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Evaluating Child Maltreatment Prevention Programs & Services: A Qualitative Study

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by

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

This is a qualitative study looking at the model of child maltreatment prevention programs within a large Midwest metropolitan area. The rate of child maltreatment is alarmingly high in the United States as over 40,000 children die of homicide every year due to child maltreatment (World Health Organization, 2014). Research suggests that there are many factors that can increase the likelihood of a parent maltreating their child including having a stressful home environment, family history of abusive tendencies, substance abuse, or other stressors. With aims of addressing these risk factors associated with child maltreatment, parenting support and skills programs are serving as a prevention strategy for parents at risk for child maltreatment. These programs typically target parenting behaviors, skills, and attitudes. The researcher interviewed professionals within child maltreatment prevention programs within a Midwestern metropolitan area. The researcher looked specifically at what each program targets, to who programs serve, and how each program is designed in relation to literature findings. The researcher systematically evaluated each program's objectives and model choices through content analysis to identify major themes. The primary theme found was *promoting a culture shift* in regards to the attitudes and methods of how child maltreatment is addressed. Three subthemes emerged to support this overarching theme: *parent empowerment, spreading the net, and providing a continuum of care*. The findings highlight the successful features of child maltreatment prevention programs and gaps in how services are delivered. The findings inform professional practice strategies for those working within the child maltreatment prevention field.

 Keywords: Child Maltreatment, Prevention, Parenting Support, Parenting Skills, Parent Participation

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Introduction

Child maltreatment is one of the most devastating and traumatic experiences a child may endure in their lifetime. Children who fall victim to maltreatment often suffer physically, emotionally, or psychologically, and in some cases, may suffer from any of these effects simultaneously. The World Health Organization (2014) defines child maltreatment as the act of abusing or neglecting a child under the age of eighteen years old. They report that the effects of child maltreatment are numerous and vary depending on the individual. According to Childhelp (2015), there are four types of child abuse including physical, sexual, and emotional, as well as neglect. Physical abuse is when a parent or caregiver intentionally causes physical harm to a child. Sexual abuse is defined as when an adult includes a child in a sexual act or uses a child for sexual reasons. Emotional abuse is when a parent or caregiver harms a child emotionally and affects their mental and social development. Finally, neglect is when a parent or caregiver does not provide care, supervision, or affection in regards to a child's health and safety. The rate of child maltreatment is alarmingly high especially after taking all forms of child maltreatment into consideration. An estimated 41,000 child homicide deaths occur every year as a result of child maltreatment (World Health Organization, 2014). Unfortunately, the rate is even higher than current statistics show due to the failure of reporting or inadequate reporting of incidences.

Negative Consequences for Children who Have Experienced Child Maltreatment

The Adverse Childhood Events (ACE) study is one of the largest studies focusing on the connections between child maltreatment and the future of a child's well-being regarding health, social, cognitive, and emotional functioning (Anda & Felitti, 2010). "An adverse childhood experience is defined as the potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian" (Felitti, Anda, Nordenberg,

Williamson, Spitz, Edwards, & Koss, 1998, p. 246). The Centers for Disease Control and

Prevention reflect that adverse childhood experiences have shown to be associated with many

negative consequences such as risky health behaviors, smoking or drug use, chronic health

conditions including but not limited to heart disease, diabetes, cancer, and alcoholism, as well as

low life potential and premature death (Centers for Disease Control and Prevention (CDC),

2016). The study found that the more ACEs an individual has, the higher the risk they are for

these poor outcomes (CDC, 2016). These findings emphasize the importance of reducing child

maltreatment and childhood adverse experiences due to the negative implications that can arise

from having too many of these experiences (Anda & Felitti, 2010; Felitti et al., 1998; Dolan et

al., 2004).

Studying child maltreatment has been a central line of research for psychologists, social

workers, and physicians for decades. Rare is there a time when a single factor is the only

contributor impacting an aspect of a child's development. Similarly, there is no single

component that contributes to child maltreatment. Because there are multiple elements that

contribute to child maltreatment, researchers have struggled to narrow down the most influential

factors. Overall, the literature has focused on the following risk factors as large contributors to

the event of child maltreatment: parents' lack of understanding their child's needs or

development, having a family history of child maltreatment, substance abuse, mental health

problems, or a stressful home environment (Child Maltreatment, 2015).

In regards to parenting, researchers suggest that the lack of parenting knowledge and

parenting skills are significant risk factors that increase the likelihood of child maltreatment

(Lovejoy, Verda, & Hays, 1997; Palusci, Crum, Bliss, & Bavolek, 2008; Strickland & Samp,

2012). It is inevitable that parents will become frustrated while caring for their child at one point

or another. In the case that a caregiver does become frustrated with their child, parents who are

categorized as high-risk are more likely to verbally or physically take their frustrations out on the child (Portwood, 2005). In regards to this stressful circumstance, having a wider variety of parenting skills may be useful and provide parents with options rather than resorting to harsh discipline tactics. Similarly, parents who are uninvolved, unaware, or unprepared to care for a child may also run the risk of maltreating their child (Hess, Teti, & Hussey-Gardner, 2004). Acknowledging the impact of parenting knowledge and parenting skills has motivated child advocates in many domains to initiate and implement programs specifically designed to target these factors in an attempt to reduce the rate of child maltreatment.

There are many types of child abuse intervention programs. Some series provide parenting education, which focuses on developing parenting skills in at-risk populations. Others center on bringing awareness of risk and protective facets to the general population and those individuals not necessarily identified as at-risk. The programs fixated on parenting strive to work with parents with the goal of giving them the tools to appropriately manage their frustration, attitude, as well as how to enhance their problem-solving skills and other parenting techniques (Child Maltreatment, 2015). Similarly, these programs focus on trying to enhance the foundation on which new parents and continuing parents build their parenting skills in order to create and maintain healthy parent-child relationships as well as foster strong parent-child attachments (The Center for Parenting Education, 2006).

Not only is it critical for caregivers to build their parenting skills and learn how to cope with stressors that can lead to maltreating behaviors, it is also important for caregivers to have a general awareness about child development and a supportive community. In addition to addressing the protective and risk factors from a parenting standpoint, the remaining programs work towards addressing community support, awareness of child maltreatment predictors or behaviors, and parent stressors. Recent research highlights that parents are more successful when

provided the knowledge and resources by their communities to parent effectively (Boyes-Watson, 2005; DiLorenzo, White, Morales, Paul, & Shaw, 2013). Similarly, community programs that work to increase protective factors for families such as social support or connections, knowledge of parenting or child development, and social competence are effective in reducing child maltreatment (DiLorenzo et al., 2013; Lanier, Kohl, Benz, Swinger, & Drake, 2014; Rodriguez & Tucker, 2015). Currently, the child protection system is very strained and overwhelmed with the amount of child maltreatment intakes. County workers and child protection workers alone cannot change the rate of child maltreatment, and frankly, the problem becomes too big and complex by the time it reaches the child protection level. There are many child maltreatment intervention programs within the community, but perhaps a community shift towards prevention would be in the best interest of reducing risk factors, increasing protective factors, and ultimately reducing child maltreatment rates.

Literature Review

The purpose of this literature review is to acknowledge that child maltreatment rates are incredibly high, to discuss the existing risk and protective factors associated with child maltreatment, as well as to bring light to current child maltreatment prevention strategies used in the field. This literature review will specifically target parenting education programs as well as other community programs that provide resources about child maltreatment and prevention, community support, and reducing parent stressors related to child maltreatment. The issue of child maltreatment is multifaceted as many pieces contribute to the problem. In this regard, it is important to understand significant risk factors and further educate society about the seriousness of child maltreatment across the United States and the world. Research reveals that there is no one single prevention or intervention method that reduces all risk factors associated with child maltreatment (Portwood, 2005; Prinz, 2016; Sidebotham, 2001) mostly because the rate of child

maltreatment affects all populations. Cultural considerations add complexity to the problem and to the challenge of finding a strategy that can be generalized to all populations (Barlow & Calam, 2011; Sidebotham, 2001). It is hard to implement a strategy that addresses all racial, cultural, and spiritual needs at the same time. The issue is finding a strategy universal to all families, yet one that ensures families feel their experience is individualized and does not overlook their unique family characteristics. In addition, there is little information on interventions that address families with numerous stressors such as substance abuse, domestic violence, and mental illness (Estefan, Coulter, VandeWeerd, Armstrong, & Gorski, 2013).

Intervention Versus Prevention

In trying to find a strategy that works, intervention rather than prevention seems to be more widely used for several reasons. Programs generally lean towards intervention as opposed to prevention methods because interventions generally allow results to be easily measured which is an important aspect for data collection and funding purposes. For these reasons, there has been a stronger focus on intervention rather than prevention methods. A prime example of a widely used intervention is child protective services. After an incident has occurred, a report can be made and a child protection team decides whether a case needs to be opened in order to work with the family, to remove a child from their home, or to terminate parental rights. Although it is more challenging to track results and progress through prevention methods, research suggests that a public health or preventative approach would incorporate more populations and create awareness of child maltreatment signs and behaviors before parents need intervention (Barlow & Calam, 2011; Prinz, 2016; Sidebotham, 2001).

Although there is not one single strategy to reduce child maltreatment, research recognizes that there are several strategies that have been effective in reducing risk features and increasing protective factors in regards to preventing child maltreatment. Parenting education

programs target parenting risk factors associated with child maltreatment behaviors while some early childhood education programs center on parent involvement. These types of programs focus on improving parent-child relationships, positive behaviors, and provide parents with the tools to work against maltreatment tendencies already exist within the community. However, there is an additional need for programs to specifically target community support, reducing isolation, and other parent stressors such as lack of resources, substance abuse, or mental illness. Some agencies are incorporating these elements into their services, but there is definitely room to fill the gaps in agencies that are not putting a strong emphasis on the above-mentioned factors.

Risk Factors

Research determined that child maltreatment and associated risk factors create a highly complex problem, one that is difficult to fully comprehend. Generally, these risk assessments are categorized into child characteristics, adult attributes, and environmental considerations. According to Sidebotham (2001), the most logical way to understand child abuse is to look at it from the ecological perspective. Many studies focus on which attributes make children more susceptible to child maltreatment as well as studies that purely look at which attributes make parents or caregivers more susceptible to child maltreatment behaviors.

Child factors. Researchers recognized several child features that increase the chance of abuse. According to Samp, Watson, and Strickland (2010), the factors that place children at higher risk for maltreatment are youth with an age of four or younger, who have disabilities or special needs, or children with difficult temperaments. Sidebotham and Heron (2003) found that children who are low birthweight are two times more likely to be maltreated than children of normal birthweight. Some additional factors that place children at higher risk for maltreatment are being less than four years old, more specifically infants, children who have disabilities or special needs, or children with difficult temperaments (demandingness and stubbornness) (Samp,

Watson, & Strickland, 2010; Sidebotham & Heron, 2003). In contrast, children with difficult temperaments wear parents down quicker and tend to provoke frustration which sometimes is taken out on the child. Children under the age of four or those with developmental disabilities are significantly more vulnerable than older children or children who are typically developing. The child's needs are only one piece of what makes them at risk for being maltreated because children are not maltreating themselves.

Parent characteristics. Parent attributes such as a parent's lack of understanding of their child's needs, lack of parenting, planning, and stress management skills, and lack of impulse control are correlated with increased risk for child maltreatment (Hess, Teti, & Hussey-Gardner, 2004; Portwood, 2005; Samp, Watson, & Strickland, 2010; Sidebotham & Heron, 2003). Important parent risk factors to consider for increased risk of child maltreatment include: single parenthood, becoming a parent before the age of 21 years, having multiples, feeling isolated, or financially stressed (Dixon, Browne, & Hamilton-Giachritsis et al., 2009). Additionally, parents who have inappropriate expectations of their children and who have less empathy are more likely to physically abuse their child (Portwood, 2005), while parents who are uninvolved, unaware, or unprepared to care for a child may also run the risk of maltreating their child (Hess et al., 2004). This is not a complete list of all the parent risk factors, but more so the most prominent risk factors. Most of these parent risk factors fall within two umbrella risk factors: lack of parenting competence and lack of parenting skills. Not only are these two parent risk factors related to an increase in parent frustration and may lead to child maltreatment (Portwood, 2005), they are what programs and services often target when working to decrease the likelihood of child maltreatment and therefore.

Parenting knowledge and competence. Parenting knowledge and the knowledge of child development is essential to becoming a competent and effective parent and building strong

parent-child relationships (Ohan et al., 2000; Strickland & Samp, 2012). Parenting competence is

defined as a parent's satisfaction or perceived effectiveness as a parent (Ohan et al., 2000). It was

hypothesized that 'perceived parental competence' and 'plan complexity' may be positively

correlated, and that the relationship between 'perceived parent competence' and engaging in

child maltreatment may be reduced by plan complexity when working through challenging child

behaviors (Strickland & Samp, 2012). Complementary to parental competence, a parent's

comprehension of child development serves as a critical component in reducing the rate of

frustration and disappointment (Hess, Teti, & Hussey-Gardner, 2004; Portwood, 2005). This

knowledge of child development is especially true when parents experience difficult child

behaviors. Similarly, Hess and colleagues (2004) found that parents who understand basic child

development and their child's needs are more likely to have a healthier parent-child relationship.

Parenting skills. The lack of adequate parenting skills are also cause for concern among

child advocates within clinical, educational, and other community settings as this construct have

been highly associated with child maltreatment. Strickland & Samp (2012) were the first

researchers to look closely at parenting skills such as planning, plan complexity, goal setting, and

positive parental attitude in relation to child maltreatment and parenting success. They found that

the act of planning impacts the relationship between parental competence and the belief in

corporal punishment (Strickland & Samp, 2012). This finding suggests that parents who are less

likely to plan, are more likely to resort to power independence or corporal punishment.

Substance abuse. A significant amount of the child protection reports made is in regards

to parents who use substances (Barth, 2009; Semidei, Radel, & Nolan, 2001). According to an

epidemiological study in 1994, parents using drugs or alcohol were about four times more likely

than parents without substance abuse problems to neglect their children (Besinger, Garland,

Litrownik, & Landsverk, 1999). One of the reasons substance abuse is one of the most

significant risk factors for parents and is a predictor of child maltreatment is because parenting competence and skill are decreased due to being high or intoxicated (Barth, 2009). Similarly, parents who are substance abusers tend to place a higher priority on their substance use, which involves accessing or even selling substances, rather than focusing on their parenting (Barth, 2009; Famularo, Kinscherff, & Fenton, 1992). Each individual responds differently to drugs or alcohol and sometimes the response is to have less patience, more likely to be irritable, and other side effects that may lead to increased frustration or anger towards their children (Barth, 2009). Barth (2009) explains that current interventions are not focusing on barriers such as substance abuse or mental health, and for the programs that are targeting these barriers, they have demonstrated effective outcomes for preventing child maltreatment. Other research has made it a point to acknowledge that it is important to address these family barriers, but it is even more important to help parents learn to be more effective with their children and then, in turn, improve their mental health and substance use (Barth, 2009; VanDeMark et al., 2005).

Mental illness. There is minimal research available focusing on parents with mental illness and child maltreatment compared to research on the other main factors (Barth, 2009). Of the available research, there has been concentration on maternal mental illness and its relation to child maltreatment. It has been found that children with mothers having a mental illness were more likely to have been maltreated (Harstone & Charles, 2012; Kohl, Jonson-Reid, & Drake, 2011; Susman, Trickett, Iannotti, Hollenbeck, & Zahn-Waxler, 1985). Venta, Velez, and Lau (2016) found that parents with depressive symptoms were more likely to have dysfunctional discipline such as neglect, over-reactivity, and hostility. Specifically, Kohl et al. (2011) found that 67 percent of all children in the study had a child maltreatment report and of those maltreatment reports, 80 to 90 percent of those children have mothers with mental illness. Mood and anxiety disorders in mothers placed children at a greater risk for child maltreatment (Kohl et

al., 2011). The remainder of the research regarding mental illness and child abuse looks at other related factors such as poverty and homelessness (Barth, 2009) and their correlation with the child welfare system (Barth, 2009; Courtney, McMurtry, & Zinn, 2004). The factors and impact of mental health are multi-layered and continue to add to the complexity of finding child maltreatment prevention strategies that address mental health components.

Environmental risks. As highlighted previously, child maltreatment is a multifaceted problem that integrates many components which can result in a buildup of negative consequences comparable to how accumulating high amounts of stress can lead to a variety of negative outcomes. Unfortunately, one of the negative outcomes of accumulative parent stress is an increased likelihood of maltreating their child (Estefan et al., 2013; Portwood, 2005; Prinz, 2016). Environmental factors that contribute to a parent's stress level and increase the likelihood of child maltreatment include but are not limited to: having a family history of substance abuse, mental illness, domestic violence, family history of child maltreatment, poverty, and stressful home environment (Barth, 2009; Child Maltreatment, 2015; Dolan et al., 2004; Dixon et al, 2009; Duffy, Hughes, Asnes, & Leventhal, 2015). In contrast, it is important to acknowledge research that supports that not all children living in poverty are maltreated (Chen & Scannapieco, 2006).

Domestic violence and history of child maltreatment. Domestic violence is another environmental risk factor found to increase the likelihood of child maltreatment. Mental illness correlates with domestic violence as there are studies that have found that an individual with major depression was more likely to use violence against women (Barth, 2009; Shay & Knutson, 2008). Another study showed that approximately a third of parents who demonstrated limited parenting skills were involved with domestic violence (Barth, 2009; Casanueva, Martin, Runyan, Barth, & Bradley, 2008). The violence used is associated with strict and corporal parenting

punishments (Barth, 2009). Parents who are currently experiencing interpersonal violence are in a more difficult position than parents who have had a similar experience in the past. The current violence not only creates problems within their parenting style but also with child behavior problems (Barth, 2009). Familial domestic violence puts a child at greater risk for child maltreatment and also puts that child at risk to maltreat their children. Dixon and colleagues (2009) found that 135 of the 4,351 families that participated in the study had a history of physical or sexual abuse during their childhood. Of those 135 families, nine families maltreated their children during their first of parenting and were considered maintainers while 126 of the 135 families did not maltreat their children, or were cycle-breakers.

This intergenerational cycle must be taken into consideration when looking at risk for child maltreatment as well as for preventing child maltreatment through these cycles (Dixon et al., 2009). The literature indicates that children who experience child maltreatment are more likely to experience child maltreatment again. Similarly, studies show that families who have been involved with Child Protective Services (CPS) once, are at higher risk for being involved in the system again (Casanueva et al., 2008; Casanueva, Tueller, Dolan, Testa, & Smith, 2015). In this light, studies indicate that the availability of child maltreatment resources is low and oftentimes contributes to the continuation of child maltreatment cycles within families; resources need to be available for at-risk families sooner rather than later in an attempt to end this cycle (Casanueva et al., 2008; Casanueva, 2015). Researchers have yet to find the best child maltreatment prevention method due to there being many factors influencing child maltreatment behaviors.

Poverty. Poverty is also an extremely complex problem within society and it may be more easily explained with an ecological systems approach. There are many factors that are related to poverty and some factors that are a result of poverty. For example, being a single

parent is a challenging role as there is only one caregiver to take care of the children, provide an income, and support the family (Prinz, 2016). When the single parent has to go to work to provide an income to feed or clothe their children, then the issue of child care presents itself as the parent cannot go to work and supervise their children, especially if they are young and do not attend school yet. In some cases, single parents may not be educated enough or have the skill set to obtain a job having traditional business hours (9am-5pm) which would also be the time children would most likely be in school. The parent may have to take off work if they cannot find someone to watch their kids and that may put them in jeopardy of losing their job which results in not having an income and leading to falling deeper into poverty (Barth, 2009; Child Maltreatment, 2015; Prinz, 2016).

Parent Protective Factors and Child Maltreatment

In addition to the many risk factors, there are parent attributes that serve as protective factors for reducing the likelihood of child maltreatment. The Center of Study for Social Policy (CSSP) highlights the key protective factors for strengthening families and in turn reducing child maltreatment as: parental resilience, social connections, knowledge of parenting and child development, concrete supports, and social and emotional competencies of children (CSSP, 2017). According to the CSSP (2017), resilience is the ability to manage stress and function well even when challenges arise. Research suggests that parents who are resilient tend to have more positive outcomes in life. Other studies have identified the critical parenting skills that serve as protective factors as the ability to plan, problem-solve, and having positive parenting attitude that falls within the main protective factors as highlighted by the Center for the Study of Social Policy (2017). Parenting education has served as a major strategy to highlight the protective factor of increased parenting knowledge and knowledge of child development. Child maltreatment prevention programs primarily focus their energy on providing parenting education

that targets a significant amount of these protective factors such as parenting competence,

knowledge of child development, parenting skills, as well as fostering social connection and

concrete supports.

Planning. The lack of adequate parenting skills serves as cause for concern among child

advocates within clinical, educational, and other community settings as this construct have been

highly associated with child maltreatment. Strickland and Samp (2012) were the first researchers

to look closely at parenting skills such as planning, plan complexity, goal setting, and positive

parenting attitude in relation to child maltreatment and parenting success. It was found that the

act of planning impacts the relationship between parental competence and the belief in corporal

punishment and power independence (Strickland & Samp, 2012). Strickland and Samp defined

power independence as the oppression of independence, which can often lead to forcing a child

to adapt to parental expectations by means of harsh discipline. This concept suggests that parents

who are less likely to plan, are more likely to resort to power independence or corporal

punishment.

Strickland and Samp (2012) also found that parents who identify a backup or alternative

plans experience less frustration in comparison to parents who do not have alternative plans.

They also discovered that parents with more alternative plans and increased parenting

competence were less likely to resort to corporal punishment. These results indicate that planning

is an essential skill for parents to have in order to avoid problem escalation and excessive

frustration. Likewise, this study demonstrates that having multiple plans allows a parent to adjust

their mindset and disciplinary strategy, and ultimately avoid having inappropriate expectations

and punishment for the child. In other words, providing parents with a variety of plans or options

is helpful for curbing the impulse to act on frustration or anger. In comparable research, Samp,

Watson, and Strickland (2010) highlight successful parent-child relationships when planning and

goal setting behaviors are put into effect. Understanding the situation first allows parents to adjust plans in order to arrive at a solution. These are important characteristics for all parents dealing with a child's unexpected misbehavior.

Problem-solving. Problem-solving is also an important parenting skill as unexpected child challenges occur daily. This skill complements planning skills, as children can be incompliant and resistant. Even if a plan is put in place, it may be dismissed as soon as a child refuses to listen or cooperate. This situation is when frustration begins to set in, as expectations are not being met. Parents unequipped with problem-solving skills often resort to yelling or corporal punishment (Samp et al., 2010). A study conducted by Webster-Stratton, Rinaldi, and Reid (2011) focused on teaching parents how to problem-solve through a series of steps in the Incredible Years Program. The program targets concepts such as defining the problem, setting goals and expectations, brainstorming solutions, making a plan, and executing a plan. Results suggest that parents who practice problem-solving skills are less likely to become frustrated when dealing with a difficult child situation.

Parental attitude. Negative parental attitude is another significant risk factor that increases the likelihood of child maltreatment (Palusci, Crum, Bliss, & Bavolek, 2008). Palusci and colleagues (2008) recognized that parents who have positive attitudes are more likely to have more patience and are more willing to understand their child's perspective. Similarly, they found that parents who have negative attitudes are more likely to become easily upset by a child's misbehavior in comparison to a parent with a positive attitude. They conducted their study concentrating on parenting attitudes and knowledge in at-risk populations in relation to the likelihood of child maltreatment. They administered a parenting education program called 'Helping Your Child Succeed' (HYCS) for several different communities. The program was based on the idea that parent positivity must be achieved first before creating successful parent-

child relationships. Participants involved in the study were from high-risk communities such as jails, rehabilitation facilities, or other community organizations.

Results indicated that at-risk populations who participated in formal parenting education programs made significant improvements in their parenting knowledge in comparison to low-risk populations (Palusci et al., 2008). These at-risk parents were more likely to maltreat their children because they had negative attitudes or less parenting knowledge. All parents who completed HYCS enhanced their parenting knowledge and attitudes. Likewise, they found that of the physically maltreating families, about 42% of those families who completed the program were no longer involved with Child Protective Services (CPS). Overall, these families maintained the positive attitudes and other parenting knowledge they learned from the program a year later.

Parenting Education

Research highlights parenting education programs as an effective strategy for parents to gain the tools they need to improve their parenting skills and to reduce the risk of child maltreatment (Child Maltreatment, 2015; Huebner, 2002). These programs have shown to be effective in reducing the likelihood of child maltreatment as their methodologies focus on parental behavioral constructs that serve as high-risk factors for child maltreatment (Strickland & Samp, 2012). More specifically, research found that the lack of parental knowledge and limited parental skills are two of the biggest constructs that have negatively impacted the rate of child maltreatment (Ohan, Leung, & Johnston, 2000; Palusci, Bliss, & Beveled, 2008; Strickland & Samp, 2012). Parental competence and understanding child development fall within the parental knowledge construct while planning, problem-solving, and parent attitude are categorized as parental skills according to The Center for Parenting Education (2006). Of the many factors that contribute to the likelihood of child maltreatment, research has shown that parental knowledge

and attitude attributed the most to child maltreatment (Querido, Bears, & Edberg, 2002). Parent knowledge is essential to becoming a competent parent in which parental competence and comprehension of child development play significant roles in effective parenting and parent-child relationships (Ohan et al., 2000). Ohan and colleagues (2000) define parental competence as a parent's satisfaction or perceived effectiveness as a parent. Problem-solving skills have been incorporated into many parental education programs as research has found them to be a critical tool for parents to appropriately navigate through difficult situations with their children.

Programs such as The Incredible Years (TIY) and Parent-Child Interaction Therapy (PCIT) give parents the opportunity to learn how to successfully problem-solve and ease their frustrations while remaining calm (Webster-Stratton et al., 2011). Webster-Stratton and colleagues conducted a study where parents were taught how to problem-solve through a series of steps in the Incredible Years Program. The program targets concepts such as defining the problem, setting goals and expectations, brainstorming solutions, making a plan, and executing the plan. Results suggested that parents who practiced problem-solving skills were less likely to become frustrated when dealing with a difficult child situation.

Similarly, PCIT is a behavior family intervention which aims to reduce disruptive child behavior through the improvement of parent-child relationships (Querido et al., 2002). The top skills PCIT targets are parent problem-solving skills and children's social skills. The theory behind this type of intervention program dates back to Baumrind's (1991) research on parent responsiveness and parent demandingness. She found that parents who did not meet the needs of their developing child were less likely to have adolescents who were successful and happy. PCIT is particularly beneficial for families with children with clinical disorders such as Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) (Querido et al., 2002). Children with these types of disorders are at higher risk for being maltreated because their

parents are more likely to become stressed or frustrated when trying to manage the child's inability to regulate their own behavior. Parenting education programs such as PCIT give parents with these special circumstances the tools and guidance to work through their most frustrating moments which in turn leads to reducing the risk of child maltreatment and improving parent-child relationships (Webster-Stratton et al., 2011). According to Estefan et al. (2013), parenting education programs are most prevalent interventions families are using while being involved in child welfare services, however, little information is available about parenting education programs for families with multiple stressors such as mental illness or substance abuse.

Stigma around Participation in Parenting Education or Prevention Programs

Research identifies that many children who are at risk for maltreatment are not receiving services or resources both at the individual and familial levels (Burns, Phillips, Wagner, Barth, Kolko, Campbell, et al., 2004; Casanueva et al., 2015; Dolan, Casanueva, Smith, Lloyd, & Ringeisen, 2012). Oftentimes parenting education programs or child maltreatment prevention programs targeting at-risk parents do not have a welcoming environment or have a negative connotation depending on how organizations frame and publicize the programs (Mikton et al., 2013; Prinz, 2016). Lack of parent participation in prevention programs has been partially attributed to framing these services as parent training programs. No parent enjoys being told how they should parent, and if prevention programs are using the expert model in which the clinician is the expert rather than the parent, parents generally are not interested in these types of programs (Bolen, McWey, & Schlee, 2008). Parents often feel prideful and feel that they do not need the 'expert' to tell them what to do. Furthermore, the parents that are being turned off from these programs and services are the parents that are at the highest risk for child maltreatment and need the support (Bolen et al., 2008). Research also emphasizes that at-risk parents or parents who have already participated in child maltreatment behaviors do not necessarily want to come

forward to talk about the problem because they fear being blamed, ridiculed, or having their

child taken away (Casanueva, 2015).

According to Prinz (2016), at least a third of parents feel a lack of confidence in parts of

their everyday parenting. The researcher conducted multiple studies to determine what at-risk

parents felt they needed to be successful as parents. They considered how to: enhance parent-

child relationships, be more involved, and reduce their risk for child maltreatment behaviors.

These studies found that parents want support groups with parents who are going through the

same experiences. Parents want interventions that are specific to their family needs rather than a

generic intervention that is applied to the entire population. Similarly, parents wanted more

options on how to better their parenting practices and where to go for resources if they wanted

help with their parenting (Bolen et al., 2008). Research suggests that if prevention programs

want to be able to work with parents, they may need to change the approach to professional-

parent relationships in order to better engage parents and receive their participation in efforts to

reduce child maltreatment (Houte, Bradt, Vandenbroeck, & Bouverne-De Bie, 2015).

Parent Needs within Child Maltreatment Prevention

Parental needs and parenting education seem to be intertwined with issues of parental

stress. Germain and Bloom (1999) refer to these intertwining concepts as transactional

relationships. Bronfenbrenner (1979) developed the ecological model and encouraged

researchers and clinicians to use this lens when trying to understand maltreatment behaviors as

well as when applying interventions. Parents who had participated in child maltreatment

prevention programs had recognized and reported those needs in qualitative interviews. Parents

explained that finances were a big stressor that interfered with their parenting. They desire help

with financial issues, social support, family specific interventions, and strategies of how to parent

better that are functional for their individual family (Bolen et al., 2008). Parents also described

wanting family specific interventions for their needs rather than a generalized approach used for all families, essentially asking for meeting them where they are at. In addition, parents were interested in having support groups available to connect with those experiencing similar situations (Bolen et al., 2008). These needs are not unusual for families who experience poverty as they are more likely to report not being provided the support that they need (Hecht & Hansen, 2001; Lengua, 2006).

Intervening after the occurrence of child maltreatment does not seem to be having as great of an impact as anticipated. Hecht and Hansen (2001) found that even after being involved in CPS allegations for physical abuse more than a quarter of the participants were still using physical punishment even after CPS taught different ways to discipline their children. Even more surprisingly, the participants indicated that CPS workers were teaching parents how to physically discipline their children so that it would not be considered child abuse (Hecht & Hansen, 2001; Lengua, 2006). These intervention methods are somewhat serving as a 'quick fix' in the regard that child protective services are indirectly supporting parents' decision to use physical discipline instead of helping them navigate other options. This may be due in part to avoiding the challenges that come with accommodating families with strong cultural and familial values of physical or corporal punishment. More likely than not, child protection workers are burnt out and find more ease in taking shortcuts such as helping families find loopholes in the system so they can continue to parent the way they feel is necessary without having their children being taken away.

Resiliency Theory

The concept of preventing child maltreatment encompasses an understanding of the protective factors for adults and children to reduce the chance of child abuse as well as the risk factors that increase the likelihood of an event of child abuse. In this regard, resilience theory

serves as a guiding conceptual framework to understand the elements that increase risk for child maltreatment and which factors help families to prevent or recover from an event of child maltreatment. According to Masten (2011), resilience is having the ability to recover from challenges that threaten stability, viability, or development. Masten (2011) also explains a pathway model of resilience where certain conditions increase the opportunity for an individual to be resilient while other conditions inhibit the opportunity for resiliency. An example of this may be a child being physically abused by a parent and they may not be able to be resilient until they move out of the violent home and into a safe home. Or perhaps another example of the pathways model of resilience is when a parent has abused a child but cannot improve or be resilient until they separate from their child to tend to their mental illness, unemployment or learn how to be a better parent before being reunited with their child.

Other researchers define resilience as the ability to change adversity into an opportunity for growth and development (Fredriksen-Goldsen, 2006; Fredriksen-Goldsen & Hooyman, 2003; Hooyman & Kramer, 2006). Hooyman and Kramer (2006) also describe the four components that influence one's ability to be resilient in the face of adversity. These factors include: 1. background characteristics including age, race, and development phase, 2. adversity, 3. the capacities of an individual, family or community, and 4. the outcome of mental and physical well-being. Many believe that the concept of resilience is to 'bounce back.' However, a more realistic concept of resilience is learning how to live through the adversity and adapt to the changes that come with that adversity. VanHook (2008) claims that the components that interact with resilience are risk factors, vulnerability factors, and protective factors. In addition, VanHook (2008) categorizes resilience into three categories including: overcoming the odds, sustained competence under stress, and recovery from trauma.

Research Questions

Based on the existing research, it is clear that there are certain protective and risk factors that increase or decrease the risk of child maltreatment behaviors. It is also clear that there is not one clear method that is the "cure all" for child maltreatment, but rather it is a combination of many strategies and factors that work towards decreasing or preventing child maltreatment behaviors. This study specifically aims to assess agencies within a large metropolitan area who have dedicated part of their program's mission to prevent child maltreatment. The researcher specifically wanted to address the three following research questions: 1. Are child maltreatment prevention programs incorporating research-supported features to address protective and risk factors through the services they provide?, 2. Which core features are missing or need improvement to bridge the gap within these programs, if any?, and 3. How are at-risk families being referred or recruited to these child maltreatment prevention programs in light of the existing intervention methods of Child Protective Services (CPS)?

Method

Participants

The participants used for this study were professionals within child maltreatment prevention programs in a large metropolitan area in the Midwest region. Each participant was asked to complete a 30-45 minute interview with the researcher. These professionals were eligible to be interviewed due to their extensive experience working with at-risk families for child maltreatment and their leadership in child maltreatment prevention programs within a large metropolitan area in the Midwest region. These professionals have educational backgrounds in the field of social work and mental health.

Prior to beginning each interview, a consent form was presented and reviewed with each respondent (see Appendix A). Each interview endured between 30 and 45 minutes and was

recorded for the researcher's use regarding data analysis. The researcher asked three

comprehension questions to each participant to confirm their understanding of the purpose and

risks of the study. Finally, the researcher reminded each participant that their participation is

voluntary and if they choose not to participate at any time, there will be no consequences for the

participant. The consent form was adapted from a template created by the University of Saint

Thomas (UST) Review Board (IRB) to incorporate the study's purpose and focus. The consent

form meets the standards of the exempt-level University of St. Thomas IRB and was approved

by an Institutional Review Board (IRB) representative, Sarah Muenster-Blakley, M.A. This IRB

representative is the director of the IRB through the University of St. Thomas.

Data Collection

Participants gave their consent to participate in the study by signing the consent form

provided by the researcher. The format of the interview was semi-structured following an

interview guide, but having some flexibility for adapting questions specifically to the

participant's experience. The duration of each interview lasted between 30 and 45 minutes and

was recorded using an iPhone audio recording app. The interviews were recorded in order to

transcribe each interview's content completely and accurately, and to ensure accurate content

analysis. The interview guide (see Appendix B) includes a set of 16 questions and was approved

by the researcher's committee members prior to data collection, and submitted to the IRB for

their review. This procedure took place in order to confirm that the questions meet the standards

of the UST IRB and Protection of Humans Subjects guidelines, as well as meet the goals of the

research question and study. The interview guide was used during each interview and the

researcher posed each question to the participant one at a time.

The interview guide was designed to apply findings from the literature related to child

maltreatment prevention and to investigate which models and components of the participating

prevention programs are used. In addition, the questions were designed to learn more about the respondent's experience in playing a major role in a child maltreatment prevention program. The interview guide was formatted using an arc model in which less focused questions were asked first, followed by more focused questions in the middle of the interview, and again finishing with less focused questions to conclude the interview. The beginning inquiries addressed the role of the professional and the population the professional had worked with followed by questions about the prevention program. The interview moved into addressing the models and frameworks for their represented program and targeted how those models were derived and beneficial for the population served. The questions advanced into discussing what progress or success looks like for the population using the program, and inquire about the outcomes for participants. Finally, the interview wrapped-up by addressing what respondents gained from their work in this field and ended with opening up the floor for the respondent to offer any other important information they thought would be useful to know about the field, and for this research study.

Confidentiality

After each interview was completed, the recorded interview in its entirety was transcribed by the researcher. Upon transcription completion, the audio recordings and transcriptions of all participant responses were taken off of the researcher's computer and uploaded to OneDrive, an online storage tool. Once data was uploaded to OneDrive, it was encrypted with a passcode. The researcher and the research chair were the only individuals that had access to the data. Once the data were uploaded to OneDrive, the researcher coded the transcribed data and presented the initial coding to the research chair. The researcher and research chair analyzed the primary codes and worked towards creating secondary codes and then translated the codes into themes. The researcher proceeded to writing the data analysis based on the codes and themes that were

identified. The researcher continued to send drafts to committee members and research chair while writing the data analysis and discussion.

Settings

There were five interviews conducted for this study. Participant recruitment was focused towards agencies providing child maltreatment prevention programs and services. Participants represented a range of settings including community programs, medical settings, and clinic settings. Participant interviews took place at each participants' place of employment, the agency they were representing. For more details, see the researcher's field notes (see Appendix C).

Data Analysis Technique

The researcher used content analysis to identify themes within the data. The data were collected through professional interviews. Content analysis was carried out through the researcher first transcribing the data from the interviews and then coding the data. Coding is the most common method for analyzing qualitative data (Padgett, 2008) and is the process of looking for similar concepts throughout the data, which will later be combined into themes. After the researcher codes the data, the researcher presented the coded data to the research chair to provide feedback and further identify codes and themes. The researcher used different highlighter colors to differentiate codes in addition to taking notes next to the respondents' responses on the transcripts to annotate themes. The researcher and research chair collaborated to derive final codes to develop themes. Recurring codes (appearing more than three times within the transcript) were translated into themes. Similarly, the researcher and research chair wrote out the codes and themes on post-it notes and organized them on a blank piece of paper. The themes identified by the researcher and the research chair were combined and placed into a chart (see Appendix D) for organizational purposes.

The collaboration between the researcher and the research chair's coding was used to enhance the coding reliability as it is a test of inter-coder reliability (Monette et al., 2014). The research chair and committee have supported the researcher in developing the research questions and interview guide questions. The researcher gave committee members a complete draft of the study's introduction, literature review, and method procedure to review and give feedback to the researcher. The researcher also gave committee members a copy of the interview guide for review and feedback. Finally, a completed draft of the findings and discussion sections were sent to committee members for review and feedback. After receiving committee member feedback, the researcher made revisions to the findings and discussion sections for final review of the School of Social Work.

Findings

This research study focused on evaluating existing child maltreatment prevention programs in a large metropolitan area within the Midwest region. Five professional interviews were conducted within a range of child maltreatment prevention agencies in a large metropolitan area within the Midwest. All of the participants' formal educational backgrounds were in social work with the exception of one participant who did not identify their educational background. The interviews were conducted, transcribed and analyzed by the researcher. The primary theme that emerged from the data was *promoting a culture shift*. In addition, three subthemes were identified within the overarching theme. These themes fed into *promoting a culture shift* and include: *parent empowerment, spreading the net, and providing a continuum of care.*

Promoting a Culture Shift

The primary theme that emerged from the data was the need for promoting a culture shift within the field of child protection. All five participants expressed that in order to continue making strides towards reducing child maltreatment, there needs to be a culture shift from

reactionary intervention methods to proactive prevention methods. One participant highlighted

that the mission of their agency is that, "Our work [focuses on] awareness and education broadly,

engaging communities and essentially aiming for a broad culture shift in change." Similarly, this

participant elaborated on the importance of research findings that have been discovered related to

understanding the biological and psychological impacts on a child maltreatment. The participant

begs the question of why is society waiting to make a shift in how child maltreatment is

approached if the research is available now to support the shift.

> *A lot of our education and awareness work is presenting that material which is…one part*
>
> *understanding development of brain and effects of trauma on the brain…one part*
>
> *understanding the adverse childhood experience study and its implications, and one part*
>
> *'how do you engage community to build resilience based on the idea [of] new science…*
>
> *In the [grand] scheme of things, it takes 75 years for science to go from discovery to*
>
> *being widely enough known to be impacting things. We don't want to wait that long*
>
> *because it's such a game changer in terms of how we think about prevention and we want*
>
> *to engage everybody in creating responses to it. We can't wait for university-tested*
>
> *responses. We all need to be innovating and practicing new things and shifting.*

Another participant seconded the importance of research influencing a culture shift for

professionals, the population affected, and society as a whole as they explained "there's

information that says research changes people's minds." Several participants discussed a need

for culture shift in terms of the medical model. They explained the need for medical providers to

take a step up in prevention efforts due to their influential role in society. This idea is expressed

through the existing changes or push for change in policies within healthcare settings. One

participant explained, "Simply having pediatricians and medical providers talk to parents about

discipline is huge" in terms of working towards a culture shift in disciplinary strategies for

parents. Another participant also talked about the importance of medical providers making a culture shift in the sense of needing to take a leadership role in having the difficult conversations to provide information to patients/parents about the consequences of maltreatment behaviors whether it be in utero or in early childhood.

> *Even working with the providers because either the providers don't want to have those [difficult] conversations with them. We [have] struggled with who was going to let them [the patient] know that they got referred to the program, because there were some providers that were like "I don't want to ruin that relationship." That's your job. If they're [the patient] struggling with substance use, you should talk to them about that… not wait for somebody else to do that. So we've come a long way on that, on figuring out who is going to make the referral.*

One participant continued to explain that there has been a culture shift amongst the medical facility in terms of policy to prevent child maltreatment in the form of mandatory infant examinations for signs of maltreatment.

> *If they see a bruise on that baby, [we need] to make sure we're doing a more in depth child abuse follow up, including a skeletal survey, getting a social worker involved to do a psychosocial assessment, [and] working with our child abuse pediatricians here. Any baby that comes into the emergency department or anybody who goes to the clinic for dermatology or for NICU follow up, will essentially be examined head to toe… If an oral injury or bruise is found, it will be an automatic call or referral to the center for safe and healthy children. So we want our staff to really be doing head to toe exams on those babies.*

Similarly, the participant explained that a no hit policy has influenced a culture shift amongst the medical team in terms of their professional work but within their own parenting practices.

We've had people on staff come up and say, I'm no longer spanking my kids because of this policy; because of what I've learned [and] what you guys have provided in terms of education. I think we have to remember that we're really planting seeds along the way with that program.

Participants expressed that promoting a culture shift does not have to be as extreme as policy change, but could be as simple as putting the power in the hands of the people most affected or at more risk for child maltreatment tendencies. In addition, several participants explained the importance of getting the whole story before having such a reactionary response. One participant portrayed this idea through the service of in-home visiting.

Home visiting is really effective because you're working with people in a natural environment, they're a little more at ease and not off guard. And you're really able to observe what's really going on. So I think working with people in the home is key.

Society has been built to think the at-risk population is helpless or that they need someone to come in and tell them how to do things better. One participant explained the importance of giving the at-risk population the tools they need to be a leader and advocate for change in promoting child maltreatment prevention.

The parent leadership team [is] another thing that has had a big impact [on reducing child maltreatment]. We have a big program in parent leadership. When people are invited in to take leadership, [it] impacts hope…. another real key component of this: we think it's super important that the information gets to those most affected, not just the people serving them.

Another participant talked about how there is potential for change in the way providers interact with at-risk parents for child maltreatment behaviors and that there needs to be a shift in the way society looks at asking for help.

It's about strengthening the family, decreasing isolation, and recognizing things can be

different, and that relationships with providers can be different… Our guiding star is

'asking for help is a sign of strength' and once they [parents] can do that, there's a lot

we can do to support that. So that's an important concept to pass along and which is not

typical in our society. People think they have to do stuff on their own.

Parent empowerment. The first subtheme identified speaks to empowering parents and

includes two categories: parent attributes and provider attributes. This subtheme is critical in

working towards promoting a culture shift in how society approaches child maltreatment and

reducing child maltreatment. The subtheme of empowering parents is seen in a couple of

capacities.

Parent attributes. The first component of parent empowerment takes into consideration

parent attributes such as increased parent knowledge of child development, parent self-

determination, parent resiliency, and parenting skills.

Several participants highlight the importance of working towards the goal of increasing a

parents' knowledge of child development: "Increased knowledge [is seen] as being huge [in

preventing child maltreatment]" and "One of the protective factors is a parent's knowledge of

child development."

Parent self-determination also seemed to be an important parent factor in empowering

parents to make changes not only for themselves, but to advocate for change within their

community or to help other families needing support. Several participants talked about their

services being voluntary so parents have the ability to make a choice for themselves if they want

to take the next step: "It's a voluntary program, so they [parents] don't have to [participate]. If

they [parents] don't want to be a part of it, they [parents] don't have to be." Similarly, another

participant reports, "So it's voluntary. I think it's one of the two of the key pieces… that it's voluntary, so the family chooses to bring their kids here [if they feel it is needed]."

> *It's about asking, is there something I can help you with? Is there something that you need? And letting them know that it's their choice. Like if they choose to use, they choose to use…It's not my pregnancy, but here's information on what is happening if you continue to use or what could happen if you continue to use. You're an adult, you can make that decision yourself.*

A different participant describes an opportunity for parents to have self-determination in the form of being a leader among other parents and what impact that has on at-risk parents for child maltreatment behaviors. "We also have a big program in parent leadership… when people are invited in to take leadership, [it] impacts hope. The parent leadership team [is] another thing that has had a big impact."

Participants also discussed parent resiliency being a key factor in empowering parents to see their own strengths and give them the confidence to make changes in light of difficult circumstances. This factor can be demonstrated by the following quotes:

> *The protective factor of increased resiliency and coping skills for parents; having somebody to call in their moment in crisis is a coping skills. Then teaching them other coping skills…Our guiding star is 'asking for help is a sign of strength' and once they [parents] can do that, there's a lot we can do to support that.*
>
> *Some of them [parents] don't even realize [the consequences], especially with pot….A lot of people use that [pot] because it's natural. It helps with nausea, it helps with nutrition; all that stuff. Well, yeah you have a point, [better than using heroine] but it's still a chemical, and you know those chemicals are still being used and going to your baby. It's still affecting your baby's development…Sometimes it's a matter of having that initial*

conversation and seeing what they [the parent] want to do, seeing where they're at. Most

of them are okay with [meeting].

The previous quotes demonstrate that parents are able to engage and be resilient despite

their past experiences and the choices they have made. Another demonstration of resiliency is

parents' ability to ask for help. Prevention services are recognizing this as a strength and are

encouraging other agencies to do the same. An additional parent factor that plays a role in parent

empowerment is parenting skills. All participants highlighted the services they offer to give

parents the tools they need to enhance their parenting skills to empower them to be the best

parents they can be. The following quotes demonstrate support for services focusing on parent

skills:

> *Parenting kids under the best of circumstances is stressful, when you're in a medical*
>
> *setting and you're trying to parent, and you have a million other stressors in your life, we*
>
> *recognize that this is really hard…We're wanting to figure out ways that we can best*
>
> *support you in a really stressful time…by providing resources and tools.*
>
> *I don't think parents want to hit their kids. I think they just want ideas. So we do see that*
>
> *can be really helpful. I think recognizing that families are stressed and providing them*
>
> *with [tools] to be successful.*
>
> *So our circle of parents program, over the years, has consistently reported that parents*
>
> *self-report that they use more positive parenting techniques rather than harsh discipline*
>
> *techniques [after completing the program].*
>
> *They're [providing] parenting education sessions on child development, parenting*
>
> *techniques, [and] healthy relationships…[Mindfulness is] becoming a really prominent*
>
> *strategy in increasing coping skills. So I think that is one of the things we're focusing on*

right now [for parenting skills]…[We're focusing on] what are some really significant

strategies that they can be using that aren't typically in the training that they already get.

Provider attributes. The second component of parent empowerment takes into

consideration provider attributes such as creating a non-judgmental environment and meeting

clients where they are at. Creating a non-judgmental environment by meeting clients where they

are at was explained by this participant's quote: "*The family defines the crisis. So we don't rank*

whose crisis is more important more than the other. So if they are calling a total stranger for

help, they are in crisis." In addition, all participants chose to talk about how it is important to

create a non-judgmental environment represented by the following quotes:

> *We're wired to be concerned and advocate for the child and yet, we believe here that no*
>
> *parent really wakes up and says 'I think I'm going to hit my child today'. So those*
>
> *stressors without support can be overwhelming. So when we think about toxic stress, we*
>
> *often think about it in the eyes of a child. We often will think that our parents that are*
>
> *calling us were once these kids that didn't get what they needed to be able to function. In*
>
> *a way that was adaptive. [We're] just trying to reduce some of that judgment.*
>
> *Maybe even go and interrupt some of that stress by saying "it looks like you've been*
>
> *waiting a long time, can I find out how much longer your wait's going to be, or can I get*
>
> *a coloring book for your kiddo? So those kinds of supportive things, but also training*
>
> *our staff that if they do see someone hit, to walk up to them and offer support in a very*
>
> *non-judgmental way, just to let you know we are a no hit zone and don't allow any hitting*
>
> *in this hospital. And figure out what they might need for support right there.*
>
> *Parenting kids under the best of circumstances is stressful… We're not judging you,*
>
> *we're wanting to figure out ways that we can best support you in a really stressful time.*

Every single person that has a positive drug screen, I always review maltreatment and

mandated reporting with them. I make them very aware that this is not a threat, but that

they need to know that this is what happens. So if there's a call, [they're] not surprised.

[They] have the information now and [they can] make that decision… I don't like to

review their lab results over the phone. I think they're able to get a little more defensive

that way. Have difficult conversations in person.

We try to tailor the intervention and work with the parent to be culturally specific, so it's

relevant and feels appropriate for the family.

Another important provider factor discussed by all participants is the concept of meeting the

parent where they are. The following quote describes the reality of what an at-risk parent might

prioritize over prenatal care:

The population you're working with… it's not their priority [prenatal care]. I mean they

have so much [going on], they think [other things] are bigger proprieties in their life

than to come in and make sure they're doing okay and that baby is doing okay.

One participant explained that, "[The] home visiting program is an extremely researched

and proven method for child abuse prevention and a pretty beneficial strategy for the high

risk and hard to reach families." Several participants also talked about the concept of

home visiting being a good way of meeting parents where they are at emotionally and

physically:

I think home visiting is really effective because you're working with people in a natural

environment, they're a little more at ease and not off guard. And you're really able to

observe what's really going on. So I think working with people in the home is key

[Offering] flexibility in the program is really important to families. That there's not a set

dosage to the home visits. If somebody needs two visits in a week, we can do that. If

somebody needs a visit once a month to keep them going, that's what we do. So I think for

families, I think flexibility and responsiveness is key.

Similar to meeting parents where they are at, participants highlighted idiographic work or working towards understanding each parent/family's personal story and context of their situation. The following quote emphasizes the importance of taking the time to understand a parent's story and making it comfortable and personable:

> *I like to meet with them in clinic and try to get their story. Sometimes it's 'I'm fine, I*
>
> *don't need any help' or they have enough support. And sometimes it's I want*
>
> *help…Sometimes it's a matter of having that initial conversation and seeing what they*
>
> *want to do, seeing where they're at.*

The subsequent quotes direct attention to the importance of truly understanding an individual's story and what is impacting their life and ability to parent. In this case, mental health and basic needs are discussed:

> *A lot of time mental health services are key to successful um results too. That a lot of*
>
> *our families have generational mental health issues that haven't been addressed.*
>
> *And once they are, we tend to see improvements as well.*
>
> *They also help with basic needs stuff. If people don't have enough to eat, or don't*
>
> *have money for utilities, they'll either access resources or make referrals to other*
>
> *community providers…they'll [also] help transport to appointments and stuff like*
>
> *that*

Spreading the net. The second subtheme found to support *promoting a culture shift is* the concept of *spreading the net.* The data highlight this subtheme in regard to expanding the network of child maltreatment prevention to providers, community members, and those directly impacted by the consequences of child maltreatment. Similarly, *spreading the net* encompasses

the idea of creating a larger network to expand child maltreatment prevention efforts through

providing education, training, having the resources to measure services and outcomes, and

requiring all providers to be involved in this shift towards proactive prevention strategies. To

create this subtheme, there are three components, including psychoeducation and training,

provider title matters, and measurement and outcomes.

   Psychoeducation. All participants elaborated on the importance of psychoeducation

within an agency, within the community, and within the services they provide to parents. The

following quote speaks to the impact education can have in changing beliefs and expanding

services or policies regarding child maltreatment prevention.

> *We can see that with like no hit, we can see that just changing people's belief system can*
>
> *help. Providing education, there's actually um really good information out there that*
>
> *says research changes people's minds, and what they found is yes, if you provide people*
>
> *across the board, with information, then they are going to change.*

Several participants talk about providing educational handouts or classes to help families

maintain safe and healthy lives.

> *[We] make sure we provide education to families about how to keep their home safe and*
>
> *healthy.*
>
> *[The] child abuse pediatrician that we spoke with…has been working on this. They have*
>
> *a lot of really good information that we utilized when we worked on it. They helped our*
>
> *program train as well, so we sort of adapted to train [here]. It's Timely Recognition of*
>
> *Abusive Injuries Collaborative. We had it made to provide education to families.*
>
> *So we do a lot of pamphlets; education type stuff. We have magazines we can give them.*
>
> *We are developing a patient education handout on marijuana use during pregnancy. We*
>
> *have some general patient education of chemical use and mental health in pregnancy, but*

sometimes it's a lot of just conversation, and helping them better understand the potential

of their use and on baby [and] what the consequences could be.

We also have the parent support group and parent education classes. Not everything is

going to fit for everybody but having different options for different needs so.

One participant placed great emphasis on how important it is to get the pertinent information out there to those who are most impacted by, or at higher risk for, child maltreatment.

We try to do…a presentation that includes many agencies working with populations and

the population themselves. So everybody gets the information. That's another real key

component of this; we think it's super important that the information gets to those most

affected, not just the people serving them. So yeah, we get specific requests from some

agencies, and we do that as well, but our biggest focus is how do we really present it to a

broad group of people across the community and get them to sharing it and ripples out in

their community.

I would say all of everything we do, we want the most affected included and their voices

listened to, and they and want them to have equal access to information and decision

making as those who are providing service.

The net can be further spread by offering educational summits or seminars to community agencies, counties, or even policy makers on specific issues related to child maltreatment prevention.

We are doing a lot of education. We have just started to plan a two day child

maltreatment/abuse summit… and we're hoping that will become an annual event. We'll

talk about a lot of different things when it comes to child abuse including prevention. We

also are planning for this fall, a half day training on corporal punishment and the no hit

zone. Our hope is to bring in some national speakers to talk to internal people but also

we hope to invite external people like child protection and law enforcement. To really

address some of the issues related to corporal punishment, but really we want to bring in

that cultural context piece because usually when people bring this up with concerns,

they're usually talking about the cultural component.

We just had a retreat where we had [the county] come in and do some networking that

way. We try to invite a speaker to come to our monthly meetings or our team meetings.

Sometimes it's with people from within our organization or from outside of our

organization presenting on specific topics"

We have been talking about going to methadone clinics and talking with them about how

they work with pregnant patients and then just getting a better idea of who we can refer

to. Just to get a better sense of how their program works, how do they specifically work

with women, with their dosing, what does counseling look like for them, case planning

type stuff? So that's super helpful to bring back.

According to several participants, the net is spread across the state and even up the chain

to legislature.

> *Right now we're doing a series of presentations around the state and really*
>
> *encouraging our partners, the children's mental health and family services*
>
> *collaborative to reach out and include parents in [these presentations] as well.*
>
> *We are actually doing some work with Harvard right now and some work with the*
>
> *University of Chicago. So my work will be much more external and doing some*
>
> *legislative work. Getting it upstream a little bit more and getting it bigger than just*
>
> *right here.*

Training. Similar to psychoeducation for parents, community agencies, and society as a whole, training was an important factor that played into creating a bigger support net to help further child maltreatment prevention efforts.

> *We are training our clinic staff and our emergency department staff to recognize bruising or oral injury in infants 6 months and younger. So what we know that if you're 6 months or younger, you shouldn't have a bruise. You should not have an oral injury. There's research that's really clear that says "no cruise no bruise", if you don't' know how to cruise, you shouldn't have a bruise. So we want our staff to really be doing head to toe exams on those babies.*

> *When I was with [another clinic], we would go out to the methadone clinics just [to] get a better sense of how their program works; how do they specifically work with women, with their dosing, what does counseling look like for them, case planning type stuff. So that was super helpful to bring that back [to train our staff].*

In spreading the net further, one participant commented on how their program focuses on training parents how to lead and facilitate parent support groups in order to keep expanding services to more communities.

> *The other element of parent recruitment is through our partners to train and support them around parent involvement and leadership.*

> *At this point we train presenters across the state. So in those communities we work most deeply with…a group of 15-30 people in that community who are trained to share that information as well. We've had lots of anecdotal information, we did a big interview process/study with informative interviews last summer. We heard from people about what the impact on their lives specifically, these are the presenters, and many of the people who are drawn to presenters [are those who had] adversity in their own childhoods.*

Provider title matters. Multiple participants noted that the provider title can be very influential for delivering critical information to parents regarding childhood development, child maltreatment consequences, and preventative measures. The following quote demonstrates the need for physicians to have conversations about these important topics with parents:

> *Even working with the providers because either the providers don't want to have those [difficult] conversations with them. We [have] struggled with who was going to let them [the patient] know that they got referred to the program, because there were some providers that were like "I don't want to ruin that relationship." That's your job.*

Social work as a profession is not always given the best reputation by society. This is partially attributed to the many interpretations that have been created about social work due to not having a full understanding of the social work role. It is common for social work to be often associated with child protection services as one of the primary roles of the profession. For this reason, one participant described their intentionality around introducing themselves to clients without the social work title:

> *I [never] introduce myself as a social worker… A lot of them [providers] don't even say that I'm a social worker and at least I can get in the door. Because if someone was like 'hey, the social worker is here to speak to you', they would be like, 'no I'm not doing that.'*

Measuring services and outcomes. All participants elaborated on the challenges of measuring prevention strategies and services. Agencies who can measure outcomes will be more likely to express results to the community and even in legislation. Although all agencies discussed the difficulty in finding optimal ways for measuring services to provide results, some agencies have had more success than others with implementing measurement tools. Each

participant reported that, "The measuring piece is our biggest challenge." Challenges with measuring is further demonstrated in the following quote:

> *We definitely wrestle with the challenge of prevention is hard to prove. We are starting to look at a tool that comes out of the center of study for social policy around protective factors as well.*

The following quote describes an aspect of why measurement can be hard with prevention and with the services they offer.

> *We can't track [measurements] them over time because the kids come and go all the time so it's a little more complicated than other places.*

Several participants talked about how they are measuring by looking at harm reduction or measuring an increase in protective factors.

> *They can see drug screens at delivery… if we are doing one at 20 weeks or something, I think they measure it that way. Measuring a reduction in people who are actively using in pregnancy.*

> *So the biggest thing [for measurement] … is the child meeting developmental milestones? Does the child remain in the home?*

> *We know that we can't say you aren't going to abuse your kid, but we do know by using these protective factors that we are reducing the likelihood that it's going to happen. So we have a whole bunch of different things that we measure….So one of the protective factors is related to a child's social and emotional competencies. So we track, based on a child's age, what are some social and emotional competencies they can work toward or demonstrate and we track that in our system and have this expectation that the target goal that 85% of the kids do demonstrate some social and emotional competencies while they're in our care.*

Spreading the net also means getting more providers involved in the responsibility of reducing child maltreatment. Several participants discussed how their internal staff are being trained on how to respond to child maltreatment as well as how to work towards increasing prevention. In addition, some participants described their agency's efforts to spread the net by creating partnerships with counties, schools, and medical providers to heighten child maltreatment prevention efforts and broaden the network. The following quotes represent the internal expansion of providers taking responsibility to reduce child maltreatment:

> *We're training everyone. The nurses, physicians, medical assistants, social work. The physicians are going to be doing the head to toe exams. But every other person will be involved in some way.*

> *We have so many professionals and disciplines to do amazing teamwork…I think what's amazing is when we get together, for example when we have our no hit zone task force, we have nurses, we have social workers, we have spiritual health, we have child and family life. You know we have everyone sitting around a table and talking about how we can provide better services to these families. So I think that strategy, that multidisciplinary strategy, is just the best because what one person can't do another person can.*

The next quotes demonstrate the expansion of the network of those working towards increasing child maltreatment prevention efforts within their community, state, and within the country:

> *Our mission is to end child abuse and neglect and we're never going to be able to do that on our own. So reaching out to other organizations to be able to support them in understanding. The goal would be that then the children, where ever they are, if they're with us or at the homeless shelter or the DV shelter, or if they're at school, or wherever*

we start to develop this community of care, then um, they would be getting similar

messages.

With circle of parents, there are partners all over the state, some are [people working in

prisons], some are in schools, domestic violence shelters, individual volunteers in

communities, health care providers, all kinds of places. In our community education

work, we have partnerships with the blue cross blue shield center for prevention, we have

partnerships with a wide group of people [up north] who represent multiple sectors in

their communities, communities of faith, criminal justice, healthcare providers.

Our other contract with the department of human services with the children's mental

health division. The children's mental health division supports family service

collaboratives and children's mental health collaboratives in school districts all over the

state. And there are 90 of them.

It's a developing program [in which we've] partnered with Dr. Rob Anda, who is one of

the authors of the adverse childhood experience study and Laura Porter who worked in

the Washington Family Policy Counsel engaging communities and responding to the

concept of ACES. They have a company called ACE Interface and have a program called

Understanding Adverse Childhood Experiences Building Self-Community Healing. And

we were the first place in the country actually to start to engage with them and use that.

So then that work [child maltreatment prevention] is about having ongoing conversations

with communities, creating learning communities. Broadly disseminating that

information across the whole community, engaging everybody in the community in

thinking about how does this [impact] how we do criminal justice, how does this change

how we work in the school, how we listen to parents, what do parents think about what

needs to change, how does this change conversations in WIC clinics? It also shares and

connects people to the broader national network of people experimenting so you can

learn what's happening through ACEs connection in other places and try things that

have worked in other places as well.

Providing a continuum of care. The final subtheme within the primary theme of

promoting a culture shift in the way child maltreatment prevention is carried out is having a

continuum of care. While participants described services their agencies were providing, it was

made clear that there is a continuum of care in working to further prevent child maltreatment.

The services on the *continuum of care* address needs at the micro, mezzo, and macro levels.

Participants expressed that providing a variety of options for services on a continuum ensures

that more needs can be met.

> *We like to talk about it as a continuum of care. So we have a 24 hour crisis line that*
>
> *families can call to just find out about us, to do some crisis de-escalation, to get some*
>
> *resources…So on our continuum of care…we offer overnight care for children birth*
>
> *through 6 for up to three days at a time for those families that are interested in it… if it's*
>
> *appropriate, we'll offer them home visiting services to kind of extend that support. We*
>
> *also have the parent support group and parent education classes. Not everything is going*
>
> *to fit for everybody but having different options for different needs.*

Participants discussed the importance of making transitions from one service to another on the

continuum of care appealing so families stay engaged:

> *We follow them throughout their entire pregnancy and we can follow them at least until*
>
> *their six week post-partum visit. We are working on our warm handoffs to peds meaning*
>
> *that we get them connected earlier to a pediatric providers so we can better coordinate*
>
> *their care…We have so many resources in this community and I think sometimes families*

don't even know about them. So it's really helpful when somebody presents some options

for them.

The services provided within the represented agencies demonstrate a continuum of care in terms of addressing services on micro, mezzo, and macro levels.

    Micro Level. Participants elaborated on the services that child maltreatment prevention agencies are providing to help parents on a micro level. On the continuum of care, these micro level services include psychoeducation to parents, providing emotional support, concrete support, and home visiting. Participants described psychoeducation that is provided through their services: "[We] make sure we provide education to families about how to keep their home safe and healthy," by "teaching parents that these [parenting skills] are things that can have a strong impact on preventing abuse and neglect", and "educating them not only on fetal development, but what substance use does to not only themselves, but what it does to the fetus. And with prevention, letting them know how the substances affect baby."

    Providing emotional support has been supported by research as a protective factor for preventing child maltreatment abuse. Participants explained how providing emotional support can be incredibly helpful to a stressed parent who may be struggling. "There's lots of support. There's lots of research and data out there that talks about [the importance of] support." These ideas align closely with CSSP (2017) in emphasizing the importance of parents having a sense of connectedness and how feeling cared for positively impacts their ability to parent. The following quotes demonstrate the importance of providing emotional support to parents undergoing challenges and who are under a lot of stress:

> *We want to make sure we are taking care of the parents so they can care for their child.*
>
> *So I think it's supporting the parent, so establishing that trust relationship with the*
>
> *parent, help the parent feel cared for so they can care for their children. The underlying*

message of our work here is you can expect help here. So if you're a child or a parent,

you can expect help here is the message and a lot of times people don't have that in their

sense of self.

If we see a family is in stress, it is per our policy, the responsibility of any staff member to

go to that family and see what support they might be able to offer…We train people about

the no hit zone, we are able to offer the resource of a child and family life specialist to

provide [emotional] support to that family.

One participant not only talked about the importance of providers giving parents emotional

support, but also how important it is for family and friends to provide that emotional support as

well:

Anytime we can get their support people; whether that's the dad of the baby, whether

that's a mom of the patient or a dad of the patient. That's huge too [because] a lot of

times it's just them and they don't have a lot of support.

Participants also spoke about the importance of providing concrete supports to at-risk parents

such as housing resources, financial assistance, transportation, and other basic needs in order to

reduce the stress level of a parent. One participant explained, "We do a lot of community

resource referrals. We help with transportation. So it's a lot of other psychosocial things that we

work with." Similarly, other participants provided feedback about concrete support by

discussing:

[We] also help with basic needs stuff. If people don't have enough to eat, or don't have

money for utilities, they'll either access resources or make referrals to other community

providers…they'll [also] help transport to appointments and stuff like that… Sometimes

it is little stuff like that, that can really be the difference between whether a family is

successful or not.

'Hey this person is having trouble getting signed up for WIC' or this person is struggling

with transportation, or this person is [experiencing] domestic violence, any number of

psychosocial issues. So we'll get those referrals as well.

We have a pretty extensive interview and we do a basic needs assessment just to make

sure they're aware of how some of those things are getting in the way of them being the

parent that they want to be. That sometimes those stressors can lead to higher risk of

abuse.

Home visiting is another micro level service that several of the participants explained within the

continuum of care. As noted previously:

[The] home visiting program is an extremely researched and proven method for child

abuse prevention and a pretty beneficial strategy for the high risk and hard to reach

families…Home visiting is really effective because you're working with people in a

natural environment, they're a little more at ease and not off guard. And you're really

able to observe what's really going on. So I think working with people in the home is key.

Mezzo Level. At the mezzo level, a participant talks about a parent leadership group and a

parent support group. The participant discusses how a ripple effect is created by training parents

to train other parents to participate in providing support for parents in their communities:

Our regional directors work with communities that want to offer circle of parents. Circle

of parents is offered through volunteer facilitators and or community partner

organizations. And one of the steps of the process is for them, when creating group

settings, is to create a referral plan within their own communities of who in their

communities serving families that might be good, who might be good candidates for

circle of parents.

Macro Level. At the macro level on the continuum of care, presenting research findings, providing training statewide, and working with other programs across the country or with legislation are efforts being demonstrated by several participating agencies.

We are actually doing some work with Harvard right now and some work with the University of Chicago. So my work will be much more external and doing some legislative work. Getting it upstream a little bit more and getting it bigger than just right here.

Right now we're doing a series of presentations around the state and really encouraging our partners, the children's mental health and family services collaborative to reach out and include parents in [these presentations] as well.

It's a developing program [in which we've] partnered with Dr. Rob Anda, who is one of the authors of the adverse childhood experience study and Laura Porter who worked in the Washington Family Policy Counsel engaging communities and responding to the concept of ACES…And we were the first place in the country actually to start to engage with them and use that.

We looked at some short and long term outcomes that we wanted to work on and then we developed two value propositions. One was around reducing the risk of child abuse and neglect and the other one was around strengthening families. They're all connected to the protective factors. So we have a whole bunch of different things that we measure… we track, based on a child's age, what are some social and emotional competencies they can work toward or demonstrate and we track that in our system and have this expectation that the target goal that 85% of the kids do demonstrate some social and emotional competencies while they're in our care.

Discussion

This research study aimed to assess and evaluate current child maltreatment prevention services within a large, Midwest metropolitan area through looking at which research-supported features, frameworks, and services provided to at-risk families for child maltreatment and within the broader community. More specifically, this study looked at three research questions: 1. Are child maltreatment prevention programs incorporating research-supported features to address protective and risk factors through the services they provide?, 2. Which core features are missing or need improvement to bridge the gap within these programs, if any?, and 3. How are at-risk families being referred or recruited to these child maltreatment prevention programs in light of the existing intervention methods of Child Protective Services (CPS)?

The results of this study were compared to the literature base which focuses mainly on the identification of protective and risk factors for families and the need for creating services that correspond with reducing risk factors and increasing protective factors based on previous research findings. Although this study is not a full representation of all programs within the targeted metropolitan area, the five agencies that participated in the study represent a wide array of services and made references to additional programs providing prevention services. Not all participating programs are using every strategy suggested in the literature, however, most strategies are being utilized through a combination of agency services that complement each other. The overarching theme identified is the need to promote a culture shift in the way families, communities, and professionals understand child maltreatment, as well as to shift the way the social services field responds to at-risk families for child maltreatment or when child maltreatment has occurred. This theme of promoting a culture shift in the way child maltreatment is approached suggests that the professional community is seeing a need to focus the work being done with at-risk families more towards proactive prevention measures rather

than the existing intervention methods. Similarly, the social services community is seeing a critical need to shift the attitudes toward child maltreatment and prevention within the at-risk population and the community. Social service workers are expressing the need to take a different approach in taking necessary steps to prevent the initial occurrence of child maltreatment instead of intervening and picking up the pieces after the event has taken place.

The subthemes of *parent empowerment, spreading the net, and providing a continuum of care* were identified and support this overarching theme *of promoting a culture shift* in attitudes towards child maltreatment prevention. The theme and subthemes will be discussed in relation to literature findings and the study's research questions regarding effective strategies for preventing child maltreatment and how those strategies can be addressed to work towards increasing prevention efforts. Bear in mind that there is no single strategy that has been proven to be effective in preventing child maltreatment and that research concludes that it is necessary to incorporate a combination of strategies in order to reduce the likelihood of child maltreatment occurrences.

Research Question 1: Are child maltreatment prevention programs incorporating research-supported features to address protective and risk factors through the services they provide?

The findings suggest that existing child maltreatment prevention programs are utilizing many of the core features supported by research. All participants explained that progress or success is not always easy to prove when using prevention strategies mostly because it is nearly impossible to eliminate all risk factors. However, prevention strategies are not always about eliminating risk factors, but instead or in addition to, increasing protective factors. There is a large list of protective elements that reduce the likelihood of child maltreatment related to the child, parent, and environment. The research-supported protective factors addressed by

participating prevention programs include: increasing knowledge of parenting and child development, improving parenting skills, increasing social connection, and enhancing emotional and concrete supports for at-risk parents. These protective factors are demonstrated through the first and second subthemes of *parent empowerment* and *spreading the net.*

Parent empowerment. Parent empowerment is the first subtheme identified from the findings. All participants discussed elements of parent empowerment and how they are incorporated into child maltreatment prevention services. It was found that both parent and provider attributes contribute to empowering parents. Parent attributes of increased parent knowledge of child development, parent self-determination, parent resiliency, and parenting skills contribute to parent empowerment while meeting clients where they are at and creating a non-judgmental environment are provider attributes that empower parents. These factors have not only been incorporated into the participating agencies' services, but also align closely with the Center for the Study of Social Policy (CSSP) findings of protective factors that have shown to reduce the likelihood of child maltreatment. These factors include: knowledge of parenting and or child development, parental resilience, fostering social connections, concrete supports for parents, and strong parent-child attachments.

Parent attributes. All participants discussed the importance of incorporating classes, resources, and support to increase knowledge of parenting and child development because it is strongly supported by research as a protective factor for reducing the likelihood of child maltreatment (Lovejoy, Verda, & Hays, 1997; Palusci, Crum, Bliss, & Bavolek, 2008; Strickland & Samp, 2012). Several agencies focus more specifically on fetal development in addition to child development post-partum. Similarly, several of the agencies offered parenting classes to increase knowledge of positive parenting practices and skills. One agency even implemented an in-agency policy to reinforce parental resilience through providing resources for parents to

problem-solve and find more positive ways for parents to cope with stress that does not involve aggression towards their child.

A high emphasis was placed on parent self-determination through discussion of how parents are ultimately in charge of their children and cannot be told what to do by providers. Participants collectively expressed how providers can give parents and families the necessary information to support them in making a decision, but in the end, parents are the ones who get to make the decisions based on their life and what is best for their children and family as a whole. Four of the five participating agencies facilitated parent self-determination by hosting voluntary participation in services. The remaining agency offered voluntary participation in receiving resources or assistance from professionals but required all families to abide by their in-agency policy of no violence in any form. This type of agency policy is somewhat of a radical shift in culture and is taking time for staff and families to adjust. Furthermore, all participants indicated that directly involving the voices of who are most affected, or at high risk, for child maltreatment behaviors must be included in the conversation, and in this regard, improve services to better serve families. Currently, agencies are making changes to include at-risk parents in the process through parent leadership groups, parent-led support groups, and seeking parent feedback on the services being provided through the administration of evaluations.

All participating agencies offer resources to increase parenting skills to complement the protective factor of increasing knowledge of parenting and child development. Agencies are providing opportunities for skills work with parents ranging from learning alternate disciplinary strategies, providing helpful parenting strategies for navigating difficult child behaviors, to how to further develop parenting skills to foster better parent-child relationships. The strategies to foster better parent-child relationships align closely with the protective factor of nurture and attachment according to the Center for the Study of Social Policy (2017). This protective factor

aims to look at trust, acceptance, and availability a child experiences from their parent(s). Several participants explained that oftentimes at-risk parents for child maltreatment behaviors had poor parent-child relationships with their caregivers and never had the opportunity to learn how to foster a stronger parent-child relationship with their own children. This is where agencies come in to assist in parents' learning in this skill.

The recognition from providers and society that parents can be resilient even after having endured difficult life circumstances and stressors is not always received by at-risk parents for child maltreatment. Participating agencies unanimously articulated that there is a significant amount of stigma that surrounds parents who have been involved in the child protection system, and even receive that stigma from their medical providers or community agencies. One participant specifically reported priding themselves on carrying out the motto, "asking for help is a sign of strength" and want to let parents know that help is available and that it is acceptable to ask for help. Parents have the ability to be resilient and recovery from decisions they regret making or difficult experiences they endured. This resiliency is commonly forgotten about and parents more often than not need support from outside sources to see their resiliency and empower them to continue their efforts to seek support and resources along their journey. Although parent resilience is identified as a parent factor, providers play a big role in helping parents to recognize how resilient they are. Providers can empower parents to continue demonstrating their resiliency through their effort to make changes in order to better their life. In this regard, participating agencies reported making efforts not only to recognize the significant stigma surrounding these parents, but are actually putting strategies in motion to reduce this stigma and shift the way providers work with these parents and families. Other agencies are promoting training around how to identify resilience in at-risk parents despite their past

experiences to help providers within the community approach parents from a strengths-based

approach and to reduce the stigma that they are 'bad parents'.

     Provider Attributes. Along with parent attributes, provider attributes have been identified

as an important contributor to empowering parents. All participants overtly or covertly placed

emphasis on providers impacting parent empowerment through two primary actions: meeting

clients where they are at and creating a non-judgmental environment. The first provider attribute

discussed was the idea of meeting clients where they are. In continuing to shift mindsets to

reduce stigma around 'bad parenting choices', it is clear that providers are making great efforts

to understand the circumstances of at-risk parents' and their stories. Agencies are carrying out

these efforts through facilitating in-person meetings to discuss difficult subjects, offering home

visiting services to maintain parents' comfort levels, letting parents use meetings to tell their

story, and then welcoming providers into their story on the parents' terms instead of the provider

inserting themselves into parents' stories through intrusive questions. Participants indicated that

simply listening to a parent's story without interrogating can be a huge first step in engaging and

empowering parents. Listening to the stories first allows providers to take the opportunity to

focus on what is important to parents and what supports are needed. Then taking the opportunity

to lift parents up through giving them the encouragement they need to take the next steps

whether that is seeking resources for child care, taking a parenting education class, or anything in

between. Agencies are practicing these strategies in order to better understand the clients who are

coming in, what can be done to provide individualized care, reduce provider judgment, and

increase parent engagement and empowerment.

     The second provider attribute identified as critical for empowering parents is creating a

non-judgmental environment. Not all agencies are at the level of 'making asking for help'

acceptable. However, participating agencies recognize that parents have the power to make

changes. There is a need to spread this message to more agencies and larger systems within counties, regions, and the country. Similarly, agencies have been making the effort to encourage community providers to share comparable messages within and beyond their professional circles and with the parents coming to them for support. The judgment that parents can often receive from providers is overwhelming and serves as a turn-off for parents' continuation of taking steps towards making changes and receiving the supports they need to make those changes. If providers and society are willing to make a shift to recognize that parents "do not wake up with the thought of hitting their child" and have the ability to be resilient and be a positive parent, despite difficult circumstances, at-risk parents will be more willing to engage and make necessary changes.

It is clear that participating agencies are recognizing that empowering parents is an important aspect of the work they do in order to engage and maintain parent participation in services. In the same vein, agencies are carrying out necessary strategies to engage and empower families in addition to serving as a vehicle to increase protective factors for at-risk families. The maintenance of parent participation allows for greater opportunity for these at-risk families to increase protective factors even when eliminating risk factors are not always possible. There is always room for improvement in regards to which services are being delivered and how those services are being delivered. The most pertinent source of feedback is from the at-risk population themselves. However, agencies may have the ability to provide services to increase protective factors, but if they cannot engage families, it is a lost cause. Participating child maltreatment prevention programs are providing services highlighted by research-supported protective factors one way or another while recognizing that there is still need for improvement mostly through ensuring that most or all agencies are striving to provide services that focus on increasing the same research-supported protective factors for at-risk families for child maltreatment.

Continuing to outspread the message of focusing on increasing protective factors in their services to providers in the community is the ultimate goal and serves as another protective factor in creating support, reducing isolation, and providing consistent and critical information for at-risk families and providers.

Spreading the net. The first research question is also addressed through the second subtheme: *spreading the net.* Protective factors of increasing social connection, as well as emotional and concrete supports are met through expanding the prevention community not only within prevention programs, but within the at-risk population as well. Making a culture shift in how to interact with at-risk parents for child maltreatment does not come easily. It requires proactive thinking, extensive outreach, and dissemination of research findings regarding the negative impacts of child maltreatment, how increasing protective factors and decreasing risk factors can reduce child maltreatment, and how fostering support through collaboration, partnerships, and collective participation will strengthen at-risk parent engagement in services. *Spreading the net* encompasses the idea that creating a larger network to expand child maltreatment prevention efforts through providing education and training, requiring all providers to be involved in a shift towards proactive prevention strategies, and having the resources to measure services and outcomes to continue expanding services to create a ripple effect in the community in regards to shifting attitudes towards child maltreatment prevention rather than intervention.

Psychoeducation and training. All participating agencies reported that psychoeducation and training are integral pieces of their models and frameworks used to better help families, providers, and communities understand the importance of child maltreatment prevention. For parents or families, the participating agencies are providing education around how child maltreatment impacts their child physically and psychologically. In regards to providers, all

participating agencies reported providing education and training to their employees as well as providing the same materials to other agencies, the county, and even to state legislators. Part of this training includes looking inward to one's self to explore what issues are coming to the surface for providers in working with at-risk parents for child maltreatment. As mentioned previously, society has placed a strong stigma on parents who have been involved in the child protection system or have made choices to physically discipline their children in a way that borders on child maltreatment. Speaking to this stigma and judgment, several agencies discussed placing emphasis on having providers assess their biases to better understand what they can be doing to create a less judgmental atmosphere or how to approach parents in a non-judgmental way. Looking inward to recognize provider-biases is heavily integrated into the social work profession and is not always an easy approach to adapt to for all professionals working to enhance child-welfare. The agencies who are already working towards the goal of providing this type of training and education are just getting started. At this point in time, there is no uniform method to deliver this type of training regarding provider biases in order to better understand and work with the at-risk population for child maltreatment. This is an area that providers are currently talking about creating uniformity and continued expansion of this type of training not only within the community, but throughout the state and beyond.

Psychoeducation and training are not only being used for providers. Participating agencies talked about helping parents to better understand what is all constituted as child maltreatment and what the negative implications of child maltreatment have on a child's physical and mental health. The agencies provide a variety of resources for parents including child development brochures and pamphlets, parenting skills classes, and discussing a number of positive parenting strategies or alternative options to aid parents in their most stressful moments. Furthermore, some agencies are taking one step further to continue spreading the net through

having parents lead parenting support groups. These parents are being shown how to train other

parents in their communities to expand the network of families receiving pertinent information

about child maltreatment and what steps can be taken to reduce risk factors and increase

protective factors. These strategies are highlighting the protective factors of increasing social

connection and emotional support.

     ***Provider title matters*.** It is important to have a united front across professions and

resources in addition to having some of the most influential providers distribute these messages

of parenting is challenging, child maltreatment happens due to high stress and limited resources,

asking for help is a strength, and resources are available. According to participating agencies,

they have found that the clients they serve have a higher respect for what their physicians have to

say. Unfortunately, the messages given by social workers are received differently than if they

were received from a physician or other medical provider. At the same time, medical

professionals have expressed discomfort or unwillingness to discuss the negative implications of

child maltreatment on physical and emotional development with parents. Participants associated

with medical settings described that medical providers tend to rely more on mental health

professionals, including social workers, to provide this information. Yet, the information is not

always received in the same regard. These same participants expressed the need for medical

providers to receive training on how to have these challenging conversations with families and

know how influential their role is in preventing child maltreatment. In a similar light, participants

discussed how social workers or child-welfare workers need to be cognizant of their professional

title being used when trying to approach or engage parents.

     The social worker title tends to be a turn-off for families due to society's view of social

workers often being associated with child protective services or taking children away. It is made

evident through participant responses that it is difficult to even get in the door to have a

conversation with at-risk parents for child maltreatment based on the title the provider carries with them. This factor is something that can be easily addressed, but is not always at the forefront of issues to address to decrease child maltreatment. Nevertheless, it is important to be aware that parents do not always have a positive perception of social workers or completely understand the role of social work in relation to preventing child maltreatment and the welfare of children and families.

At the same time, social workers should not be the only professionals addressing issues of child maltreatment or taking steps to further prevent child maltreatment. Participating agencies collectively recognized the importance of spreading the net to include a variety of providers and promote a shift in culture so that all professionals are responsible for child maltreatment prevention. Providers including medical professionals (physicians and nurses), teachers, county workers, homeless shelter workers, mental health practitioners, and so on need to take responsibility for consistently distributing the same message that parenting is challenging, child maltreatment happens due to high stress and limited resources, asking for help is a strength, and resources are available. There is clear consensus that these messages are pertinent to shifting the approach from reactionary intervention to proactive prevention and reducing child maltreatment rates.

Measuring services and outcomes. Participants discussed measuring prevention as a significant challenge within their programs. Prevention is difficult to measure due to determining what needs to be measured in order to prove that services are in fact preventing maltreatment behaviors from happening. Based on the findings, each agency is at a different stage in the process of establishing reliable tools and strategies for measuring prevention outcomes. Some agencies have established surveys to administer to parents in support groups or to track if children are meeting developmental milestones and social/emotional competencies. Another

agency is measuring their prevention services through tracking the amount of out-of-home placements that occur in which less out-of-home placements indicate that an agency's services are proving to be effective. Of the participating agencies, one agency was particularly organized and well versed in what they are measuring and how it is being measured. This agency was able to collect program outcomes and compile data to create reports for state legislators and funders.

Measurement is an area of growth for child maltreatment prevention agencies. Having successful measurement tools allows agencies to potentially receive funding for more resources, education and training materials, and providing continuity in child maltreatment prevention efforts across multiple professions will further provide the opportunity to spread the net of support. Inconsistent measurement limits spreading the net through failing to demonstrate the importance of prevention and effectiveness of existing prevention services, and not gaining access to additional educational and training resources. Although measurement is a point of improvement for many agencies, several agencies have caught onto measuring increases in protective factors rather than trying to measure decreases in risk factors. This is mostly because risk factors such as income, neighborhood crime, single parenthood, high stress, and so on cannot always be controlled for. Participants agree that it is much easier to demonstrate how increasing protective factors contribute to maltreatment prevention rather than trying to prove that services are decreasing risk factors.

Research Question 2: Which core features are missing or need improvement to bridge the gap within these programs, if any?

This research question is addressed through the last identified subtheme of *providing a continuum of care*. Gaps in what core features are included in prevention program services are mostly attributed to the lack of resources to improve current services or in the lack of bridging one agency and other agencies together in order to work together to better complete the

continuum of care. Creating partnerships to offer a service that one agency is unable to provide due to potential factors of an agency not encompassing that service in their mission or not having the physical or financial resources to offer a particular service.

Providing a continuum of care. As noted previously, providers and research together have not found a 'catch-all' solution to preventing child maltreatment. Agencies have either attempted to provide a continuum of care to further prevention child maltreatment within their own agency, or provide one area on the continuum of care. The findings suggest that of the agencies that participated in the study, a majority of them only provide one or two elements on the continuum of care due to small capacities of the agency, lack of funding and resources to expand services, or not having an interest in providing services based on an agency's mission statement. The services provided by the agencies within the community can best be conceptualized through the micro, mezzo, and macro level systems. Some agencies only provide micro level services on the continuum while other agencies provide mezzo and macro level services. It was found that only one agency had the means and capacity to facilitate services across micro, mezzo, and macro levels on the continuum of care for child maltreatment prevention. For agencies that were unable to provide more than one level of care on the continuum within their organization, many had reached out to form partnerships with agencies who have the necessary resources to provide another piece of the continuum. For example, one agency may provide home visiting as part of their strategy to increase protective factors of emotional support and reduction of isolation, while another agency facilitates training within the community around how to better work with families who demonstrate having many risk factors associated with child maltreatment. Together, these two agencies would be able to provide multiple levels on the continuum of care and improve prevention efforts.

Some of the smaller organizations are recognizing where they fall short in helping families to increase protective factors and decrease risk factors that they are reaching out for support to get closer to meeting this goal through further completing the continuum of care for families. These smaller agencies recognize that they may not receive funding to expand their services, but instead, can form alliances with other agencies and even corresponding counties to provide these services without having to seek additional funding. Approaching services from a continuum of care standpoint is an innovative and adaptive way to address gaps in the services that are being offered within the community. Not all organizations are forming these partnerships or collaborations to create a more complete continuum of care services that are necessary to increase prevention of child maltreatment as determined through extensive research findings. Even though it seems clear that all agencies should be providing services that address all the risk factors that are impacting families by increasing protective factors, it is a huge ask of agencies to do this with limited resources and funding. Therefore, it would be more efficient and resourceful to shift towards a culture of creating partnerships or collaboratives to provide a continuum of services across agencies. This shift will foster an image of connection and support within the field of child maltreatment prevention.

In creating this collaborative partnership, there are some potential limitations to having the continuum of services spread out amongst several agencies with one drawback being the inconvenience of having to travel from one agency to the next. Another drawback is the potential need for a required position to facilitate and coordinate these partnerships which can be time-consuming and complicated due to many parties being involved. These are issues some agencies have considered or are starting to think about as they have set up contracts with counties, medical facilities, and other related organizations that could provide these outside services in-agency.

Based on the findings, the core features highlighted by the literature are being addressed within existing prevention services. However, there is a need to better link services to create a cohesive community that works together to approach a child maltreatment concerns from a preventative perspective. The gaps do not fall within the services being provided, but how the services are being provided. Engaging at-risk parents has been a constant challenge for decades as society has worked off the idea that child protective services (CPS) is the answer to ending child maltreatment. However, child maltreatment rates are still incredibly high and in the process of making CPS the go to intervention, a stigma has been created that working with families who are at-risk for child maltreatment is directly associated with children being removed from parents by way of CPS.

There is a needed shift in the way parents, community, and professionals think about reducing child maltreatment. Prevention agencies are already working on and utilizing strategies to build better relationships with at-risk families, communities, and other community organizations with the intention of maintaining engagement and bringing a positive light to prevention strategies unlike the negative image associated with current CPS intervention strategies. Respectfully, CPS does play an important role in the continuum of services provided regarding child maltreatment prevention but it should not be the primary method for addressing child maltreatment.

Continuing to expand the continuum of care within a big metropolitan community will provide the opportunity for services to more broadly impact families at-risk for child maltreatment because more circumstances and needs are being addressed and more exposure to protective factors will occur. An expansion in this manner will also promote a shift in how providers interact with families and project an image of support and collaboration: it is okay to ask for help and that they are not alone in this journey.

Research Question 3: How are at-risk families being referred or recruited to these child maltreatment prevention programs in light of the existing intervention methods of Child Protective Services (CPS)?

Participants were asked how they recruit families to their programs mainly because they are prevention based and there is no direct door leading them to these types of services in contrast to the intervention strategies of child protective services (CPS). One agency indicated that once a family enters the agency, they are required to abide by the policy created to reinforce a violence free environment. Several participants explained that recruitment takes place through word of mouth. Parents who have benefited from the agency's services share their insight with other families who then come and utilize the agency's services. In this regard, the net is being spread by parents utilizing and promoting the agency's services and benefits. The other method of recruitment highlighted by participants was referrals from other community agencies. This recruitment style fits with the theme of providing a continuum of care by recognizing that one agency may not be equipped to respond to a particular need but through making a referral to another agency, they can better respond to the need. This recruitment strategy also speaks to spreading the net by creating informal and formal partnerships with community agencies working to prevent child maltreatment.

Another referral source sometimes comes from CPS workers if they are knowledgeable of the prevention services within the community. Generally, CPS has their own workers to do safety planning and education with families. They do not always make referrals to other prevention services in the community. As mentioned previously, CPS has a specific protocol they follow once an incident of child maltreatment has been reported. If the incident meets certain criteria, a case is opened for investigation. From there, parenting classes, safety planning, home-visits, and other related services may be required for a family to demonstrate their capacity

to keep their children safe. At this point in time, contacting CPS is mandatory after learning about an incident of child maltreatment. The sequence of events after a case has been opened serves as somewhat of a temporary solution as CPS workers follow a family's case for a certain amount of time until it no longer meets criteria to be an open case. If the community made a shift towards prevention, community agencies, including CPS, could more readily make referrals to prevention programs that work with families long-term. Prevention services are designed to support families so that an incident of maltreatment does not occur or inhibits families from continuing on the path leading to risk of child maltreatment. Having CPS on the prevention side of the equation would definitely help towards making a huge culture shift in the way child maltreatment is addressed and potentially change the view of CPS for the better.

Limitations

The findings from this study contribute to the literature base as it provides an example of how agencies in a large community are putting research findings to use within the services provided to at-risk families for child maltreatment. It is exciting to learn that within the range of this study, all participating agencies are structuring their programs and services based on previous research findings that have shown to be helpful in preventing child maltreatment. Although the findings provided desired results regarding the researcher's questions, there are some limitations to the study's findings. The first limitation is that the results of this study cannot be generalizable to all agencies within the large metropolitan community where the sample was taken from. Only five agencies participated in the study, but while not all agencies within this metro area could not participate in the study, participating agencies did reference other community agencies that were either providing similar services or complementary services to add to the continuum of care. Additionally, participants referenced other agencies or counties as formal partners in the continued efforts to prevent child maltreatment which aligns with the

subtheme of spreading the net. Referencing other partners in the efforts to prevent child

maltreatment continues to support the idea that one agency cannot put an end to child

maltreatment, but if many agencies and communities work together, there is a greater likelihood

for progress to be made in reducing the rate of child maltreatment.

      Another limitation of the study was the methodology in which participant recruitment

took place. Snowball sampling was used for this study which was deemed by the Institutional

Review Board (IRB) as the most ethical methodology for this type of study to reduce coercion

and protect confidentiality. The sample was determined by professionals' voluntary response to

the researcher's recruitment posting. The researcher had little to no control over which

professionals would participate with the exception of one agency which was directly contacted

by the researcher with the use of an agency permission form signed by the agency and approved

by the IRB. This type of sampling limited the researcher from interviewing professionals from

desired agencies. Although the researcher was limited in this regard, the researcher was fortunate

in that participants unexpectedly represented a diverse range of settings in which child

maltreatment prevention services are being provided.

Implications for Social Work Practice

      Based on the findings of this study and previous research, several implications have been

developed. This study highlights the importance of understanding the protective and risk factors

associated with child maltreatment as well as how to address those factors through prevention

services. Understanding both the protective and risk factors for families at-risk for child

maltreatment is essential for creating prevention services that support families in what they need

to make changes in their lives. The existing services incorporate most if not all of the core

features supported by research for preventing child maltreatment. The gaps in services are more

so related to how services are delivered rather than what services are delivered mainly due to the stigma and judgment surrounding families who have been involved in child protective services.

      This stigma often inhibits parents from engaging in any type of prevention services. In this regard, implications for practice call on providers to work towards reducing the stigma through strategies of meeting parents where they are and creating a non-judgmental environment. Reducing the stigma is easier said than done but can be achieved through receiving specific education and training in how to better recognize the needs of at-risk populations for child maltreatment and how to better understand personal biases that serve as barriers to reducing a judgmental environment. Additional implications for practice include enforcing a shared responsibility for preventing child maltreatment. The shared responsibility includes professionals outside of the social work field such as medical providers, school providers, other mental health practitioners, and even parents. There is a need for providers to work together to create a common message that asking for help is a sign of strength as opposed to a sign of weakness. Collaboratively delivering the same message also requires the integration of training into continued education for those who do not typically have to facilitate difficult conversations regarding the consequences of child maltreatment or changing parenting practices. In creating the opportunity for professionals to become more comfortable in having these difficult conversations, the more likely these conversations will happen and the more parents will be receiving the same message from multiple providers.

      Finally, implications of the findings suggest that there is a need for better integration of prevention services into the community and how society addresses child maltreatment. One way of doing this is through incorporating the voices of those who are most affected in the creation and facilitation of prevention services. Prevention programs that are already providing this service have received positive feedback from the parents who participated and expressed desire

that they felt this strategy is beneficial for them in making changes. Similarly, these services empowered parents to teach other parents about the consequences of child maltreatment and what can be done to make improvements to their lifestyles and parenting in order to reduce the risk of child maltreatment.

Social workers advocate for their client's needs and empower them to make changes that will improve the well-being for the client and their family. Those who understand the factors that put children at risk for maltreatment, and caregivers at-risk for maltreating behaviors, will be better equipped to formulate prevention strategies. In combination with having a better understanding of the features that put families at-risk for child maltreatment, participation in training to gain the skills to reduce the stigma, learn the value of shared responsibility for the problem, and to better integrate prevention services into the community are all important steps in further reducing the rate of child maltreatment overall.

Appendix A: Consent Form

Consent Form
977191-1
Evaluating Child Maltreatment Prevention Programs & Services: A Qualitative Study

I invite you to participate in a research study assessing child maltreatment prevention programs and how they are related to reducing the rate of child maltreatment. I invite you to participate in this research. You were selected as an eligible possible participant because you are a human services professional within a child maltreatment prevention program in addition to having experience with at-risk families for child maltreatment. Please read this form and ask any questions you may have before agreeing to be in the study. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Laura Abrass, a graduate student at the School of Social Work, St. Catherine University-University of St. Thomas and supervised by Renee Hepperlen, PhD, LICSW. This study was approved by the Institutional Review Board at the University of St. Thomas.

Background Information
My research questions are: 1. Are child maltreatment prevention programs incorporating research-supported features to address protective and risk factors through the services they provide?, 2. Which core features are missing or need improvement to bridge the gap within these programs, if any?, and 3. How are at-risk families being referred or recruited to these child maltreatment prevention programs in light of the existing intervention methods of Child Protective Services (CPS)? The purpose of this study is to interview child maltreatment prevention program professionals in order to explore and asses the key components that are targeted for at-risk families of child maltreatment, how families are referred to these types of programs, and what models are used to create the foundation for these types of programs. This research will provide more information as to how existing child maltreatment prevention programs are structured, what they are address, and how they address it. This information will be helpful to bridge the literature on identifying the risk and protective factors associated with child maltreatment and how better serve at-risk families from a prevention standpoint.

Procedures
If you agree to be in this study, I will ask you to do the following things: Answer the provided questions as completely as possible in a brief informational interview about your roles in your position at this agency, about your experience working for a child maltreatment prevention program, and your knowledge about the program itself. The interview will occur at your place of employment and will take approximately 30-45 minutes of your time. The interview will be audio recorded in order for the researcher to accurately transcribe the data for analysis and presentation to complete their Master's Degree in social work. The interview data will also be reviewed by the researcher's research advisor to provide data reliability.
Risks and Benefits of Being in the Study
This study has little to no risk. A potential risk for this study is breach of confidentiality. The device in which the audio recordings are contained on could be compromised (stolen, lost, or

damaged), and or the computer that the data will be transcribed on could be compromised (stolen, lost, or damaged). To avoid a breach of confidentiality, all data will be stored in OneDrive. When the data is uploaded into OneDrive, it is automatically encrypted and requires a password to access the data. As soon as the data is uploaded into OneDrive, the data will be removed off of the researcher's computer and recording device.

The study has no direct benefits. There will be no monetary reward for completing this interview with the researcher, Laura Abrass.

Privacy

Your privacy will be protected while you participate in this study. No identifying information will be collected for data analysis. Identifying information will only be used for recruiting the participant. To provide privacy throughout the interview process, the interview will take place in a private office space with a door within the participant's place of employment.

Confidentiality

The records of this study will be kept confidential and only used for this study. In any sort of report I publish, I will not include information that will make it possible to identify you. As a university protocol, research records and audio recordings will be kept on a password-protected, online data storage tool on the researcher's computer. Upon printing the transcript of this interview to code the data, the researcher will keep the transcript in a locked cabinet when it is not being used for analysis. At any point in time, the researcher and the researcher's advisor will be the only individuals who have access to the data including identifying information. Findings from this interview will be presented, without identifying information, in a clinical presentation to the researcher's research committee and classmates in order to complete her Masters of Social Work Degree in May, 2017. The audio recording and transcript will be destroyed by June 15th, 2020. All signed consent forms will be kept for a minimum of three years upon completion of the study, and will be destroyed on June 15th, 2020. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw from the study, your data will not be used for this research study.

Contacts and Questions

My name is Laura Abrass. You may ask any questions you have now. If you have later questions, you may contact me at abra5122@stthomas.edu or Renee Hepperlen at hepp1989@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 with any questions or concerns.

Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this study.

You will be given a copy of this form to keep for your records.

_____   _____

Signature of Study Participant   **Date**

_____

Print Name of Study Participant

_____   _____

Signature of Researcher   **Date**

Appendix B:

Interview Guide for Child Maltreatment Prevention Program Professional

1. Tell me about the work you have done through this agency with child maltreatment prevention.

2. Tell me about your position and roles in this organization.

3. How are families referred to this program?

4. What services and programs does this organization provide in regards to child maltreatment/abuse prevention?

5. What problems or concerns do these services address?

6. Which strategies are used in the services offered here to target these problems?

7. In your experience working with at-risk families for child abuse, which strategies have demonstrated a reduction in maltreatment behaviors for families?

   a. How is this measured?

   b. Why is this factor measured over other factors?

8. Of these interventions or strategies, which are the most helpful to families in terms of reducing stress and likelihood of maltreatment behaviors?

   a. How is this measured?

9. How are these strategies derived? Are they grounded in theory, evidence-based practice, both?

10. What framework or model guides the services provided by this agency to prevent child maltreatment?

11. Why is this particular model used?

12. In what ways is this model effective?

   a. How do you measure effectiveness?

13. What adjustments or improvements would you make to the existing services within this agency to further prevent child maltreatment?

14. In what ways does this organization promote child maltreatment prevention within the agency, community, and families?

15. Are there other programs that work with families prior to being involved in the system?

16. Is there anything else you think would be important for me to know about the program or the work being done with child maltreatment prevention?

Appendix C: Field Notes

Interview: Medical Setting

- Interview took place in a closed office room. The office was dimly lit.
- The participant was focused on the interview with the exception of taking a personal call that she thought might be an emergency from a family member.
- The participant was new to their position within the agency and was a major player in the implementation of the program.
- The interview was lengthy; approximately 40 minutes.
- The participant spoke with excitement, passion, and extensive expertise on the problem, program, and what's to come in the future.

Interview: Medical Setting

- Interview took place in a closed conference room off of a common walkway/hallway.
- The participant was focused on the interview and did not take any phone calls or pages during our time together.
- The participant had been in her role for several years within the agency. She worked collaboratively with other related professionals to implement the program.
- The interview was approximately 30 minutes.
- The participant seemed self-conscious about her knowledge of the program and asked if she was saying the right things. She did know a lot about the agency and the program to satisfy the researcher's needs.
- The participant also spoke passionately about the program's participants' needs and means for success in the program.

Interview: Community Setting

- Interview took place in a closed office room. The office was dimly lit and the participant and researcher sat side by side. The participant was not feeling well and frequently stopped to use tissues.
- The participant had been with the agency for many years but had recently switched her role to focus more on community outreach and education.
- The interview was approximately 30 minutes.
- The participant spoke with much knowledge and passion for the topic and the role of the agency, community, and population facing the problem.

Interview: Community Setting

- Interview took place in a closed office room. The office was brightly lit and the participant and the researcher sat across from each other.
- The participant seemed to be rushed in the interview and not wanting to elaborate on answers. This could be partially because the participant was not directly involved in the program they spoke about, but rather oversaw multiple programs throughout the agency. The participant may have been too high up to be a good candidate for this research project.
- The interview was approximately 13 minutes.

- The participant spoke about the needs of the population and what they thought is one of the best strategies for the problem, but seemed to lack the same passion as the other participants. The research credits this to the rushed manner of the interview.
- The researcher felt like she was inconveniencing the participant even though they had agreed to do the interview. I think the participant was under the impression that it would be a 15 minute interview even though the researcher explained the interview would last between 30 and 45 minutes.

Interview: Community Setting

- Interview took place in a spacious closed office room. The office was lit by natural light from the windows.
- The participant sat across from the researcher separated by a table. The participant was not feeling well during the interview.
- The participant has been with the agency for many years and has just recently switched her role to focus more on outreach and preventative strategies.
- The participant was well versed in the research, strategies and community participation surrounding the topic matter. Participant provided researcher with some data collection materials and program information.
- Interview was lengthy and lasted approximately 40 minutes.

Appendix D: Thematic Guide

1. Are child maltreatment prevention programs incorporating research-supported features to address protective and risk factors through the services they provide?
2. Which core features are missing or need improvement to bridge the gap within these programs, if any?
3. How are at-risk families being referred or recruited to these child maltreatment prevention programs in light of the existing intervention methods of Child Protective Services (CPS)?

Primary Theme	Subthemes

1. Promoting a Culture Shift	1. Parent Empowerment
	   1. Parent Attributes
	      - Knowledge of parenting and child development
	      - Parent Self-Determination
	      - Parent Resiliency
	      - Parenting Skills
	   2. Provider Attributes
	      - Meeting clients where they are at
	      - Creating a Non-Judgmental Environment
	2. Spreading the Net
	      - Psychoeducation and Training
	      - Required Involvement of all Providers
	      - Provider Title Matters
	      - Measuring Services and Outcomes
	3. Providing a Continuum of Care
	   1. Micro Level
	   2. Mezzo Level
	   3. Macro Level

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