families as long as necessary in the program, particularly when assisting families with goal attainment, which might take a longer period of time in some cases. However, some workers stated their individual programs placed restrictions as to the length of service.

Similarly, respondents also disclosed site-specific rules for the use of flex funding. Some agencies had rules governing single use of funding, and many had team or supervisor review processes prior to making a request. The largest group of respondents (10/15) recalled using flex funding for housing, rent, and utility needs. Others discussed using this funding for basic needs like food, home furnishings, or clothing, or for transportation. Most sites also offer financial literacy programing, sometimes in conjunction with issuance of flex funding. Some sites had particular curriculums for financial literacy and budgeting, such as Cooking Matters (1), Money Matters (1), Dollar Works (4), My Money, My Goals (1), and Bridges out of Poverty (1). Four respondents stated that attention to financial literacy helped families develop new financial habits, including cost cutting, budgeting, and using money wisely.

Referrals

When asked about the referrals received, all respondents expressed the majority they received were appropriate for the prevention program. Respondents stated the only deviations from this are those cases with actively occurring child abuse and neglect, or those cases where there were undisclosed safety threats to workers such as weapons in the home. Most respondents expressed appreciation for the amount of information received from the child welfare agency, however, for those that only received the contact information for families, they desired to also see the reason for referral, or what the child welfare agency hoped the family would receive from prevention programming.

Outreach barriers and facilitators

Word frequency analysis indicated that when asked about barriers to engagement during outreach, worker responses were most commonly synonymous to the association of the outreach program with Child Protective Services (e.g. “CPS,” “DHS,” “Department of Human Services,” “Human Services,” “Child Welfare,” “Social Services,” “government,” and “Family and Child Services”) in 9 out of 15 interviews. Evaluators coded all these in the same manner (“association with CPS”) to reflect the variance in terminology. Using Key Words in Context analysis, the most widely associated emotions and subsequent barriers to uptake of the outreach program, by families were

fear and embarrassment. When hearing about CPS, families were described as "leery," "on guard," "feel(ing) like they're being watched," or "freak(ing) out." One worker said the main barrier to acceptance of prevention services were families' perceptions that "help from the government is a little scary." Triangulation of this finding with quantitative data, however, indicated very small difference in the decline rates for the four agencies that were located within DHS as opposed to those programs that utilized a community provider (68% and 70%, respectively).

Full text coding of the outreach process as described by 12 outreach workers was used to identify general strategies for communication with all families entering the referral pool. During early contact with the families, many workers emphasized that participation in the outreach program would help families find community resources (8/12) and that the purpose of the prevention program is to provide *voluntary* support to families (6/12). Several workers reported that they used the phone when possible to attempt to setup a face-to-face meeting as soon as possible (4/12). In contrast, other workers reported that they sent letters or performed unannounced visits to the family home during initial contact with the family. In addition, some workers expressed that the phone was not the best place discuss the referral (5/12). One worker stated she prefers to keep the initial phone call "positive," sharing with families with screened-out reports that, "that's a good sign, that means that DHS doesn't have any problems. . .. . .they [CPS] do want to offer a place where they [families] can get some resources and some support."

The 12 outreach workers reported a variety of factors that facilitated engagement with the family. One-third of workers shared that outreach was considerably easier when the referral was a closed assessment (4/12). Only one stated that outreach was easier when the referral was screened out and they were "cold calling" the family. Outreach workers credited personal success in engaging families with their ability to show they were not judgmental of family situations (3/12). One worker stated, "Treat [families] with respect, they're going to talk to you with respect and they're gonna [*sic*] be more welcoming, you know, letting you come into their homes or coming to see you." Three workers credited distancing themselves from CPS as an effective strategy. One worker described,

> We come in as, 'we're not them.' This is who we are. Let's just sit down and talk about what we might have that might be helpful for you and if it is helpful, then we'll look at what that might look like for a few months, and see if we can support you through this.

Initial phone call

With-in case decision modeling indicated some variability with regard to outreach strategies. The most common themes are represented in a final cross-case display. The final display (see Figure 1) reveals five main decision points in the dominant process of initial outreach calls: (1) Does someone from the family answer the initial phone call? (2) Is this a closed assessment? (3) Is this a screened-out report from the hotline? (4) Does the family ask for the source of the referral? (5) Is the family willing to schedule a face-to-face meeting? Each of the points determined the overall course of the outreach call as described by the worker.

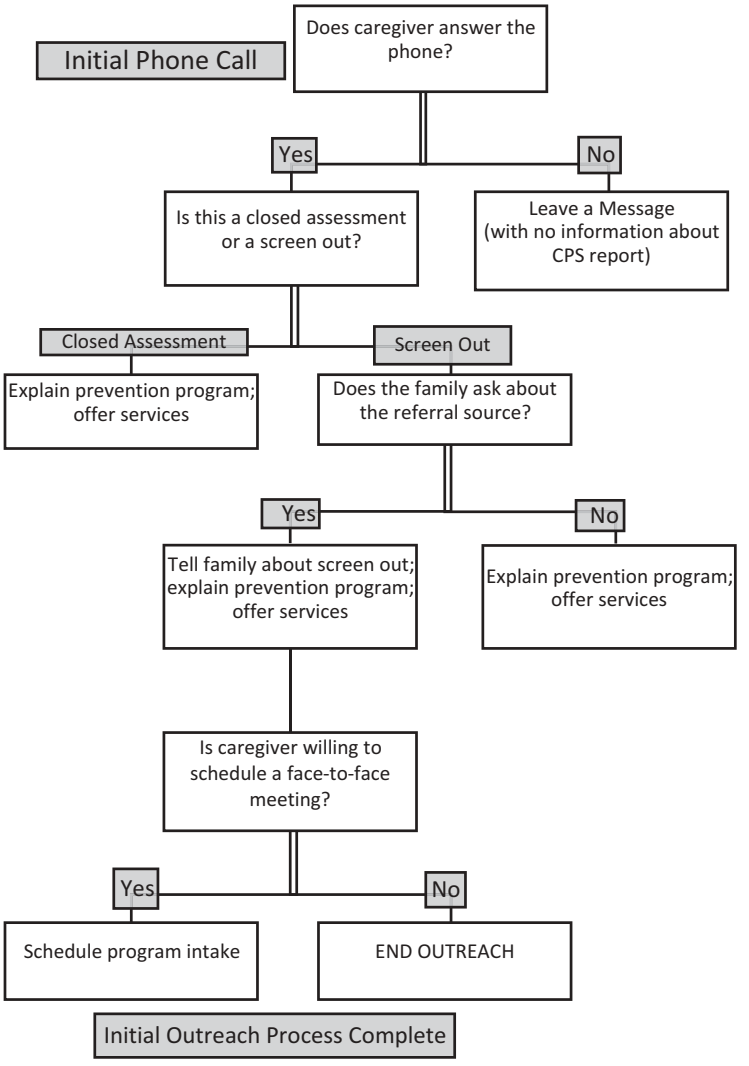

Figure 1. Dominant initial outreach protocol.

Five workers stated that they always share upfront that the source of the referral is CPS. The rest either stated they wait for the family to ask, and/or wait until after the initial face-to-face meeting with the family has been scheduled. While most did not articulate whether or not they leave a voicemail if parents do not answer the first call, there was an even split among workers who did address this nuance as to whether or not they left a voicemail.

Program success

When asked about a success story related to the outreach process, many workers responded with scenarios where the prevention program and their site's iteration of support services helped families. Workers named single mothers and fathers, young parents, and adolescent parents they were able to assist in setting and attaining goals related to protective factors and risk mitigation. In addition to supportive services and relationship building, one worker was able to name a family who had not only met their goals but was also assisting with the programing at the family resource center, as a form of social capital building. From the workers' perspective, good engagement and relationship between the worker and the family members facilitates this type of success. Workers also attributed success to characteristics of certain families receiving the initial outreach, describing family members as "motivated," "engaged," and "open."

Alongside the success stories, the interviewer asked participants about the barriers to success for those families that initially engaged with the prevention program but did not follow through to service completion and/or goal attainment, another common problem in prevention programing. Fourteen of the 23 interviewees attributed lack of success to families' willingness to engage and follow through with the program. Some of these were not "ready" to make change, or were "not motivated." Many workers and supervisors (7/23) cited transience and frequent moves by families as a barrier to completion of the program. This made it difficult, according to interviewees, to establish and complete goals. Many workers and supervisors (7/23) also discussed that families had multiple co-occurring issues such as substance abuse, mental health concerns, and even new contact with CPS.

Limitations

As with all inquiries, there are limitations to what we might understand as a result of these interviews and analysis of referral log data. Specifically, limitations spanned five main areas. First, because the interviewee group was a convenience sample relying on volunteers for interviews, the interviewees did not represent all sites in the project. We are unable to describe

what characteristics might define those staff who volunteered for interviews as compared to those who did not. This limits our ability to provide generalizable results from across all 21 sites. Further, some sites had multiple interviewees per site, whereas others were represented either by one supervisor or one worker. This may have biased the sample such that other outreach protocols, as well as facilitators and challenges to outreach, were overlooked, or that others were overemphasized. Second, the overall evaluation where interviews took place was in an applied setting, where the evaluation team communicated regularly with site staff. Consequently, respondents may have exhibited social desirability bias when recounting strategies for program delivery, challenges, and successes in the prevention program.

Third, more steps would be necessary to promote methodological rigor for the qualitative interview portion of this work. Member checking of transcribed interviews, decision modeling, and resulting analysis could have served to better validate the analysis. Multiple coders could have been assigned to each narrative *in lieu* of cross-checking to more adequately ensure inter-rater reliability. Fourth, evaluators experienced constraints with recordings of worker interviews. Evaluators did not transcribe three interviews due to audio recording failure during or after the interview. This problem made the small sample size for the qualitative analysis even more limiting in scope.

Fifth, the length of experience providing services in the prevention program varied across interviewee respondents. For example, some sites began implementing the prevention program six months from the time of interviews (January 2016), whereas others began over one year prior. As such, some of the newer sites may have still been developing their protocols at the time of the interview. Data analyses did not account for this variation in responses. Further exploration and data triangulation might achieve more contextual findings, such as a clearer view of what outreach protocols work toward achieving higher acceptance rates and with which sub-populations (i.e. screen outs and closed assessments).

Discussion of implications

Despite the limitations delineated, this analysis affords a small window into the challenges and successes involved with government-initiated child welfare prevention programming. While readers must not generalize this information to other jurisdictions offering similar programs, the lessons learned from the findings suggest implications for similar endeavors. Practical implications might be best viewed first through the lens of the public health literature, which provides guidance and suggestions for issues encountered in this program and by the outreach workers who generously offered their

stories. Then, this section examines possible implications for policy-makers and a charge for further evaluation and research.

In the public health literature, there are seven best practice recommendations that may be adopted to improve outreach activities focused on child abuse and neglect prevention, although not all recommendations directly apply to the outreach conducted by workers. (Rippke, Briske, Keller, & Strohschein, 2001). Several of the recommendations must occur during program development, rather than program implementation: using a data-driven approach to understanding the needs of the community, tailoring the intervention to the community, engaging key stakeholders during the program development, and integrating the outreach program with other relevant programs for the target population. The remaining recommendations focus on the implementation of outreach activities. First, Rippke et al. (2001) recommended that the outreach activities use a holistic, synergistic approach with existing programs and community resources. In our sample, many respondents (18/23) identified resources and referrals to community service as the most common and helpful aspect of the program. However, only 8 of 15 workers identified strong relationships with community members, though they also identified shortages in community resources. Specifically, nine identified transportation concerns, nine stated that parenting supports were not available, and three other reflected on shortages in mental health service, legal services. Two respondents each mentioned substance abuse service shortages and lack of access to domestic violence services. Availability of low-income, accessible housing was mentioned by almost half of respondents. Housing issues and transience may be a challenge for outreach programs, as staff may be unable to reach potential participants. In our sample, staff were unable to reach more than half of families, in part due to unreliable or outdated contact information. Increasing the availability of affordable housing may increase the reach of the program, but it may also increase the success of the program. Almost a third of workers reported that frequent moves negatively impact the success of families, as it was difficult to establish and complete goals. Since the outreach staff were unlikely to resolve this community issue alone, it may have been beneficial to partner with existing programs to address this ongoing concern.

Rippke et al. (2001) second recommendation is that the outreach program plan must consider and take steps to address barriers to outreach. In our sample, the most frequently cited barrier to engagement was association with the state CPS. In outreach worker descriptions, families were fearful or embarrassed upon learning that the referral came from CPS. The outreach workers described several techniques they used to overcome this barrier, ranging from withholding the referral source and distancing themselves from CPS to directly acknowledging that CPS provided the referral but did not have sufficient cause to open a case. For barriers such as this, it may be

beneficial to systemically address the barrier, rather than leaving it open for the outreach workers to resolve.

Finally, Rippke and colleagues recommend that the outreach methods should be evidence-based for similar communities or be tailored to the community and rigorously pilot-tested. One of the strengths identified by many staff was the ability to tailor the outreach program to the community, using evidence-based approaches. Many sites in this study used the Parents as Teachers program, but the decision was made at the site-level, which enabled consideration of the unique community characteristics, local economies, and geography.

A unifying theme of the seven best practice recommendations is a reliance on data, collaboration, and development that arises from local communities. Respondents in this evaluation also noted this facet, expressing the unique needs of their local communities and the varied constellations of barriers and struggles facing families they contacted. Similarly, some respondents noted distancing from CPS and emphasis on the local community and sources of support. In this program, the most obvious barrier was the source of the program referral (i.e. CPS); while sites found their own unique ways of handling this, a standardized protocol that is both transparent, crafted with local needs in mind, and non-threatening would be beneficial for standardizing outreach efforts across the program.

In addition to adopting these best practice recommendations, public health literature indicates that outreach activities may be improved if workers feel their outreach work is important to the community. This connection to the community at large did not emerge as a theme in this evaluation. However, hiring workers from the community, also known as lay health advisors or lay advisors, or encouraging workers to be actively engaged in the community may be one way to support community-based outreach and improve uptake of the services by the community (Tembreull & Schaffer, 2005). For workers who are not members of the community, formal work assignments in the community may encourage further engagement (Tembreull & Schaffer, 2005).

From a policy perspective, this inquiry and subsequent review of public health literature provide considerations for child maltreatment prevention outreach and programing. Bearing in mind prevention programming is often based on ecological systems theory focusing on the child–family dynamic, it is important to also design policies and procedures around exosystems such as the government and community agencies directly involved in outreach. Care can be taken to ensure families understand how prevention programing fits within that context, including how and why referrals go from the government agency to the community agency, what information does or does not exist in public-held records about the family, and clear communication about the voluntary nature of prevention programing. Similarly,

communication strategies for messaging around the role of CPS might also be helpful for community agencies who must navigate discussions of risk for CPS involvement. Based on the small sample of workers interviewed for this article, program leaders may delineate desired aspects for communication and programing in a manual or policy, but it may also be important to train and coach outreach workers specifically on outreach strategies to translate policy to practice.

Finally, from a research and evaluation perspective, the field needs more understanding of outreach in child maltreatment prevention programs. A review of the California Evidence Based Clearinghouse for Child Welfare indicates a program similar to the program in this evaluation (Parent Support Outreach Program) lacks sufficient research evidence to be rated on the site's scale (California Evidence-Based Clearing House for Child Welfare, n.d.). Regardless of level of evidence on programs, evidence on the process of outreach in all these cases must be elevated for replication in the same manner as programing content and subsequent outcomes. Currently, evidence-based outreach strategies for engagement of families are not explicitly identified in the California Evidence Based Clearinghouse.

Conclusion

This evaluation assists us in enhancing understanding of the outreach process for a government-led child maltreatment prevention program. Ronald Reagan's adage rings true in this case with government outreach, where closely associated with the CPS system, was somewhat off-putting to families in need, at least as perceived by outreach workers in the sample. Other challenges of prevention programming remain, including identifying and building relationships with target populations, and consistent articulation of program components. Public health literature does provide strategies that might enhance the outreach process of prevention programming. By utilizing community-level data, knowledge, and resources, public child welfare agencies might be able to better serve families at risk of child maltreatment. Stories of prevention program success encourage this work, but strategies for standardization of communication and outreach protocol could potentially improve typically low uptake of similar programs. Similarly, attention to evidence building around outreach in a child maltreatment setting might serve to set the bar for future programing efforts.

Note

1. In all cases, the percentage of acceptances plus declines should equal 100%. However, outreach was permitted to last for over a month, so the outcome of some referrals (accept or decline) was not yet recorded at the time of analysis.

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