Engaging & Retaining Participants in the Healthy Families Program: Hope is an Essential Ingredient

By Craig LeCroy, Ph.D.

Many studies have reported variation in the effectiveness of Healthy Families programs. The results raise a fundamental question: Where studies have shown positive results what factors are likely to have created such conditions? Many experts will rightly argue over how they could answer this question but one factor likely to be discussed is hope. Hope has long been recognized as one, if not the, essential ingredient in helping people.

How can we better understand the role of hope in our work with families? Hope is often related to how people think about goals. What happens to people when they are overwhelmed with stress, negative emotions, and difficulties in coping? They are stuck, and can’t see a pathway or begin a process toward a desired goal. Research studies have confirmed two important findings related to this observation. First, people experience negative emotional responses when blocked from achieving their goals (See Brunstein, 1993; Snyder, 1994). Second, people experience positive emotional responses and maintain hopefulness when they are able to pursue their goals.

When people experience a “powerlessness to change” there is no determination to move toward goals. How can Healthy Families workers combat such powerlessness and instill hope in families? The work of Frank (1991) and Synder et al. (1999) suggest four ways:

1. Develop a positive and hopeful relationship with the family. Healthy Families workers must have confidence that their families can make positive changes. A helper’s hope enables people to change (Snyder et al., 1997).

2. Relay a positive expectation that families can and will make changes that improve their lives and their children’s lives. The families need to know that other similar families have successfully reached their goals.

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From the Editor:

This issue of *Building Bridges* is dedicated to issues of engagement and retention in the Healthy Families program. Why have these ideas of engagement and retention become so central to Healthy Families? In prevention we must figure out how to serve participants who will benefit from services. After we identify the right participants we also need to keep them involved long enough for the impact of our services to produce a meaningful result. If too many people drop out early without receiving the services then our impact is significantly reduced. Research continues to discover low retention and high dropout rates among families recruited into Healthy Families programs. Why do some families take advantage of the services offered and others fail to take full advantage? A common concern is that perhaps the families that need the services the most are the most likely not to engage in the program and to drop out of treatment prematurely. The articles in this issue attempt to shed some light on what research can tell us about these critical factors of program implementation. Together, we must continue to support all efforts at getting families involved in our program and do whatever we can to keep them involved. The success of our program depends on it! Happy reading!

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3. Help families understand that parenting is difficult and that they can learn new skills to make it less difficult. If families agree that all parents can benefit from support and new parenting skills, they will be more determined to accomplish goals related to parenting.

4. Practice and gain confidence in the parenting techniques that the Healthy Families program promotes. Healthy Family workers that have confidence in and mastery of chosen methods will enhance the family’s belief in their potential for change. Workers can model hopeful thinking through their confidence and mastery of the Healthy Families techniques they use.

If we can build hope, family improvement is more likely. In fact, research shows that a tremendous amount of family improvement occurs within the first 3-4 weeks of treatment (See Howard et al., 1993; Ilardi & Craighead, 1994). This is why obtaining early data is critical when evaluating the program! Synder et al., (1999) estimate that over half of all participant change occurs in the early stages of treatment. The very act of agreeing to be part of the Healthy Families program represents a notion of wanting to achieve a goal such as “being a better parent.” In summary, build hope and create engagement with the program. If we do this, our families will receive the greatest benefit they can from our efforts.

Sources:


Anyone familiar with the Healthy Families program has debated, discussed, and analyzed issues related to participant engagement and retention. What do we know about why some families stay in the program and other families drop out? What can be done to improve engagement and retention in the program? Healthy Families and other home visitation programs with similar goals are generally designed for a two to five-year period. Findings on attrition, however, suggest a lack of congruence between program design and the reality of participant attrition in many home visitation programs. For many years, program administrators have struggled with this issue and this is one of the reasons “engagement and retention” became a hot topic in the field. This article presents a brief review of some of the more recent studies to examine these questions.

An early study of Healthy Families in Indiana reported that the most common time period for parents to leave the program was between 60 and 90 days after enrollment, and by six months after enrollment, half of the program families had terminated (Myers-Walls, Elicker, Bandyk, 1998). This pattern of early attrition has been supported in other more recent studies as well. Daro, McCurdy, Falconnior & Stojanovic (2003) studied over 800 participants across 17 program sites and found the average participant enrolled in services for 14.8 months with a large variation in the time enrolled for services. Myers-Walls et al., found that prenatal families tended to leave earlier than those enrolled in the postnatal period. The most common reasons reported for leaving were moving, refusal of services including refusal of change in home visitor, and never fully engaging.

A nagging research question: Who leaves and why? Daro et al., 2003 noted participant mobility and inability to locate participants as two of the primary reasons accounting for early termination. Daro et al., also found that older participants, those unemployed or in school, and those who enrolled in the program early in their pregnancy were more likely to remain in services longer, and African American and Hispanic participants were more likely than Caucasian participants to remain. Other studies have also found higher dropout rates among younger participants (Mccurdy & Jones, 2000). The most recent study on participant attrition by McCurdy et al., 2006 suggests that lower infant birth weight and greater comfort with a home visitor in one’s home are significant predictors of maternal intentions to remain engaged with the program.

Considering worker characteristics, McCurdy et al., found that the optimal home visitor may not be one defined by worker characteristics, but the one whose background compliments the goals of the program and fits best with the participant group. At the program level, lower caseloads and greater success in matching participants and providers on parenting status and race were important predictors of participant longevity (McCurdy et al., 2006). McGuigan, Katzev, and Pratt (2003) found that retention improved when the home visitor received more hours of direct supervision. These authors also examined the community as a possible influence on attrition. They found that program attrition is greater in communities where community violence is higher.

Engagement and retention remain a concern for Healthy Families programs because prevention programs are often judged by the number of participants who are recruited and remain in the program. Many programs have addressed the earlier concern that families were not receiving the 2-5 years of services that the program was based on by retooling their programs so that the biggest impact from the program can be realized within the first 6 months and there is some evidence to support this notion. Furthermore, many programs now state that services are available for up to 5 years but that the program model doesn’t expect all of the participants to remain in the program for that long.

Sources:


Improving Parent Recruitment and Retention

By Judy Krysik, Ph.D.

If voluntary parenting programs such as Healthy Families are to have a widespread and positive impact, then it is necessary that they attract and retain diverse groups of parents. Recruitment and retention issues have been demonstrated to be especially problematic when targeting populations exposed to multiple risk factors, e.g., low-income, low levels of education, and problem behaviors such as substance abuse (Catalano et al., 1993). This article presents 8 principles to consider when strategizing how to improve parent recruitment and retention, and also addresses the context of participation.

#1. Motivation – Motivation to change behavior implies both a personal desire to change and a stage of readiness. Many individuals who enter programs such as Healthy Families that are designed to promote change are motivated by external rather than internal forces. For example, external pressure may come from the family, school, the child welfare system, or even from someone such as a Family Assessment Worker or nurse who is perceived as an authority figure. Thus, early commitment to personal change may be lacking. Voluntary prevention programs, however, are generally designed for those who are internally motivated and may be inappropriate for those who are ambivalent about change (Prochaska et al., 1992). This lack of fit between the program and the participant who is not internally motivated can result in failure to engage and early dropout. Reid & Hanrahan (1982) emphasized that motivational congruence, the fit between participant’s motivation and the services that practitioners attempt to provide, can be enhanced by emphasizing participant choice whenever possible, informing participants about what to expect and their role in the program, contracting around the participant’s goals and intervention procedures, and fostering participation throughout the process.

#2 Self-efficacy - It is important to pay attention to the verbal messages a potential participant offers. What he or she says reflects not only his or her desire to act, but also the belief of whether or not he or she is able to act. When it comes to determining commitment, perceived ability weighs approximately three times more heavily than desire. This principle suggests the need to increase the focus on the participant’s perceived ability, rather than their desire to change. This implies that the home visitor should emphasize statements such as, “I know you can …,” rather than “I know you want to …”

#3 Avoiding confrontation - If a participant is, for instance, committed to an addictive lifestyle, dissonant information from the family assessment worker or home visitor has a poor likelihood of changing the individual’s attitude and may actually induce defensiveness. Thus, the worker should gauge the participant’s attitude and determine the usefulness of providing information. For example, a confrontational or demanding approach that pressers for a higher level of commitment than the person is able or willing to make may result in the person misrepresenting the truth to appease the worker, or withdrawing from making any form of commitment. At times it may be better to acknowledge that contact may not be right at this time, and a later call or letter may induce a different response.

#4. Behavioral economics – This principle suggests that the perception of program effectiveness is important. For instance, if a potential participant feels that the effectiveness of the program is more certain, he or she is more likely to participate. Second, to the extent that the program initially focuses on other goals than those that motivated the individual to participate, the program may fail to meet the expectations of the participant and fail to attract or engage him or her. The perception that there is some value in the program for the participant is important from the first impression.

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5. **Resistance** – Resistance is considered a normal and functional response to the process of self-exploration and change that can be fearful and painful (Milgram & Rubin, 1992). Resistance to a prevention program can take many forms, e.g., anger, denial, superficial compliance, testing the limits by missing sessions, not being ready, silence, externalization of the problem, and devaluation of the home visitor. Resistance is especially strong among substance users for several reasons (Milgram & Rubin, 1992). One of the major reasons to abuse drugs or alcohol is to gain momentary comfort and reduce pain. Second, withdrawal from alcohol and drugs can cause addicts to become physically ill. Third, sense of self may center on drug use and fear of rejection may occur among others who do not use drugs. Resistance should be expected, recognized in its different forms, and the home visitor should receive assistance on how to counteract it.

6. **Reciprocity** - According to sociologists and anthropologists, one of the most widespread and basic norms of human culture is embodied in the rule of reciprocity. The rule of reciprocation says that we should try to repay, in kind, what another person has provided us. Cialdini, a social psychologist, reports that the reciprocation principle is so strong that it matters little whether or not the gift was requested or even valued by the receiver. Providing a gift, favor, or incentive before a request to participate can improve compliance. Appropriate gifts for home visitation could include a child’s book or diapers. Incentives can also be non-monetary such as a list of helpful phone numbers for local area resources.

7. **Social proof** – To an extent we determine what is correct by finding out what other people think is correct. Behavior is viewed as correct in a given situation to the degree others are observed performing it. This principle works best in a context of uncertainty, when the situation is unclear or ambiguous such as in deciding to participate in a program one knows little about. It also works best when observing the behavior of people considered similar as one is more likely to follow the lead of a similar individual than a dissimilar one. Application of this principle to home visitation could include endorsements of the program by current or former participants.

8. **Liking** - People prefer to say yes to individuals they like. One feature that influences liking is similarity; we like people who we perceive to be similar to ourselves. A second feature is praise, therefore, compliments generally enhance liking and thereby compliance. Third, increased familiarity through repeated contacts normally facilitates liking, especially when the contact takes place under positive rather than negative circumstances. A fourth factor is association, by connecting self or product with positive things and disassociating with the unfavorable, liking is increased through the process of association. This implies that family assessment workers and home visitors should be likeable to the participants, the participants should be able to identify with them, and they should use a strength-based approach and positive reinforcement.
Worker Retention is Key in Family Retention

By Judy Kryslak, Ph.D.

The review article on participant attrition in this issue points out that the reason some families give for ending their involvement in home visitation services is a change in the home visitor. In Healthy Families Arizona, 81 families terminated services between January 2003 and June 2006 because they refused to change home visitors. A qualitative study that involved semi-structured interviews with 16 current and former participants provides some insight into the meaning of the home visitor/participant relationship from the perspective of the participant. This study was conducted by LeCroy & Milligan Associates, Inc. in 2005.

Aside from the help they received, participants reported that the home visitors were one of the major strengths of Healthy Families Arizona and a primary reason they remained involved. Although the services including developmental assessments, parenting information, emotional and economic support reportedly helped induce initial interest in the program; it was the relationships with the home visitors that often influenced participants’ to continue in the program. Participants generally reported the perception that their home visitors were “nice,” “supportive,” and “caring.”

Despite the friendly, respectful characteristics of the home visitors in general, many mothers discussed the difficult process of building relationships and the difficulties when they experienced more than one home visitor throughout their involvement with HFAz. For instance, one mother responded: “There was some inconsistency among the family workers. I think there is such a high turnover and it impacts our relationship. We’ve had a couple and it’s hard to rebuild relationships and feel comfortable again. It takes time. And then they seem to leave.”

Many of the 16 mothers interviewed echoed their concern over the turnover among home visitors. Five of the 16 participants interviewed had experienced between three and six home visitors. These women mentioned that the turnover created problems for them since it produced the need to readjust to a new relationship and get comfortable again. For instance, one mother indicated she had “several workers quit so I had trouble adjusting to each one. I’ve had this one for a while now so I’m more comfortable with her.” Similarly, three mothers felt there was a little “setback” when they had a new home visitor. For instance, “It seemed like we started all over again. She didn’t know where we left off or what I had shared, so we basically started over.”

The 16 participants interviewed had a strong commitment to HFAz. The participants initially grew interested in HFAz as a result of the informational services and support the program provided, but they expressed continued participation in the program largely as a result of their relationships with their home visitor. These relationships are perceived as helpful and significant in achieving successful program effects. This suggests that program administrators need to attend to obstacles to retain home visitors. It also suggests more attention to managing transitions when worker change is imminent.
The Healthy Families Longitudinal Study is a 5-year, randomized control study in Pima County designed to examine the effectiveness and long-term impact of the post-natal component of the Healthy Families Arizona program. Upon consent, participants are randomly assigned to one of two groups, a control group or an experimental group. The experimental group consists of 95 new mothers who have engaged with Healthy Families. The control group also consists of 95 new mothers who have no involvement with Healthy Families. Control group families are screened to make sure they fit the enrollment requirements of Healthy Families. A major aspect of the study is to examine a wide range of outcomes including child and maternal health, lifestyle behaviors, stressors, etc., and to see how these outcomes change over time and how they are impacted by participation in Healthy Families.

Retention Efforts

There are two important efforts occurring with this study that are key to retention. The first is removing all possible barriers to keep in contact with participants. The second is establishing a positive relationship between the research assistants and the participants. These efforts are crucial because the longitudinal study requires a long-term commitment, seven one-hour visits over a period of five years, it asks sensitive questions, and data collection usually occurs in the participant’s home. The research assistants have been challenged by maintaining contact with the participants and not losing contact before their next scheduled visit. The following data collected at baseline has been extremely helpful in maintaining contact with the participants:

- Current contact information (address, phone, cell phone, alternative phone, e-mail)
- Partner’s contact information (boyfriend, father of baby, or husband)
- Any plans to move in the next 6 months and any information they have about their new address
- Employment and/or school information
- Contact information for two people we could contact in case we cannot reach them.

All of these sources of information have been utilized in contacting participants to schedule the next visit if their primary information has changed and contact failed. This information is updated at each visit.

Additionally, because the participants are asked to commit to a five-year study and to share a lot about themselves, it is important to reciprocate by providing some incentives for participating in the study. The participants have been very pleased with the incentives and most make comments that the one-hour they spend with the research assistants is well worth their time, especially with the incentives. These incentives include:

- Information about local resources for basic needs, child care, domestic violence, Arizona Early Intervention Program, etc. as requested
- The control group is administered the Ages and Stages Questionnaire at 6 months and at each birthday until age 5 to identify the possibility of developmental delays and a referral to a local service provider is given if requested
- Small monetary incentives are given at each visit that increase over the duration of the study
- Monetary incentives are given if the participant provides any change of contact information (to date, 42 of these incentives have been provided)
- Four cash drawings are held throughout the 5 years for participants who remain active in the study.

Most important to establishing a positive relationship with the participants is making sure they have ongoing and frequent contact with the same Research Assistant throughout the study. To date, the two Research Assistants that started with the study are still onboard and are continuing visits with the participants they recruited from the beginning. Additional retention efforts that help with establishing a positive relationship include:

- Providing a self-addressed stamped postcard at the 1st visit for the mothers to send in if their contact information changes
- Providing a magnet and business card with contact information for the Research Assistants, including a 1-800 number, e-mail address, and mailing address
- Sending thank you cards following each visit
- Sending birthday cards for the mother and the child
- Sending reminder letters to participants about the next visit that emphasize the importance of their continued participation
- Reminder phone calls before each visit
- Being available to the participants throughout the study if assistance is needed.

We have found that a little effort can go a long way when it comes to keeping in touch with families and establishing a relationship where the families look forward to each visit and want to stay in the study. Many of the retention strategies used in the longitudinal study could also be considered by Healthy Families.
Healthy Families America Implementation Study

- On average, about half of families remain in the program for at least one year, though some sites retained a higher percent of families for one year or longer.
- Older sites and those with high staff retention had higher family retention, though the difference was small.
- Older sites show significantly higher retention than newer sites at 12 and 24 months.
- Mothers who are older and have fewer risk factors, but less formal education, tended to stay in the program longer.
- Years of education was significantly related to retention.
- Married mothers had higher retention than single mothers.
- Retention was higher when the home visitor was older than the mother.
- Family retention was greater when mothers and FSWs were of the same race/ethnicity. Retention among moms of the same race/ethnicity as the FSW averaged 10.2 months.
- At the 3 month retention marker only, sites serving predominately Latino families showed higher retention.
- Sites with greater retention of FSWs for at least 24 months were associated with higher family retention from 3 to 24 months.


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Child Development For Children 5-10 Years of Age

Spring 2007
Working With Teen Mothers

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