Engagement and Retention in Home Visiting Programs

Healthy Families Florida

The Technical Report

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Table of Contents

List of Figures

List of Tables

Chapter I
Introduction and Justification for Looking at Healthy Families Florida Participant Engagement and Retention

An effective voluntary long-term program that provides home visits and other services to prevent child abuse and neglect must be able to engage and retain families. Yet, as is true for other types of home visitation programs with a variety of intended outcomes, such programs struggle to engage and retain participants to the degree specified by the program design (Gomby, Culross, & Behrman, 1999; Sharp, Ispa, Thornburg, & Lane, 2003). If families do not receive services at the intensity and duration intended by the program model, the program may face increased difficulty in achieving its intended outcomes.

In most of the relevant research literature, engagement of families is conceptualized as occurring in three major phases. Engagement in the initial phase of program involvement ensures that an assessment to determine program eligibility can be conducted. Initial engagement of the family leads to actual enrollment in the program. Ongoing engagement or the retention of families during services through completion must be successful as well. In Gomby et al. (1999), programs find that 10 percent to 25 percent of the families eligible for the program and invited to participate do not enroll (p. 16). Participants leaving the program prior to completion has also been identified as a shortcoming in home visiting programs with the percentage of families not completing some programs as high as 67 percent (Gomby et al., p. 16). Participant enrollment and retention can vary widely for the same program across sites with different administering agencies. To illustrate this variation, the percent of families leaving the program during a year has been as high as 64 percent at one site and as low as 38 percent at another (Gomby et al., p. 17).

Also noteworthy, the growing need to develop a better understanding of engagement and retention has been linked by some researchers to the emergence of more "structured" service delivery models and programs, such as those adhering to the Healthy Families America model or the Nurse Family Partnership program (Daro, McCurdy, Falconnier & Stojanovic, 2003).

Interest in improving the retention of participants in Healthy Families Florida (HFF) was evident early in the implementation of the program and has been ongoing. An initial example of this interest was an HFF Quality Improvement Committee that convened in the fall of 2002 to discuss and develop "best practices" for improving retention and engagement. This was followed by a study conducted by Williams, Stern & Associates in 2003 on participants who leave the program before completion. Findings based on this study identified factors that were related to shorter stays in the program.

More recently, even with the success of Healthy Families Florida in preventing child abuse and neglect documented in the HFF Five-year Evaluation Report (Williams, Stern & Associates, 2005), the program is still faced with the need to improve the retention of participants. In the HFF Five-year Evaluation, two methods for calculating retention were used with one calculating higher rates than the other. For the more recently served families, 3 month retention rates of families ranged from 77 percent to 89 percent. At 6 months, retention rates ranged from 63 percent to 72 percent and at 12 months, retention was 45 percent to 50 percent. These percentages are similar to those calculated by Healthy Families America in an analysis of data from program sites throughout the country (Harding, Reid, Oshana & Holton, 2004). Based

on an analysis completed by Healthy Families America, around half of the families enrolled in the program do not remain with the program beyond one year (Harding et al., p. 18-20).

Recognizing the need for more information on engagement and retention over the past two decades, theoretical models have been developed and ambitious analyses of the factors related to engagement and retention have been conducted. These theoretical models and the related analyses have taken us a step further. However, some recent results have been mixed or inconsistent with theoretical assumptions. Findings have also varied across analyses. Some of these inconsistencies raise additional questions and may present additional hurdles in attempts to respond programmatically.

There are also special challenges that make ongoing study of engagement and retention in home visiting programs designed to prevent child abuse and neglect necessary but difficult. Participants in Healthy Families Florida are generally lower income and all are at high risk of abuse and neglect. The needs of the participants are often numerous and complex. Variations across projects in the implementation of the program also exist and need to be accounted for in analyses. Examples of these variations include the timing of the assessments to determine program eligibility and the type of lead entity. Several key factors identified in previous research and included in analyses of recent participants can help solidify the identification of factors that are the most important. In addition, introducing new factors that are considered important but have not been tested previously can further enhance understanding of this challenge. Better understanding of engagement and retention through these statistical analyses can lead to better program performance.

In this report, a comprehensive review of research on engagement and retention in home visiting programs designed to prevent child abuse and neglect is presented. The report includes the following sections:

- Review of important components in theoretical models that explain engagement and retention in home visiting programs that have the prevention of child abuse and neglect as a major goal
- Presentation of findings in previous relevant research on engagement and retention in these programs
- Calculation of retention rates for Healthy Families Florida families and analysis of relationships between explanatory factors and retention among families enrolled during 2003-2004
- Review and analysis of Healthy Families Florida families who closed from December 2005 through March 2006
- Presentation of results from a mail survey of Healthy Families Florida participants who closed due to “Not Interested” or “Other” reasons
- Discussion of research that tapped expertise at the Healthy Families Florida project level on reasons families do not engage or remain in the program and tips for engaging families and keeping them in the program
- Summary of each chapter in the report, presentation of the major observations based on the findings in previous and current research and presentation of recommendations for program improvement in engaging and retaining families based on these findings

Chapter II
Review of National Research on Engagement and Retention of Families

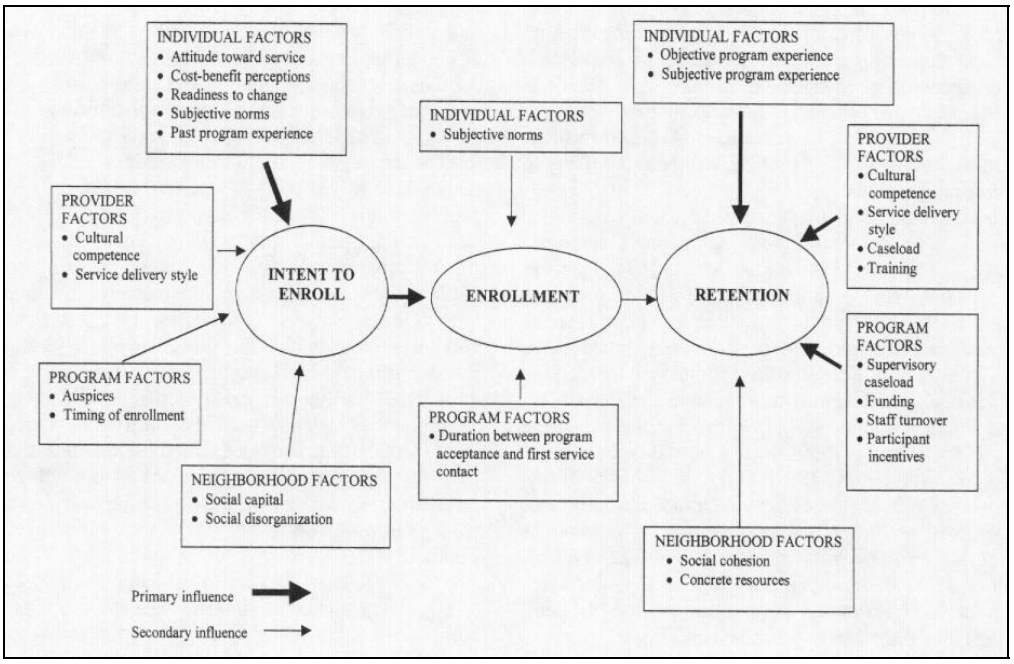
A review of past research is essential in order to provide the appropriate context through which to understand the current research on Healthy Families Florida (HFF) introduced in this study. Based on the number of studies and large number of possible factors included in theoretical models and tested in analyses, previous research on engagement and retention in home visiting programs with the goal to prevent child abuse and neglect has been comprehensive. The relationships of interest have been numerous and complex which has added to the challenges in this research.

The major theoretical models and the domains or categories in the models explaining engagement and retention in home visiting programs are discussed in this chapter first. The rationales and assumptions supporting the anticipated relationships between the factors in each of these theoretical domains with engagement or retention are explained. Next, previous analyses that tested these theoretical assumptions are presented. The results generated from these analyses are covered with similarities and differences in the findings highlighted. The chapter ends with a discussion of several key findings in previous research and a comprehensive list of the major studies and findings.

Theoretical Models and Considerations: Participant Engagement and Retention

Research on engagement and retention in home visiting programs with the goal to prevent child abuse and neglect has been comprehensive based on the large number of possible factors considered. Much of the recent research has as its platform a theory of parent involvement in support programs. McCurdy and Daro (2001) developed one theory called the integrated theory of parent involvement. The integrated theory encompasses four domains: 1) individual characteristics, 2) provider attributes, 3) program characteristics and 4) neighborhood or community context. This model attempts to explain enrollment, retention and what the authors identify as an "antecedent" outcome, the "intent to engage" in the behavior. Distinct from expressing support for the program, the intent to engage in the program or utilize the program is identified as a stronger predictor of actual use of the service. The major domains of the models and how the factors are related to each outcome are discussed below. The comprehensive or integrated model presented in McCurdy and Daro (2001) appears in Figure 1.

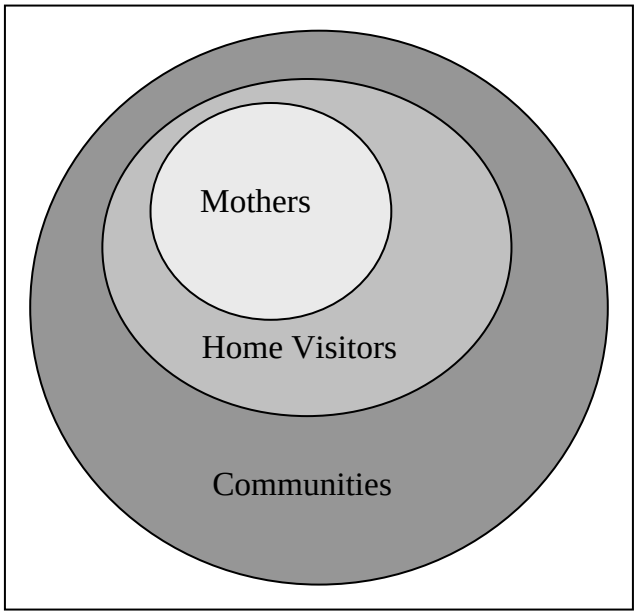
Figure 1: Conceptual Model of Parent Involvement



Source: McCurdy & Daro, 2001, p. 115.

Another model explaining retention was developed and presented in McGuigan, Katzev and Pratt (2003). In this report, the model appears in Figure 2. While appearing more parsimonious, this model has some similarities to the integrated theory of McCurdy and Daro (2001). It categorizes attributes related to retention as 1) attributes of communities, 2) attributes of home visitors and 3) maternal attributes. These three categories of attributes are also represented in the McCurdy and Daro (2001) integrated theory of parental involvement.

Figure 2: Ecological Model of Mothers, Home Visitors and Communities



Source: McGuigan, Katzev, & Pratt, 2003, p. 367.

Each of the theoretical domains in the research literature on engagement and retention in home visiting programs are discussed in the following paragraphs.

Individual Domain

Individual factors important in predicting enrollment and retention can refer to a broad range of characteristics from demographic to psychosocial factors. In McGuigan, Katzev and Pratt (2001), ethnicity, education, marital status and infant health risk were identified as maternal attributes related to retention. In the McCurdy and Daro (2001) integrated theory, individual factors cover internal beliefs, attitudes and perceptions. For predicting intent to enroll, perceived risk is one of the constructs developed among the individual factors in the integrated theory. If the individual perceives that there is a risk to the infant or the parent or both, the attitude toward the service is likely to be positive. Infant health risk was also identified as an attribute related to program retention in McGuigan, Katzev and Pratt (2001). The costs and benefits of a service are also posited as important in decision making and guiding one's behavior to participate. If there is a perception of little benefit from a service, then individuals are less likely to participate. A third construct in this set of factors is the readiness of the individual to change and accept the service. The subjective norms in one's reference group are also identified as possible determinants of participation in a program. The support or acceptance of friends or family members can be important in one's decision to enroll in a program. A final construct is the individual's previous experience with a similar service or program. If there was a positive experience in a previous program, then the individual is more likely to be receptive to the new program.

In the McCurdy and Daro (2001) integrated model, the intent to enroll is directly related to the actual enrollment. In addition, another individual factor emerges as a determinant of actual enrollment. This factor refers to subjective norms or the support of the program by another family member or a partner. This factor could be more important for programs in which a provider actually enters the home to visit with the family participant.

Individual characteristics related to retention emphasize subjective beliefs or judgments. If the participant's experience is stable with "predictable service delivery," the participant receives tangible benefits such as food or clothing, or enrolls prenatally; retention in the program should be more likely. The participant's subjective beliefs that are suggested as impacts on retention include the match between program and personal goals, providers meeting the participant expectations, services being consistent with the participant's expectations and personal benefits outweighing costs.

Other individual characteristics that should be included in theoretical models explaining engagement and retention refer to several risks or concerns that could not only affect a family's desire to be in the program but also how effective the program is with that family. These primary risks or concerns refer to substance abuse, domestic violence and mental health. These are concerns that are often identified in assessment tools used to determine the eligibility of individuals and their needs in programs.

A theoretical model that emphasizes personality and the quality of the relationship between the home visitor and the participant was unveiled in Sharp, Ispa, Thornburg and Lane (2003). This model proposed that personalities with more "positive emotionality" would be associated with more positive relationship quality. As an additional benefit, it was proposed that these two factors would be related to more time spent in home visits.

Provider Domain

In this review of the research literature, provider factors in home visiting programs typically refer to characteristics of home visitors and personal interaction with the family. In McGuigan, Katzev and Pratt (2003), provider factors include age, race, gender, educational attainment, prior experience on the job, hours of individual supervision and interpersonal skills with emphasis on the ability to adopt other viewpoints and ability to show empathy with others. Provider factors that are considered important in predicting the intent to enroll focus on the interaction of the home visitor and the participant. Two factors that have been identified as important in previous research are the cultural competence of the home visitor and service delivery style (McCurdy & Daro, 2001, p. 116). Communication style could also be included among the provider factors. As predictors of retention, cultural competence and service delivery style are also important in the integrated theory. Other factors related to retention include provider caseloads and comprehensive training for providers. Smaller caseloads are believed to allow more time for each family and better relationships with those families. The impact should be positive on retaining families. Comprehensive training for providers should cover several topics and prepare the providers to assist families in diverse living environments. Training is also important in addressing the strengths and weaknesses of paraprofessionals compared to professionals. While paraprofessionals are considered strong in areas of cultural competence and service delivery style, expertise in health or mental health issues might be acquired sufficiently through training (Duggan, Windham, McFarlane, Fuddy, Rohde, Buchbinder, & Sia, 2000, p. 257).

Although participant retention was not the primary topic of interest, Wasik (1993) discusses the importance of hiring home visitors who possess the necessary traits to help home visiting programs achieve their goals. Wasik explains that the shift from child and individually focused services to family and family systems focused services calls for more skills and responsibility on the part of the home visitor. Wasik cites an individual's initial level of interpersonal and communication skills as one of the most important criteria to consider during the hiring process. These skills are difficult to teach and improve with training but are necessary for the development of relationships between home visitors and clients that can foster change. Other important skills include an ability to assess and meet the needs of diverse families, strong clinical skills, knowledge of family and child functioning, maturity, good judgment, flexibility and the ability to work as a team member. Wasik suggests that a home visitor coming from the same community as a participant can encourage the development of a trusting relationship. Rather than matching home visitor and participant on race, she suggests hiring staff who have demonstrated a respect for the values and beliefs of people from a variety of cultures and the ability to respond to others with sensitivity. Suggested means of assessing an applicant's experience with and sensitivity to cultural diversity include a review of prior job experiences, use of rating forms or role-playing during the interview.

Program Domain

Several program attributes have also been identified as predictive of participant intent to enroll, actual enrollment and retention. Intent to enroll has been affected by the association of the program with child welfare public agencies or other public social services and is believed to have a negative impact on enrollment (McCurdy & Daro, 2001, p. 116). Prenatal enrollment or initiation of service during pregnancy is another program attribute that has been identified as a factor that influences decisions to enroll. One of the reasons for the identification of this

attribute as important is the willingness of the pregnant woman to obtain advice about parenting before giving birth. In predicting actual enrollment, an additional factor that is identified and labeled intervening is the time between enrollment and the receipt of services (McCurdy & Daro, 2001, p. 117) The longer the length of time between the family's intent to enroll and actual enrollment, the more likely the participant will acquire other information that will affect actual enrollment. A long length of time between assessment and enrollment could weaken the connection between intent to enroll expressed at assessment and the actual enrollment. Another program factor considered important in affecting retention is the match between the participant and the home visitor on race or parenting status (McCurdy, Gannon & Daro, 2003). Program factors that are considered predictive of retention refer to low supervisory caseloads, stable funding, low staff turnover and tangible incentives (McCurdy & Daro, 2001, p. 117).

Neighborhood or Community Domain

The final category of factors in theoretical models explaining engagement and retention is neighborhood or community factors. In the integrated theory proposed by McCurdy and Daro (2001), resources available in the neighborhood or community and whether the individual or family has the knowledge or ability to access these will impact decisions to enroll in a program. The presence of more resources can have more than one direction of impact. The availability of other community resources can reduce the need for enrollment in one program. A positive impact on enrollment can be due to the family's comfort with early intervention making them more open to participation in a program. Other neighborhood or community factors are broadly referred to as "social disorganization" with the presence of crime and poverty having a negative impact on enrollment in a social program. Neighborhoods and communities that have a "high degree of social cohesion" should foster higher retention rates in social programs. Another neighborhood or community factor posited to be related to program retention is the availability of concrete resources that make it possible for the family to leave the program or the absence of resources that make it necessary for the family to leave the neighborhood and drop out of the program. The importance of community factors was also recognized in McGuigan, Katzev and Pratt (2003) which asserted that high levels of violence and crime or distress in a community result in lower enrollment and retention in a program.

A summary of the factors in the integrated theory of parental involvement explained in McCurdy and Daro, 2001 was also presented in Daro, McCurdy and Nelson (2005). In the 2005 summary, the authors suggest that their earlier review of the relevant research indicated that:

1. A new parent's intent to enroll in services is primarily a function of the readiness to change, attitude toward seeking help and prior service experiences.
2. Program retention is influenced by a range of factors, including:
    a. Objective experiences: Participants will stay in a program longer if services are provided on a regular basis, if they receive incentives (or have concrete needs met), if they have a consistent provider and if the program delivers what it claims or promises to provide.
    b. Subjective experiences: Participants stay longer if they like their home visitor and feel "connected" to the provider and comfortable in the program.
    c. Provider characteristics: Participants will remain when service providers are competent, well trained and experienced in presenting the material.

d. Program characteristics: Programs adhering to best practice standards and demonstrating a respect for local cultural norms and customs will retain a higher proportion of their participants.

e. Community characteristics: Families living in communities that are more chaotic may be less likely to access and remain in voluntary support programs for an extended time period. (Daro, McCurdy & Nelson, 2005, p. 2)

Findings in Previous Analyses of Engagement and Retention

Consistent with the integrated theory of Daro and McCurdy (2001), the model developed by McGuigan, Katzev and Pratt (2003), as well as other theoretical assumptions discussed above, explaining and predicting engagement and retention must include:

- Participant characteristics
- Provider characteristics
- Program experience
- Community/neighborhood characteristics

These multiple categories or layers of factors are considered more informative than explanations based on single factors and a closer fit to the experience of participants while being served. This subsection highlights some of the major findings on engagement and retention of participants in home visiting programs based on previous research. These findings are then summarized and used as a platform for the subsequent analysis of engagement and retention in Healthy Families Florida.

Daro, McCurdy and Nelson (2005) present the findings for two analyses of engagement and retention in programs adhering to the Healthy Families America model. An analysis of a retrospective sample of 815 participants who enrolled in 17 HFA programs between June 1995 and June 1997 is the first set of results presented (Daro, McCurdy, Falconnier & Stojanovic, 2003). Hierarchical linear modeling (HLM) allows measurement of the impacts of several different layers of factors and a determination of which layers explain the most variation in a dependent variable. The two dependent variables used in the analysis were the length of time the participant was enrolled and the number of completed home visits (Daro et al., 2003, p. 1115). In the analysis presented in Daro et al. (2003), the provider and program level factors or levels in the models used in the analysis were much more successful at explaining variance in the dependent variables compared to the participant level variables. The statistical significance of each of the predictor factors in each model was identified as well. These findings (fixed effects only) are listed below by category:

1. **Participant level**: Older, unemployed and those who enrolled early in their pregnancy were more likely to be in services longer and have a higher number of home visits. Current school enrollment was a predictor for time in services but not number of home visits. Referring to race, Hispanic and African American participants were more likely to remain in the program longer and African American participants were more likely to receive a higher number of home visits (Daro et al., 2003, p. 1115).
2. **Provider level:** Home visitor's age (younger) was related to longer length of service and higher number of home visits. African American home visitors were more likely to

retain participants longer. Prior experience of the home visitor was also related to number of home visits (Daro et al., 2003, p. 1115).

3. **Program level:** Average caseload was significantly related to number of home visits. Matching home visitors and participants on parenting status, race or ethnicity were more likely to retain participants in the program longer and complete a higher number of home visits (Daro et al., 2003, p. 1115).

While the significant findings support some of the theoretical assumptions, not all of the relationships proposed in theory were confirmed in the analyses. The absence of several significant findings is also of interest with no significant relationship between risk score based on the Kempe Family Stress Checklist and both dependent variables being particularly noteworthy. Figures 1 and 2 in Appendix II list all of the significant predictors in the service duration and service dosage models. Table 1 in Appendix II presents those factors tested in the models that were not significant.

In another attempt to test additional factors in the "integrated theory of parental involvement," a second analysis was conducted and presented in Daro, McCurdy and Nelson (2005). This analysis used a prospective sample of 343 parents served in nine HFA programs and occurred between January 2001 and March 2002 (Daro, McCurdy, & Nelson, 2005, p. 6). In this analysis, the dependent variables were retention at 3 months, 6 months and 12 months. The predictor variables were divided into four categories:

- **Socioeconomic Characteristics**: SES scale and race
- **Presenting Problems/Concerns**: infant risk, informal support and number of concerns
- **Program Experiences**: Support for the program in the participant's informal network, the participant's perception of the program changing them, receiving tangible benefits from the program, participant's judgment of their relationship with the home visitor and the participant's perception of whether the home visitor encouraged them to use informal support and other community resources
- **Community Context**: Community distress scale, disorganization within the participant's census block group, ratio between the number of individuals in need of care and those able to provide care within the census block group and the extent to which the participant used other local service programs previously

Comparing the results from the logistic regression analysis of retention at 3, 6 and 12 months, there were more significant predictors for the 6 and 12 month retention. For 3 month retention, infant risk was the only significant predictor. Infant risk was identified if the infant was born prematurely, not held after birth, had a low birth weight or was placed in a special nursery after birth. If the infant was high risk based on at least one of several indicators, the parent was more likely to be retained in the program at 3 months. At 6 months, infant risk remained significant and other predictors emerged as significant in the analysis. The additional predictors included level of social support, the attitudes of others close to the participant regarding the service and the community context. More specifically, if the participant's personal network supported their participation, they were more likely to be retained. Countering this was the finding that the more the participant relied on "informal support"; the less likely they were to remain in the program. A higher level of community distress was related to retention in the program at 6 months.

At one year, the predictors of retention in the logistic regression analysis changed. The strongest predictor of retention at one year was the participant's "subjective assessment" of the program's impact on their life. If the participant felt that the program changed their life, provided useful information or changed the way they cared for their child, they were more likely to continue in the program. Community context continued as an important predictor with increases in community distress resulting in higher statistical odds of remaining in the program.

Hierarchical linear modeling was also used to analyze relationships between predictors and 12 month retention as well as number of home visits completed. Once again, there were multiple levels of variables included, participant and provider in one test. Consistent with the logistic regression analysis, the significant predictors were the participant's belief in the program's impact and residing in a distressed community. At the provider level, the race of the provider and the service delivery style were significant predictors. Participants with African American providers (home visitors) were less likely to remain in the program. A more engaging and personal service delivery style on the part of the provider led to higher retention. This delivery style was described as one in which the home visitor attempted to establish a friendship with the participant, expressed concern for the participant and made attempts to see the participant in addition to the times scheduled for home visits.

When analyzing predictors for dosage or the number of home visits completed, the significant predictors were the following:

1. **Race**: African American participants received fewer home visits than White participants.
2. **Infant risk**: Participants with infants presenting at least one risk indicator received more home visits than participants with infants not at risk.
3. **Informal support network**: The more extensive a participant's informal support network, the fewer number of home visits they received.
4. **Relationship with home visitor**: The more positive the relationship with their home visitor, the more visits a participant received.
5. **Community distress**: The more distressed and disorganized the participant's community, the greater the number of home visits (Daro, McCurdy, & Nelson, 2005, p. 15).

As a summary of the predictors of service dosage (number of home visits) in this analysis, the researchers suggest that programs should "focus their home visits on new parents with high-risk infants, little social support and who live in the most distressed communities" (Daro, McCurdy, & Nelson, 2005, p. 16). Figures 3 and 4 in Appendix II present the significant predictors of service duration and dosage. Table 2 in Appendix II presents the predictors that were not significant.

Contrary to some of the assertions in the theoretical models proposed for explaining engagement and retention, Daro, McCurdy and Nelson (2005) indicate that the following factors were not identified as significant predictors of service length or service dosage:

1. Socioeconomic status of the participant did not predict initial enrollment, service retention or service dosage.
2. A participant's personal motivation as readiness of change, predicted only her intent to enroll in voluntary prevention services, not her duration in the program or number of home visits.

3. Prenatal enrollment did not translate into longer duration or more home visits during the initial year of enrollment.
4. Retaining the same home visitor had no predictive power in determining duration or dosage
5. The educational level of the home visitor did not predict duration or dosage.
6. A home visitor's level of supervision, sense of personal support by her agency, current caseload or involvement in external activities did not predict number of home visits or duration.

A close look at the relationship between ethnicity and engagement or retention was presented in McCurdy, Gannon and Daro (2003). After studying families in 19 Healthy Families America programs, it was found that the ethnic matching of home visitors occurred most frequently for Latinos and less frequently for African American families. In determining the impact of matching on engagement and retention, the results from a multivariate analysis varied across race or ethnicity. Among Latinos, the ethnic match between home visitor and participant did not significantly affect retention. Instead, the strong predictors for Latinos were having the same parenting status and a smaller age difference. Among African Americans, the importance of the match on race or ethnicity between the home visitor and the participant emerged. In addition, having a smaller age difference predicted better engagement. Comparing the three ethnic groups, European Americans or Whites left the program earlier and received fewer home visits. However, none of the matching predictors examined in this study were significant for the White ethnic group.

The findings in McGuigan, Katzev and Pratt (2003) identified the significant maternal attributes, home visitor attributes and the community attributes related to retention of families for one year. The families studied were participants in the Oregon Healthy Start program in 12 different communities. In bivariate analyses of the maternal attributes and retention, the significant maternal attributes were older, Hispanic, married and giving birth prematurely. Home visitor attributes that were significantly related to retention at one year were Hispanic, lower than a bachelor's degree and received more hours of monthly supervision. In multivariate analyses, higher levels of community violence resulted in lower retention at one year. Other results in the multivariate analyses indicated that the more hours of monthly supervision of home visitors resulted in better retention at one year. Among the maternal attributes in the multivariate analysis results, being Hispanic and older were significant. When all three levels of attributes were included in a model, mother's marital status and infant health risks were not significant.

The relationships between personalities of the mother and the home visitor, the quality of their relationships and the length of time in a home visit were tested in Sharp, Ispa, Thornburg and Lane (2003). The sample for the analysis was African American, first time mothers enrolled in Early Head Start in a large Midwestern city. The measurement tools used in the analysis were Tellegren's Multidimensional Personality Questionnaire (MPQ) and the Working Alliance Inventory (WAI) as measures of personality and quality of relationship, respectfully. Positive emotionality was based on scores on four MPO subscales: well-being, social closeness, social potency and achievement. Negative emotionality was based on scores on three MPO subscales; stress reaction, alienation and aggression. Time spent in the home visits was the mean number of minutes spent with each mother per month. The findings were the following:

1. Maternal negative emotionality was related to increased time spent in home visits (Sharp et al., p. 598).
2. Maternal positive emotionality was related to decreased time spent in home visits (Sharp et al., p. 598).
3. Relationship quality between mother and home visitor, as assessed by home visitors, did not mediate or impact the relationships between personality and time spent in home visits (Sharp et al., p. 599).
4. Mother and home visitor negative emotionality was related to the mother's assessment of her relationship with the home visitor but positive emotionality was not (Sharp et al., p. 603).

In the discussion of some of their results, Sharp et al. suggest that home visitors were adjusting their time spent with the mothers in accordance with perceived need. Those mothers with negative emotionality were perceived as needing more time with their home visitors. In addition, negative emotionality for the mother and the home visitor was related to the mother's higher rating of her relationship with her home visitor. What was suggested as an explanation of this finding is that the relationships between the mother and the home visitor become stronger when crises and more distress are experienced by either. Empathy between the mother and the home visitor may be more prevalent when measures of their personalities reflect the presence of negative emotions.

During their discussion of the Healthy Families America program framework, history and status, Daro and Harding (1999) reviewed findings related to program attrition and retention from evaluations of Healthy Families programs across the country. The authors note that attrition rates for these programs appear similar to those for other early intervention programs serving similar populations. Their review of Healthy Families evaluations revealed some disparate findings regarding factors related to program attrition. For example, some evaluations indicated that programs had more success engaging teenage mothers, while others experienced more difficulty engaging this population. Additional factors found to be related to attrition included communities characterized by high mobility, someone in the household refusing to allow home visits and the tenure and stability of the program's sponsoring agency, with those having a more established presence in the community showing better retention of participants. Higher retention rates were noted for programs that conduct assessments in person, either at the hospital or during prenatal medical visits and those offering incentives at enrollment. Some evaluations reviewed by Daro and Harding (1999) found that Hispanic and African American participants were retained longer than White participants.

The analysis of participant and program data by Healthy Families America generated several findings that indicate the importance of program and participant characteristics in family retention (Harding, Reid, Oshana & Holton, 2004). Of particular interest in this analysis were factors that were not included in other previous studies of family retention. These factors include project site maturity, community size and host agency type (1. family support services and social services, 2. medical and public health and 3. other). Regarding site maturity, the relevant finding was older sites had significantly higher retention than newer sites at 12 and 24 months (Harding et. al., p. 21). Those projects established from1992 through1996 had 61 percent of their families retained at 12 months compared to 53 percent of the families at projects established in 2000 or

after. For 24 month retention, sites established from1992 through 1996 had 39 percent retention of their families compared to 25 percent for families in sites established in 2000 or after. There were no significant relationships between community size and retention and between host agency type and retention.

The Healthy Families America analysis also examined the relationships between participant characteristics and family retention (Harding et. al., p. 23). While detected in the analyses, most of the significant relationships were considered weak and "influenced by additional factors" (Harding et al., p. 23). Maternal assessment or risk score was significant in several sites with lower risk mothers having higher retention. Maternal age at enrollment was significant at several sites with older mothers having high retention. Maternal education at enrollment was related to retention at several sites with more educated participants less likely to remain enrolled. Results were unclear for marital status at enrollment and results indicating a relationship between race/ethnicity and retention were mixed.

Characteristics of staff (Family Support Worker) and the similarity of the program staff (Family Support Worker) and the mother were also examined in the HFA analysis of family retention. Three characteristics of the Family Support Worker's (FSWs) that were examined were years of education, years of experience in home visiting and age at hire. None of these staff characteristics were related to family retention. However, similarities between FSW and mother were significant in their relationship with retention. When the FSW was older than the mother by at least 5 years and particularly at 15 years or more, retention of the family was higher. Retention was higher when the race/ethnicity of the FSW and mother was the same.

Findings in a study conducted by Williams, Stern & Associates (2003) are referenced in a later chapter (Chapter V) that describes the results of a survey of closed participants in 2005-06.

Summary

Summarizing all of the results in the Daro et al. (2003) and Daro et al. (2005) studies, as well as other relevant studies, the factors that have been proposed as having effects on the engagement and retention of participants are in several different categories or levels as part of an integrated theory. Decisions to engage and stay in a program are influenced by participant, provider, program and neighborhood or community level factors. While these factors have appeared in theoretical models, their significance in predicting engagement and enrollment has not always been confirmed in results based on statistical analyses. Recognizing this, it is still important to mention many of them.

Participant factors in theoretical models include age, race/ethnicity, infant health risk, perception of benefits, the subjective norms among the participant's reference group or whether participation is supported among friends and family members and previous experience in similar programs.

In theoretical models, provider factors in home visiting programs typically refer to characteristics of home visitors and personal interaction with the family. Characteristics of the home visitors refer to age, race, gender, educational attainment, prior experience on the job, hours of individual supervision and interpersonal skills with emphasis on the ability to adopt other viewpoints and ability to show empathy with others. Provider factors that are considered important in predicting the intent to enroll focus on the interaction of the home visitor and the

participant. Two other factors that have been identified as important in previous research are the cultural competence of the home visitor and service delivery style.

Several program attributes in theoretical models have also been identified as predictive of participant intent to enroll, actual enrollment and retention. Intent to enroll has been affected by the association of the program with child welfare public agencies or other public social services and is believed to have a negative impact on enrollment. Prenatal enrollment or initiation of service during pregnancy is another program attribute that has been identified as a factor that influences decisions to enroll. In predicting actual enrollment, an additional factor that is identified and labeled intervening is the time between enrollment and the receipt of services. The longer the length of time between the family's intent to enroll and actual enrollment, the more likely the participant will acquire other information that will negatively affect actual enrollment. Another program factor considered important in affecting retention is the match between the participant and the home visitor on race or parenting status. Program factors that are considered predictive of retention refer to low supervisory caseloads, stable funding, low staff turnover and tangible incentives.

Among the neighborhood or community level factors in theoretical models, resources available in the neighborhood or community and whether the individual or family has the knowledge or ability to access these will affect decisions to enroll in a program. Other neighborhood or community factors are broadly referred to as "social disorganization" with the presence of crime and poverty posited to have an impact on enrollment in a social program.

Other explanations of what is important in predicting engagement and retention are also important to mention here. Factors that influence initial engagement are not the same as those related to ongoing engagement or retention. Enrollment of a mother is determined by her "readiness to change" and her needs as they relate to the health of her infant. After enrollment, decisions to remain in the program are shaped continuously. Retention is influenced by having her concerns addressed, her subjective experiences or comfort with the program and provider characteristics, such as having an experienced home visitor. Researchers also state that "many new parents are initially drawn to these programs out of concern for their infant's well-being. However, they remain in a program only if they perceive that their needs are being addressed or if they are receiving information they find useful" (Daro, McCurdy & Nelson, 2005, p. 21). This is identified as a dual mission, which makes it essential for the program to improve parenting while addressing the basic needs and personal concerns of the parent. Also, the researchers contend that the importance of subjective experiences of the participant appears to be greater than objective experiences. Community context is important but contrary to what was proposed in the theoretical model, participants living in distressed communities are more likely to remain enrolled. Matching home visitor and participant ethnicity, age and parenting status varies in importance across ethnic groups. As a final factor highlighted here, older project sites have better participant retention.

When comparing the findings for all of the previous studies covered in this chapter, the picture of what is explanatory or predictive is mixed. There are variations in whether a factor is significant in its relationship with a measure of retention as well as the direction of that relationship. These inconsistencies make the platform for future analysis less stable and make confirmation of findings in future analyses more important but also more difficult. Table 1 lists the studies covered in this chapter and their findings for statistical relationships between

retention and participant, provider, program and neighborhood/community factors. Based on the previous studies reviewed in this chapter of the report, very few factors have a consistent significant relationship with engagement and retention across more than one study or analysis. Those that do are listed below:

1. Participant Factors
   a. Age: Older participants have higher retention.
   b. Race: African American and Hispanic participants have higher retention.
   c. Infant Risk: The higher the infant risk at birth, the higher the retention.
2. Provider Factors (These factors did not meet the criteria with only one study for each significant factor or findings were not consistent across studies.)
3. Program Factors
   a. Matching FSW and participant on race/ethnicity: African American participants matched with African American FSWs have higher retention.
4. Neighborhood and Community Factors (These factors did not meet the criteria with only one study for each significant factor or findings were not consistent across studies.)

Table 1: Key Factors and Significant Findings in Previous Studies

Factor	Findings	Previous Study
Participant		
Age	Older retained longer, received more visits. Older participants more likely retained	Daro et al. (2003) McGuigan et al. (2003)
Race	African American and Hispanic enrolled longer African American received more home visits African Americans received fewer visits than Whites Hispanics more likely retained at one year	Daro et al. (2003) Daro et al. (2005) McGuigan et al. (2003)
Employment	Unemployed retained longer and received more visits	Daro et al. (2003)
Education	If enrolled in school during participation, retained longer More education, less likely retained	Daro et al. (2003) Harding et al. (2004)
Marital Status	Married mothers more likely retained	McGuigan et al. (2003)
Socioeconomic status (SES)	SES scale **not significant**	Daro et al. (2005)

Factor	Findings	Previous Study
Participant continued		
Timing of Enrollment	Those enrolled prenatally retained longer and received more home visits Prenatal enrollment **not predictive** of longer retention or more home visits	Daro et al. (2003) Daro et al. (2005)
Support Network	More likely retained at 6 months if informal network supports participation More reliance on informal support network, less likely retained at six months More extensive social network, fewer visits.	Daro et al. (2005)
Risk Assessment	FSC score **not related** to retention or # of visits. Lower risk, more likely retained	Daro et al. (2003) Harding et al. (2004)
Infant Risk	Risk predictive of 3 and 6 month retention and higher # home visits Premature delivery, more likely retained	Daro et al. (2005) McGuigan et al. (2003)
Subjective Assessment of Program Impact	More likely retained at 12 months if they believe the program changed them, provided useful information or changed the way they care for their child	Daro et al. (2005)
View of Relationship with FSW	Retained longer, more visits if they "like" FSW and feel connected and comfortable	Daro et al. (2005)
Emotionality of mother (sample only included African American, first-time moms	Negative emotionality predicted more time spent in home visits; positive predicted less	Sharp et al. (2003)
Provider		
Age of Home Visitor	Those with younger home visitors were retained longer and received more visits Age at hire **not significant**	Daro et al. (2003) Harding et al. (2004)

Factor	Findings	Previous Study
Provider Continued		
Race of Home Visitor	Those with African American home visitors were retained longer	Daro et al. (2003)
	Those with African American home visitors were not retained as long	Daro et al. (2005)
	Those with Hispanic home visitors were more likely to be retained at one year	McGuigan et al. (2003)
Education of Home Visitor	**Not predictive** of retention or # of visits	Daro et al. (2005)
	Not significant	Harding et al. (2004)
	If lower than bachelor's degree, participants more likely retained	McGuigan et al. (2003)
Experience of Home Visitor	Prior experience related to # of visits	Daro et al. (2003)
	Employed longer, participants retained longer (significant at the trend level only)	Daro et al. (2005)
	Years of home visiting experience **not significant**	Harding et al. (2004)
Service Delivery Style	Better retention for those with an "engaging" service delivery style	Daro et al. (2005)
Encourage Use of Informal Support and Resources	**Not significant**	Daro et al. (2005)
Program		
Match on Parenting Status	Latinos longer enrollment and more home visits	McCurdy et al. (2003)
Match on Race/Ethnicity	Significant for African Americans; not for Latino or White participants	McCurdy et al. (2003)
	Higher retention when matched	Harding et al. (2004)
Match on Age	Higher retention when FSW at least 5 years older	Harding et al. (2004)
	Small age difference, higher retention for Latinos and African Americans	McCurdy et al. (2003)

Factor	Findings	Previous Study
Program continued		
Family Caseload	Low supervisory caseload predictive of retention **Not significant** for retention or number of visits	Daro et al. (2003) Daro et al. (2005)
Level of Supervision	**Not significant** for retention or number of visits More supervision related to retention at one year	Daro et al. (2005) McGuigan et al. (2003)
Change in FSW	Same home visitor **not predictive** of retention or number of visits	Daro et al. (2005)
Project Site Maturity	Older sites had higher retention at 12 and 24 months	Harding et al. (2004)
Host Agency Type	**Not significant**	Harding et al. (2004)
Tangible Benefits	Receipt of material goods **not related** to retention or number of visits	Daro et al. (2005)
Neighborhood/Community		
Community Distress	More distressed, more likely retained at 6 and 12 months, more visits	Daro et al. (2005)
Community Violence	High levels, lower retention at one year	McGuigan et al. (2003)
Community Size	**Not significant**	Harding et al. (2004)

Chapter III
Engagement and Retention of Healthy Families Florida Participants Enrolled in 2003-2004 FY

The review of theoretical models and findings in earlier research served as justification for studying engagement and retention, suggested approaches for calculating retention and guided subsequent analyses to determine the strength of relationships between predictive factors and engagement and retention. In this chapter of the report, the primary focus is ongoing engagement or the retention of families. Participants included in the calculation of retention and in the analysis of factors related to retention include those who enrolled in 2003-2004 fiscal year (FY) (July 1, 2003 through June 30, 2004). The study time period ended in mid-July 2005, which is the month the participant data were retrieved from the Healthy Families Florida (HFF) Data System for this study. The questions answered in this chapter are the following:

1. How successful is Healthy Families Florida at retaining families?
2. What participant characteristics and programmatic experiences in Healthy Families Florida are related to whether or not families are retained at 3 months, 6 months or 12 months?
3. What participant characteristics and programmatic experiences in Healthy Families Florida are related to the number of days in the program?

Before addressing each question above, this chapter presents closure information for participants who enrolled during the 2003-2004 fiscal year. Reasons for closing are currently coded in the HFF Data System and one reason for closing is assigned to each closed participant. Variations in frequency distributions for closure reasons across length of time or stay in the program are presented. Retention rates calculated for HFF and other HF programs that were calculated and documented in the HFF Five-year Evaluation Report and an analysis conducted by Healthy Families America are presented next. Retention rates or percentages for the participants who enrolled in 2003-2004 fiscal year and subgroups of that set of participants calculated as part of this study are displayed and discussed. Differences in retention rates across type of community served and enrollment cohort during the 2003-2004 fiscal year are also examined. Statistical relationships between participant demographic characteristics, participant risks or concerns on the *Healthy Families Florida Assessment Tool (HFFAT)*, programmatic experiences and retention at 3, 6 and 12 months are documented in the next subsection. Statistical relationships in a conceptual model that includes predictive factors for number of days in the program are calculated in the final analytical subsection. A summary at the end of the chapter highlights the findings and observations based on the analyses conducted and covered in this chapter.

Closure Reasons for HFF Participants

In the Healthy Families Florida Data System, one of several codes can be entered to indicate the reason for closing when a family closes. Some of these codes refer to situations or experiences of the families that are not related to actions by project staff. Examples of these are primary participant miscarried, primary participant died, or the family was transferred to another HF project. A closure reason might also refer to the goal that the program is trying to achieve, completing the program. Other closure reasons may reflect family experiences that are not

desirable and may be indications of challenges that face the projects in serving families. Some of these reasons can be considered "in the control" of project staff and are "Vanished (Lost Contact)," "Not interested," or "Child Removed by Child Protective Services." The closure reason, "Vanished (Lost Contact)" is not used until program staff have conducted 90 days of respectful outreach with the family. For HFF families that enrolled during the 2003-2004 fiscal year, all of the closure reasons and the corresponding frequency distribution for those reasons are in Table 2. The number of those who continued in the program during this study period is in the first row of Table 2.

Table 2: Frequency Distribution Closure Reasons, Families Who Enrolled 2003-2004 FY

Number in the Study and those who Closed by Closure Reason	Frequencies for Study	Percent for Study	Percent for Closed Only	Cumulative Percent for Study
None Selected (Still in Program)	1934	45.8		45.8
Parent Incarcerated	12	.3	.52	46.0
TC Miscarried/ITOP/Died	24	.6	1.1	46.6
Moved out of Service Area (MOOSA)	697	16.5	30.4	63.1
Vanished (Lost Contact)	418	9.9	18.2	73.0
Other	89	2.1	3.9	75.1
Completed HFF	2	.0	.0	75.1
Referred Out	6	.1	.003	75.3
Parent School/Work Full-Time	352	8.3	15.4	83.6
Child Adopted Out	3	.1	.0	83.7
Child Removed by CPS	40	.9	1.74	84.6
Transferred to HF/Non HFF Program	10	.2	.4	84.9
Transferred to Another HFF Site	17	.4	.74	85.3
Primary Participant Died	3	.1	.0	85.3
Not Interested	619	14.6	26.99	100.0
Aged Out	1	.0	.0	100.0
Subtotal -- Closed Participants	2293	54.2	100.0	
Total	4227	100.0		

Note: Percentages might not add to 100% due to rounding

Closure reason frequency distributions change across lengths of time in the program. Cumulative frequency distributions by closure reason for those not retained at 3 months, 6 months, 9 months and 12 months are displayed in Table 3.

Table 3: Frequency Distributions for Closure Reasons by Closure Subgroups (Cumulative) Families Who Enrolled in 2003-2004 FY

Closure Reasons	Not Retained at 3 months		Not Retained at 6 months		Not Retained at 9 months		Not Retained at 12 Months	
	#	%	#	%	#	%	#	%
Parent Incarcerated	0	.0	5	.6	9	.6	11	.6
TC Miscarried/ITOP/ Died	7	2.0	17	1.9	18	1.3	22	1.2
Moved out of Service Area (MOOSA)	127	35.5	279	31.4	452	31.7	562	30.5
Vanished (Lost Contact)	11	3.1	82	9.2	190	13.3	290	15.8
Other	11	3.1	26	2.9	54	3.8	70	3.8
Completed HFF	0	.0	0	.0	0	.0	0	.0
Referred Out	1	.3	3	.3	5	.4	5	.3
Parent School/ Work Full-Time	58	16.2	145	16.3	225	15.8	284	15.4
Child Adopted Out	0	.0	1	.1	2	.1	2	.1
Child Removed by CPS	2	.6	14	1.6	24	1.7	33	1.8
Referred to a NON-HFF Healthy Families Program	3	.8	3	.3	5	.4	8	.4
Transferred to Another HFF Site	5	1.4	8	.9	12	.8	15	.8
Primary Participant Died	0	.0	1	.1	2	.1	3	.2
Not Interested	133	37.2	304	34.2	429	30.1	536	29.1
Aged Out	0	.0	0	.0	0	.0	0	.0
Total	358	100.0	888	100.0	1427	100.0	1841	100.0

Note: Percentages might not add to 100% due to rounding

Referring to the percentages based on the cumulative retention numbers in Table 3, the closure reasons with the highest percentages were identified. The closure reasons that have the highest percentages for all frequency distributions are "Moved out of Service Area" (MOOSA), "Not Interested," "Vanished (Lost Contact)," and "Parent School/Work Full-time." However, the percentages for some of these categories change across retention time periods with the percentage for "Not Interested" dropping from 37.2 percent for those not retained up to 3 months to 29.1 percent for those not retained up to 12 months. The closure reason "Vanished (Lost

Contact)" increases substantially from 3.1 percent for those not retained at 3 months to 15.8 percent for those not retained up to 12 months. Based on the frequency distributions for cumulative retention numbers in the above table, it is important to examine these distributions by family subgroups based on actual length of time in the program. If those not retained up to 12 months are divided into subgroups based on when they close or their length of time in the program, the percentages change again. Table 4 displays these percentages.

Table 4: Frequency Distributions for Closure Reasons by Closure Subgroups Families Who Enrolled in 2003-2004 FY

Closure Reasons	Closed prior to 3 months		Closed between 3 to 6 months		Closed between 6 to 9 months		Closed between 9 to 12 months	
	#	%	#	%	#	%	#	%
Parent Incarcerated	0	0.00	5	0.94	4	0.74	2	0.48
TC Miscarried/ITOP/Died	7	2.00	10	1.89	1	0.19	4	0.97
Moved out of Service Area	127	35.50	152	28.68	173	32.10	110	26.57
Vanished (Lost Contact)	11	3.10	71	13.40	108	20.04	100	24.15
Other	11	3.10	15	2.83	28	5.19	16	3.86
Completed HFF	0	0.00	0	0.00	0	0.00	0	0.00
Referred Out	1	0.30	2	0.38	2	0.37	0	0.00
Parent School/Work Full-Time	58	16.20	87	16.42	80	14.84	59	14.25
Child Adopted Out	0	0.00	1	0.19	1	0.19	0	0.00
Child Removed by CPS	2	0.60	12	2.26	10	1.86	9	2.17
Referred to a NON-HFF Healthy Families Program	3	0.80	0	0.00	2	0.37	3	0.72
Transferred to Another HFF Site	5	1.40	3	0.57	4	0.74	3	0.72
Primary Participant Died	0	0.00	1	0.19	1	0.19	1	0.24
Not Interested	133	37.20	171	32.26	125	23.19	107	25.85
Aged Out	0	0.00	0	0.00	0	0.00	0	0.00
Total	358	100.00	530	100.00	539	100.00	414	100.00

Note: Percentages might not add to 100% due to rounding

Referring to the percentages in Table 4, the retention subgroups with the highest percentage having a closure reason of "MOOSA" are those closed prior to 3 months and those closed between 6 and 9 months. The percentages for these subgroups are 35.5 percent and 32.1 percent, respectively. The retention subgroup with the highest percentage "Vanished (Lost Contact)" includes those families who closed from 9 to 12 months. This percentage is 24.15 percent. The subgroup with the highest percentage having a closure reason of "Not Interested" includes those closed up to 3 months with that percentage being 37.2 percent. These percentages

suggest that "MOOSA" and "Not Interested" are the most prevalent reasons for closing in the family subgroup that closes before participating 3 months in the program.

Family Retention in Healthy Families Florida

Family retention in Healthy Families Florida has been calculated statewide and by project for several years. One retention rate relies on a calculation that considers the number of participants open at the beginning and end of an annual cycle. This measure is calculated as a percentage and is used in the assessment of project performance. The numerator is the number of open families at the end of a 12 month time period plus families that transferred to another HFF site, completed the program or had a target child that aged out of the program. The denominator is the number of families served during the 12 month time period. Using this calculation method, the HFF retention rate was 71 percent for 2005-2006 fiscal year. The program goal for retention of HFF families using this formula is 70 percent

Relying on another set of formulas, retention of participants in Healthy Families Florida was calculated and documented in the final report for the HFF Five-year Evaluation (Williams, Stern & Associates, 2005). The measures of interest in that report were retention at 3, 6, 12, 18, 24, 36 and 48 months for different cohorts based on year of enrollment. There were two calculation methods used for these rates, one method used the dates for the initial and last home visits to determine months in the program and the other used the enrollment and closing dates. As displayed in Table 5 and Figure 3, the first method resulted in lower retention percentages and represented the actual time receiving home visits.

Table 5: Retention of Families Based on HFF Enrollment Cohorts

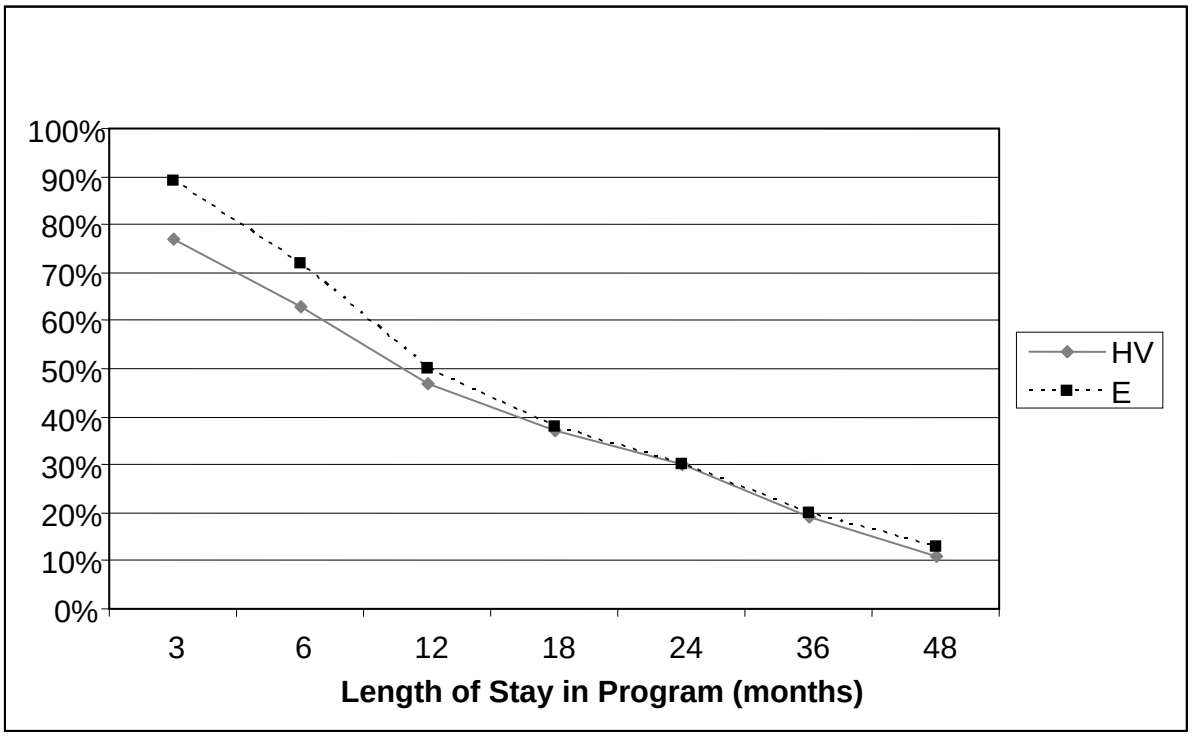
	Length of Stay (months)*													
Entry Year	**3**		**6**		**12**		**18**		**24**		**36**		**48**	
	HV	**E**	**HV**	**E**	**HV**	**E**	**HV**	**E**	**HV**	**E**	**HV**	**E**	**HV**	**E**
1999	79%	89%	65%	74%	48%	50%	37%	38%	32%	31%	22%	21%	11%	13%
2000	77%	90%	64%	73%	47%	49%	38%	38%	30%	30%	18%	20%		
2001	78%	89%	64%	73%	47%	50%	37%	37%	29%	30%				
2002	78%	88%	63%	72%	45%	50%	34%	41%						
2003	73%	87%	58%	70%										
Overall	77%	89%	63%	72%	47%	50%	37%	38%	30%	30%	19%	20%	11%	13%

*HV = Length of stay (LOS) calculated with first and last home visit date; E = LOS calculated based on enrollment and closure dates

Source: Williams, Stern & Associates (2005) *Healthy Families Florida Evaluation Report, January 1, 1999-December 31, 2003,* p. 32.

Figure 3: Primary Participant Retention

January 1, 1999 – December 31, 2003



*HV = Length of stay (LOS) calculated with first and last home visit date; E = LOS calculated based on enrollment and closure dates.

Source: Williams, Stern & Associates (2005) *Healthy Families Florida Evaluation Report, January 1, 1999-December 31, 2003*, p. 32.

In the 2004 study conducted by Healthy Families America, retention rates were averaged across the study sites (Harding, Reid, Oshana & Holton, 2004). The sites included in these calculations were part of large systems in a single state or smaller systems serving only a portion of a state. In the calculation of these retention rates, all families had received at least one home visit and families were enrolled at or before the beginning of the time period for which retention was measured (Harding, et, al., 2004, p. 18). The average percentages of families retained at different periods of time in that analysis are in Table 6

Table 6: Family Retention Rates, Healthy Families America Analysis (2004)

Retention Period	% of Families Retained	Number of Sites (HFA State Systems)
At least 3 months	83%	100 (9 systems)
At least 6 months	70%	100 (9 systems)
At least 12 months	51%	93 (8 systems)
At least 24 months	30%	79 (8 systems)
36 months or longer	22%	43 (4 systems)

Even with the slight difference in the calculation methods for retention rates, when comparing the retention rates documented in the HFF Five-year Evaluation Report (Williams, Stern & Associates, 2005) and the retention rates calculated in the HFA analysis, there are similarities. At six months, the retention rate calculated using enrollment and closure dates for HFF was 72 percent and the average retention rate for this time period in the HFA analysis was 70 percent. At 12 months, the retention rates were 50 percent and 51 percent, respectively.

Computation of Retention Rates for HFF Participants Enrolled in 2003-2004 FY (Statewide and by Project)

In this study, the method for the calculation of retention is identical to one of the methods used in the HFF Five-year Evaluation Report (Williams, Stern & Associates, 2005). This method uses the date of enrollment in the program (DEIP) and closure dates to determine length of time in the program. The second method used in the HFF Five-year Evaluation Report was not used in this study and that method was based on the date of the first and last home visit. If all participants who enrolled during fiscal year 2003-2004 and those who closed for any reason are included in the retention rate, the formulas for 3, 6, 9 and 12 month retention are:

3 month retention: 91.5 percent

- Numerator: Participants who enrolled during 2003-2004 and were still in the program at 3 months
- Denominator: Participants who enrolled during 2003-2004

6 month retention: 79.0 percent

- Numerator: Participants who enrolled during 2003-2004 and were still in the program at 6 months
- Denominator: Participants who enrolled during 2003-2004

9 month retention: 66.2 percent

- Numerator: Participants who enrolled during 2003-2004 and were still in the program at 9 months

- Denominator: Participants who enrolled during 2003-2004

12 month retention: 56.4 percent

- Numerator: Participants who enrolled during 2003-2004 and were still in the program at 12 months
- Denominator: Participants who enrolled during 2003-2004

Some of the reasons for closure are not due to or affected by the actions of project staff. So, in an attempt to calculate a measure of retention that reflects only closures that are controlled by project staff, subgroups of the families that are closing due to completion or for reasons that project staff cannot control are deleted. The reasons for closure that were included in the remaining subgroup are in Table 7.

Table 7: Closure Reasons for Participants Who Close for Reasons That Are Controlled by Project Staff

Number in the Study and those who Closed by Closure Reason	Frequencies for Study Subgroup	Percent for Study Subgroup	Percent for Closed Only in Subgroup	Cumulative Percent for Study Subgroup
None Selected (Still in program)	1934	50.8		50.8
Parent Incarcerated	12	.3	.6	51.1
Moved Out of Service Area (MOOSA)	697	18.3	37.2	69.4
Vanished (Lost Contact)	418	11.0	22.3	80.4
Other	89	2.3	4.7	82.7
Child Removed by CPS	40	1.1	2.1	83.7
Not Interested	619	16.3	33.0	100.0
Subtotal-Closed Participants	1875	49.2	100.0	
Total	3809	100.0		

Note: Percentages might not add to 100% due to rounding

When the HFF participants who close for reasons that are completely out of the control of the project staff are removed from the calculation of the retention rate, the new numerator and denominator in the formula are:

- Numerator= Participants in the denominator who were still in the program at a specified number of months
- Denominator= Participants who enrolled 2003-2004 and were still in the program at a specified number of months or closed for reasons that can be controlled by project staff and appear in the above table

The participants removed from the above formula include those who enrolled during 2003-2004 but closed for one of the following reasons: target child miscarried or died, completed HFF, parent is in school or working full-time, parent transferred to another HF site, or the child aged out of the program. The participants who closed for the reasons listed in Table 7 are included in the new calculation of retention. The retention rates based on this participant subgroup are higher because the same number of active participants in the program are included in this subgroup but there is a lower number of closed participants (Table 8). However, the revised retention rate should be more accurate as a measure of retention that is more closely associated with the performance of project staff.

Table 8: Comparison of Retention Rates, for All Families Enrolled 2003-2004 FY

Months Retained	All Participants/Families who Enrolled in 2003-2004	Participant Subgroup (those who were retained and those closed for reasons that are controlled by project staff)
3 months	91.5%	92.5%
6 months	79.0%	81.4%
9 months	66.2%	69.6%
12 months	56.4%	60.6%

Variation in family retention across individual projects and type of project or community served is also of interest in this research. Retention at 3, 6 and 12 months was calculated for each project data unit for all families enrolled in 2003-2004 fiscal year and for the subgroup that includes only those still open in the program and those closed for reasons that are not encouraged. The retention rates for each HF project data unit (referred to as project in the remaining text of this paragraph) appear in Appendix III as Tables 1 and 2. For all of the families enrolled in 2003-2004 fiscal year, 25 of 43 projects listed in the table have retention rates above the state rate for 3 month retention, 22 of 43 projects were above the state rate for 6 month retention, 20 of 43 projects were above the state rate for 9 month retention and 22 of 43 projects were above the state rate for 12 month retention. The retention rates for projects decrease as the length of time in the program increases and variation in retention rates across projects is greatest for the 12 month retention rates with the highest 12 month retention rate for a project being 77.3 percent and the lowest being 35.6 percent. The patterns for the retention rates calculated with the subgroup that includes only those with closure reasons not encouraged or out

of the control of the projects are similar to those just described for all families that enrolled in 2003-2004 fiscal year. For this subgroup, the variation in the 12 month retention rates across projects was the widest. The highest 12 month retention rate for a project was 80.0 percent and the lowest was 40.9 percent.

Retention Rates by Type of Community Served

Retention rates by "type of community served" were also calculated and are documented in this report. The types of communities are consistent with those used in the HFF Five-year Evaluation Report (Williams, Stern & Associates, 2005) and are described as follows:

- Major cities with a total population of 500,000 or more
- Mid-sized city, population of 250,000 to 499,999
- Small cities or towns with a population of 10,000 to 249,999
- Rural communities with a population less than 10,000

The subgroup of families that remained open or closed for reasons that are in the project's control was used for the calculation of the retention rates by type of community served. Tables 9 through 12 display the retention rates (3, 6, 9 and 12 months) for participants served by projects in each type of community

Table 9: Crosstabulation of Type of Community Served by 3 Months Retention

	Retention - 3 Months		
Types of Community Served	**Not Retained**	**Retained**	**Total**
Major City	75 8.0%	867 92.0%	942 100%
Mid- Size City	30 6.7%	421 93.3%	451 100%
Small City or Town	155 7.6%	1876 92.4%	2031 100%
Rural Community	24 6.2%	361 93.8%	385 100%
Total	284 7.5%	3525 92.5%	3809 100%

Table 10: Crosstabulation of Type of Community Served by 6 Month Retention

	Retention - 6 Months		
Types of Community Served	**Not Retained**	**Retained**	**Total**
Major City	165 17.5%	777 82.5%	942 100%
Mid- Size City	81 18.0%	370 82.0%	451 100%
Small City or Town	393 19.4%	1638 80.6%	2031 100%
Rural Community	71 18.4%	314 81.6%	385 100%
Total	710 18.6%	3099 81.4%	3809 100%

Table 11: Crosstabulation of Type of Community Served by 9 Month Retention

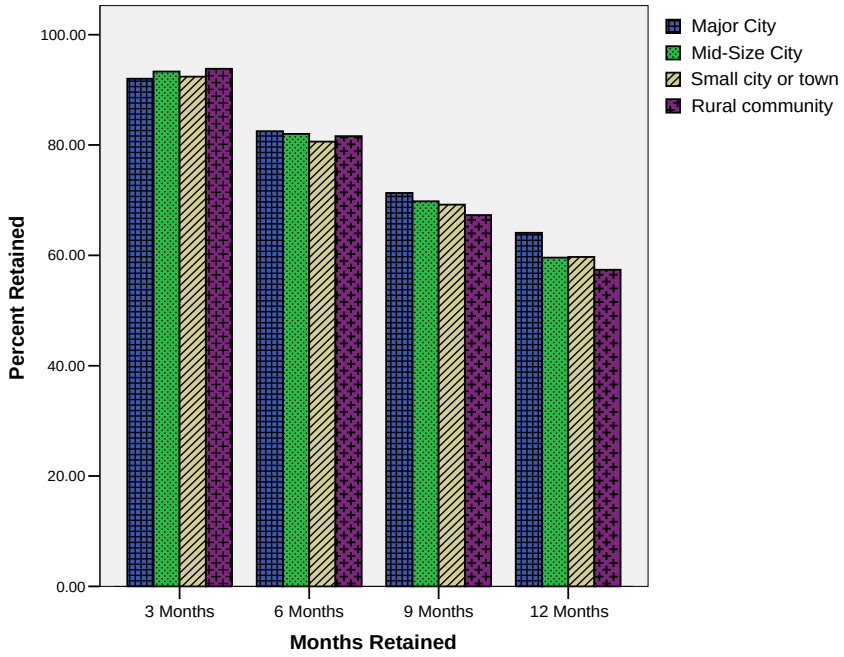
	Retention - 9 Months		
Types of Community Served	**Not Retained**	**Retained**	**Total**
Major City	270 28.7%	672 71.3%	942 100%
Mid- Size City	136 30.2%	316 69.8%	451 100%
Small City or Town	626 30.8%	1405 69.2%	2031 100%
Rural Community	126 32.7%	259 67.3%	385 100%
Total	1158 30.4%	2651 69.6%	3809 100%

Table 12: Crosstabulation of Type of Community Served by 12 Month Retention

	Retention -12 Months		
Types of Community Served	**Not Retained**	**Retained**	**Total**
Major City	338 35.9%	604 64.1%	942 100%
Mid- Size City	182 40.4%	269 59.6%	451 100%
Small City or Town	818 40.3%	1213 59.7%	2031 100%
Rural Community	164 42.6%	221 57.4%	385 100%
Total	1502 39.4%	2307 60.6%	3809 100%

Figure 4 shows the variation in retention rates for 3, 6, 9 and 12 months across types of communities served.

Figure 4: Retention by Types of Community Served



The greatest variation in retention rates across different types of communities served is at 12 months. Those projects serving families in major cities had a 12 month retention rate of 64.1 percent and those serving families in rural communities had a 12 month retention rate of 57.4

percent. The statistical significance of the association between retention (3, 6, 9 and 12 months) and type of community served using a chi-square analysis did not indicate that retention varies significantly across type of community served. However, there are differences in the rates across types of communities served with retention in the rural communities at 9 and 12 months being the lowest. Based on this analysis, one can only suggest and not confirm statistically that retaining families in rural areas is more challenging than retaining families in major cities at 9 and 12 months.

Retention Rates Across Enrollment Cohorts

In addition to reviewing retention rates for all HFF families as well as subgroups of families across type of community served, it is useful to look at retention across enrollment cohorts. Looking at retention across enrollment cohorts can be one indication of whether retention changes and whether retention has improved for the more recent enrollment cohorts. For this part of the study, an enrollment cohort is identified by the quarter during which families enrolled with four quarters or four cohorts represented in the 2003-2004 fiscal year. Tables 13 through 16 display the retention rates for each enrollment cohort.

Table 13: Crosstabulation of Enrollment Quarter by 3 Month Retention

	Retention - 3 Months		
Enrollment Quarter	**Not Retained**	**Retained**	**Total**
1st Quarter, 2003-04	73 9.5%	692 90.5%	765 100%
2nd Quarter, 2003-04	85 8.4%	932 91.6%	1017 100%
3rd Quarter, 2003-04	80 6.8%	1088 93.2%	1168 100%
4th Quarter, 2003-04	120 9.4%	1157 90.6%	1277 100%
Total	358 8.5%	3869 91.5%	4227 100%

Table 14: Crosstabulation of Enrollment Quarter by 6 Month Retention

	Retention - 6 Months		
Enrollment Quarter	**Not Retained**	**Retained**	**Total**
1st Quarter, 2003-04	154 20.1%	611 79.9%	765 100%
2nd Quarter, 2003-04	200 19.7%	817 80.3%	1017 100%
3rd Quarter, 2003-04	242 20.7%	926 79.3%	1168 100%
4th Quarter, 2003-04	292 22.9%	985 77.1%	1277 100%
Total	888 21.0%	3339 79.0%	4227 100%

Table 15: Crosstabulation of Enrollment Quarter by 9 Month Retention

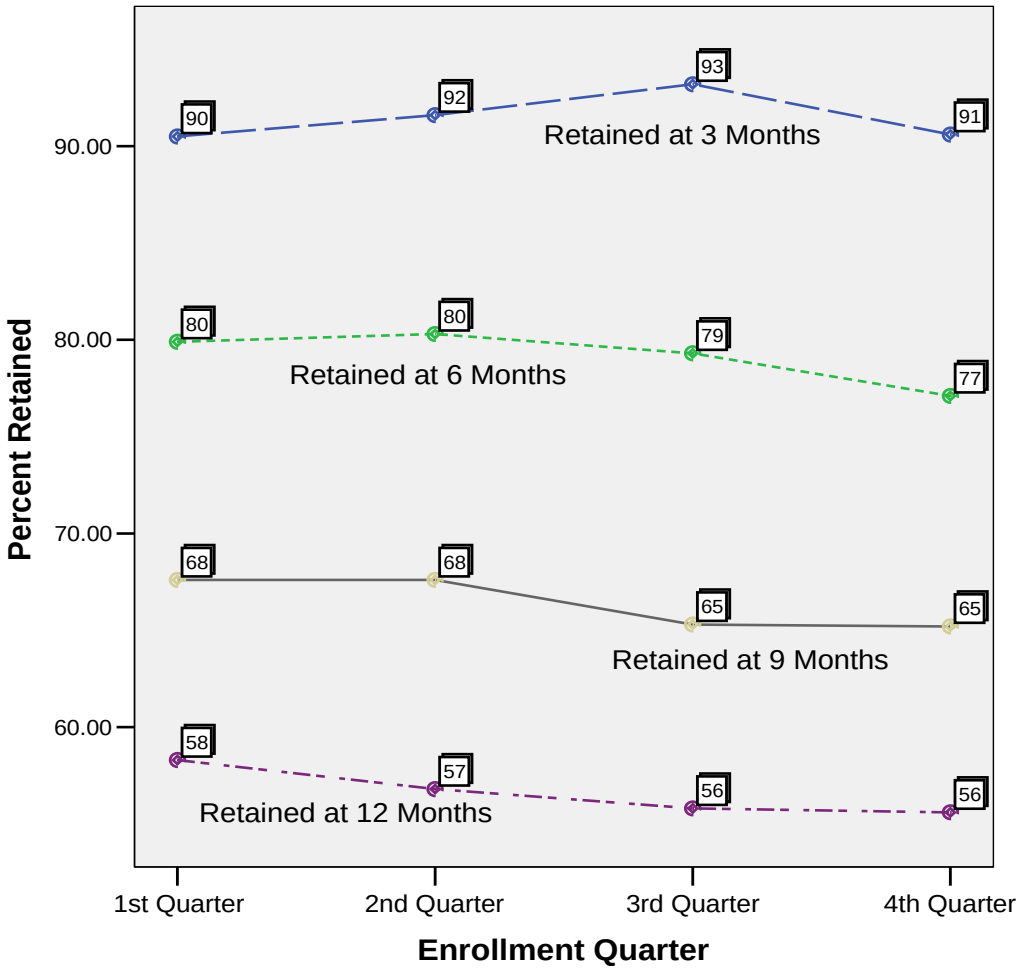
	Retention - 9 Months		
Enrollment Quarter	**Not Retained**	**Retained**	**Total**
1st Quarter, 2003-04	248 32.4%	517 67.6%	765 100%
2nd Quarter, 2003-04	329 32.4%	688 67.6%	1017 100%
3rd Quarter, 2003-04	405 34.7%	763 65.3%	1168 100%
4th Quarter, 2003-04	445 34.8%	832 65.2%	1277 100%
Total	1427 33.8%	2800 66.2%	4227 100%

Table 16: Crosstabulation of Enrollment Quarter by 12 Month Retention

	Retention - 12 Months		
Enrollment Quarter	**Not Retained**	**Retained**	**Total**
1st Quarter, 2003-04	319 41.7%	446 58.3 %	765 100%
2nd Quarter, 2003-04	439 43.2%	578 56.8 %	1017 100%
3rd Quarter, 2003-04	516 44.2%	652 55.8 %	1168 100%
4th Quarter, 2003-04	567 44.4%	710 55.6 %	1277 100%
Total	1841 43.6%	2386 56.4%	4227 100%

The retention percentages in the above tables do not indicate substantial changes in retention across enrollment quarters during the 2003-2004 fiscal year. An analysis of the statistical association between enrollment quarters and retention using chi-square test confirms that there were no significant differences across enrollment quarters for each retention rate (3, 6, 9 and 12 months). This finding suggests that there have not been significant increases or decreases in retention for enrollment cohorts for that fiscal year. Retention success has remained constant across enrollment cohorts during the 2003-3004 fiscal year. Retention rates are displayed for the four enrollment cohorts in Figure 5.

Figure 5: Retention by Enrollment Cohorts



Analysis of Factors Related to Retention (3, 6 and 12 Months)

Identifying factors that are related statistically to retention of families in HFF is an important step for improving retention in a program. Most of the demographic factors identified in this test of these statistical relationships have been included in previous research interested in these relationships and include race, age and education. This analysis also includes the mother's total score on the eligibility assessment tool used for HFF, the *Healthy Families Florida Assessment Tool (HFFAT)*, which is considered an indicator of the potential risk for abuse and neglect. In addition, the statistical relationship between the presence of individual risks and concerns on the assessment tool and retention are examined. Relationships between two program experiences and retention rates are also presented. These program experiences are having an assessment conducted during pregnancy and the other is number of home visits completed on Level 1. Retention in this analysis is measured as dichotomous variables (retained and not retained) for retention at 3 months, 6 months and 12 months. The participants included in the data file for this analysis include those who were open through the study period and those who closed for reasons that are in the control of HFF project staff. These closure reasons include

"Parent Incarcerated," "MOOSA," "Vanished (Lost Contact)," "Child Removed by CPS," "Not Interested," and "Other."

Participant Demographic Characteristics and Retention

The first step in this analysis was to test the strength of bivariate relationships between participant characteristics and retention at 3, 6 and 12 months using chi-square or one-way analysis of variance (ANOVA). The participant characteristics included in these tests are education (< high school), number of children at intake, race (Black, Hispanic and White), age at intake and single parent status. The results for these tests of statistical significance are listed for each retention time period in Table 17.

Table 17: Statistical Relationships, Participant Characteristics and Retention at 3, 6 and 12 Months (p <.01)

Participant Characteristic	3 Month Retention	6 Month Retention	12 Month Retention
Less than High School	Not significant	Not significant	Not significant
Number of Children at Intake	Significant (participants with a higher number of children at intake not retained)	Significant (participants with a higher number of children at intake not retained)	Not significant
Black	Significant (1.386 higher odds of being retained)	Significant (1.207 higher odds of being retained)	Significant (1.138 higher odds of being retained)
Hispanic	Not significant	Not Significant	Significant (1.267 higher odds of being retained)
White	Significant (.704 lower odds of being retained)	Significant (.741 lower odds of being retained)	Significant (.716 lower odds of being retained)
Age at Intake	Not Significant	Not significant	Significant (older participants retained)
Single Parent	Not Significant	Not Significant	Significant (.761 lower odds of being retained)

***Healthy Families Florida Assessment Tool (HFFAT)* Total Scores and Retention (3, 6 and 12 months)**

The next step in this analysis was to test the significance of the variation in the mother's *Healthy Families Florida Assessment Tool (HFFAT)* total scores between those who were retained and not retained at 3, 6 and 12 months using analysis of variance (ANOVA). At 6 and 12 months, the variation in HFFAT scores between those who were retained and those not retained were significant. Those retained had lower HFFAT scores.

Healthy Families Florida Assessment Tool (HFFAT) Items or Concerns and Retention (3, 6 and 12 months)

Relationships between individual concerns on the mother's HFFAT and retention were also of interest in this study. Because the entry of the scores for each concern on the HFFAT in the HFF Data System was not conducted until December 2003, only half of the participants enrolled during the 2003-2004 fiscal year have the item scores required for this analysis. Because of the limited number of participants with a complete set of HFFAT items in the data system, the number of participants in this analysis was 2377. Table 18 summarizes the results of the bivariate tests for each HFFAT item using chi-square analysis and the calculation of odds ratios.

Table 18: Statistical Association between HFFAT Items and Retention*

Healthy Families Florida Assessment Tool Items or Concerns **(number of the item on the HFFAT)**	Significant Statistical Association with Retention ($p < .01$) **(higher or lower odds of being retained indicated or blank for not significant)**			Concern Identified
	3 months	**6 months**	**12 months**	**%**
(1)--Inability to meet basic needs				4.3%
(2)--Inadequate income/housing			Higher	49.3%
(3)--Social isolation				5.0%
(4)--As Child, Witnessed Domestic Violence				27.1%
(5)--Instability of care during childhood				20.0%
(6)--Raised by Caregiver who Abused Substances/Mentally Unstable				29.7%
(7)--Verbalized experiencing abuse/neglect in Childhood				39.2%
(8)--MOB and/or SO placed in protective care				11.4%
(9)--Current mental illness requiring treatment/hospital				8.3%
(10)--Active Substance Abuse in Home (not MOB)		Lower		13.4%
(11)--Suicidal Ideation/Attempted Suicide	Higher			5.9%
(12)--History of Mental Illness or Substance Abuse				14.3%

Healthy Families Florida Assessment Tool Items or Concerns **(number of the item on the HFFAT)**	Significant Statistical Association with Retention ($p < .01$) **(higher or lower odds of being retained indicated or blank for not significant)**			Concern Identified
	3 months	**6 months**	**12 months**	**%**
(13)--History of Alcohol/Substance Abuse			Lower	20.0%
(14)--MOB and/or SO committed violence against another person				14.0%
(15)--MOB and/or SO committed 3 or more victimless crimes			Lower	5.6%
(16)--Late prenatal care (12 weeks or later)				40.4%
(17)--Little or no prenatal care (< 5 visits) or poor compliance with treatment/medication	Lower	Lower	Lower	7.5%
(18)--Upon knowledge of pregnancy, continued use of alcohol/drugs or positive drug screen				3.5%
(19)--Continued smoking/tobacco use	Lower	Lower	Lower	15.2%
(20)--Current Maternal Depression				31.2%
(21)--No medical home for children				11.7%
(22)--Others with special needs in the home				18.0%
(23)--Drug/alcohol use during pregnancy prior to knowledge of pregnancy				9.7%
(24)--Currently-victim of DV or other abuse				12.5%
(25)--Past abusive relationships (not childhood)				20.4%
(26)--Limited contact with close friends/family				18.7%
(27)--Expressed fear of violence in the home				2.9%
(28)--Current physical response to anger				9.4%
(29)--Inappropriate coping mechanisms				3.2%

Healthy Families Florida Assessment Tool Items or Concerns **(number of the item on the HFFAT)**	Significant Statistical Association with Retention ($p < .01$) **(higher or lower odds of being retained indicated or blank for not significant)**			Concern Identified
	3 months	**6 months**	**12 months**	**%**
(30)--Negative verbalization about the baby				21.2%
(31)--Verbalized unrealistic expectations about child development	Lower			38.7%
(32)--Limited awareness of discipline options	Lower	Lower	Lower	57.2%
(33)--Verbalize need to physically punish child				24.3%
(34)--Verbalize feelings of inadequacy about parenting				10.1%
(35)--CPS report on parent				6.6%
(36)--Parent's other children placed in protective care or TPR				2.1%

*Note: MOB refers to Mother of the Baby and SO refers to Significant Other

The final set of bivariate relationships tested included two programmatic experiences and retention at 3, 6 and 12 months. The two programmatic experiences tested were having the assessment conducted during pregnancy and the number of home visits completed on Level 1. The statistical associations between being pregnant at assessment and retention at 3, 6 and 12 months were significant. Participants pregnant at assessment had 2.9 higher odds of being retained at 3 months, 2.17 higher odds of being retained at 6 months and 1.46 higher odds of being retained at 12 months. Based on one-way analysis of variance, the number of home visits completed during Level 1 was significantly related to retention at 3 months, 6 months and 12 months. Those retained at each time period had a significantly higher number of home visits completed on Level 1.

Analysis of Participant and Programmatic Factors Related to Days in the Program

The continuation of the examination of retention and the relationships between key factors and measures of family retention includes estimation of multiple relationships in a conceptual model. Testing a model that depicts relationships between several predictors or explanatory variables and a measure of retention is another valuable exercise in attempts to identify what needs attention in efforts to improve retention in a program. One analytical technique used for this test is linear regression with multiple factors as the predictive variables and one dependent variable, number of days in the program. In this model, number of days in the program is operationalized as number of days between the date of enrollment in the program (DEIP) and closure date. Descriptive statistics and bivariate tests of statistical significance for all of the variables in the model are displayed first in Table 19.

Table 19: Descriptive Statistics and Bivariate Relationships, All Families, Predictors and the Dependent Variable (Number of Days in the Program)

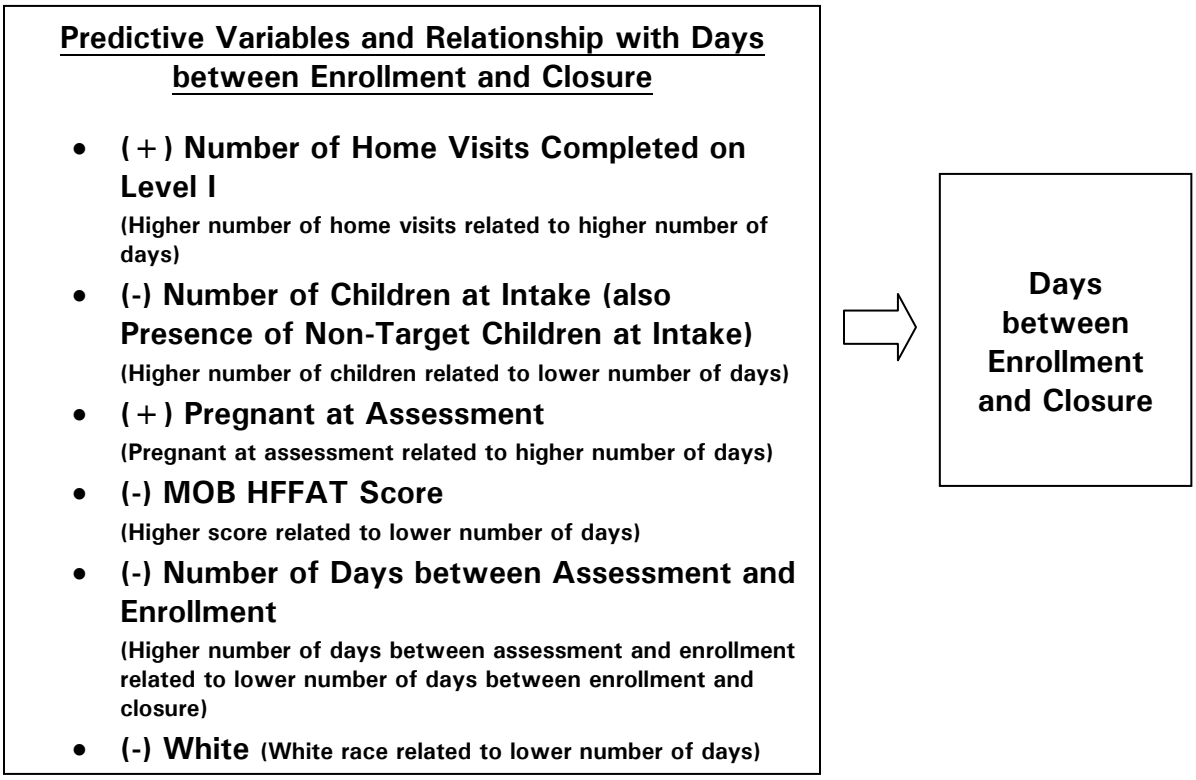
Dependent and Predictive Variables	Mean or %	Std. Deviation	N	Bivariate Relationship with Number of Days in the Program*
Days between DEIP and Closure or DEIP and End of Study	366.93	187.220	4088	Dependent Variable
MOB Total HFFAT Score	24.75	9.924	4088	-.055 ($p < .001$) Significant negative correlation, the higher the MOB HFFAT Score the lower the number of days in the program
Pregnant at Assessment	62%	.486	4088	F=43.044($p <.001$) Pregnant at Assessment-Mean # of Days in Program is 381.97 Not Pregnant at Assessment-Mean # of Days in Program is 343.43
Days Between Assessment and Enrollment	22.10	21.637	4088	-.061 ($p <.001$) Significant negative correlation, the higher the number of days between assessment and enrollment, the lower the number of days in the program
White	31%	.461	4088	F=22.490 ($p <.001$) White-Mean # of Days in Program is 346.66 Not White-Mean # of Days in Program is 376.17
Black	39%	.488	4088	F=2.075 ($p <.150$) Not significant
Hispanic	27%	.445	4088	F=13.627 ($p <.001$) Hispanic-Mean # of Days in Program is 384.46 Not Hispanic-Mean # of Days in Program is 360.69
Participant Age at Enrollment	22.45	5.873	4088	.035 ($p <.013$) Significant positive correlation, the higher the age of the participant the higher the number of days in the program
Less than HS	52%	.500	4088	F=2.270 ($p <.132$) Not significant
Single Parent	75%	.436	4088	F=11.249 ($p <.001$) Single Parent-Mean # of Days in Program is 361.49 Not Single Parent- Mean # of Days in Program is 383.84

Dependent and Predictive Variables	Mean or %	Std. Deviation	N	Bivariate Relationship with Number of Days in the Program*
Total Number of Children at Intake	1.20	1.269	4088	-.034 (p <.014) Significant negative correlation, the higher the number of children at intake, the lower the number of days in the program
Number of Home Visits Completed on Level 1	16.45	12.403	4088	.642 (p <.001) Significant positive correlation, the higher the number of home visits completed the higher the number of days in the program

*Based on Pearson Correlation Coefficient or ANOVA F Statistic (level of statistical significance)

Based on the estimation of all of the relationships for predictors and the dependent variable in the model using the multivariate linear regression (stepwise), the statistically significant predictors and the directions of the relationships are presented in Figure 6.

Figure 6: "Best Fit" Model for Predicting Days between Enrollment and Closure



The equation used to predict the number of days between enrollment and closure contains all of the predictive variables in the "best fit" model in the above figure. The components of the equation are:

- Days between Enrollment and Closure = Constant +

  Coefficient for MOB HFFAT Score * MOB HFFAT Score +
  Coefficient for Pregnant at Assessment * (1) +
  Coefficient for HVs Completed at Level 1 * HVs Completed at Level 1 +
  Coefficient for # of Children at Intake * # of Children at Intake +
  Coefficient for # of Days from Assessment to Enrollment * # of Days between Assessment and Enrollment
  Coefficient for White * (1)

For all participants who enrolled during 2003-2004, the projected number of days between enrollment and closure can be computed using the unstandardized coefficients. The values of the unstandardized coefficients are as follows:

- Days between Enrollment and Closure= 190.290 +

  (9.808 * Number of HV Completed at Level I) +
  (-7.429 * Number of Children at Intake) +
  (52.520 * Pregnant at Assessment or 1) +
  (-.874 * MOB HFFAT Score) +
  (-.319 * Days between Assessment and Enrollment) +
  (-20.196 * White or 1)

In Appendix III, an example of how to use this formula to calculate the number of days for a model participant is presented.

The same model or same set of relationships between the predictive variables and dependent variable were estimated for a subgroup of the participants enrolled in 2003-2004. This subgroup was also used to calculate a set of retention rates presented earlier in this report and only includes those who closed for reasons that could be controlled by project staff. In other words, this participant sample does not include those who completed or those who left the program for reasons that were encouraged or beyond the control of the project staff in this study. The descriptive statistics for this sample of participants are presented in Table 20.

Table 20: Descriptive Statistics and Bivariate Relationships, Participant Subgroup, Predictors and the Dependent Variable (Number of Days in the Program)

Dependent and Predictive Variables	Mean or %	Std. Deviation	N	Bivariate Relationship with Number of Days in the Program *
Days between DEIP and Closure or DEIP and End of Study	381.83	185.523	3683	Dependent Variable
MOB Total HFFAT Score	24.92	9.988	3683	-.069 (p <.001) Significant negative correlation The higher the MOB HFFAT score, the lower the number of days in the program
Pregnant at Assessment	62%	.485	3683	F=30.066 (p <.001) Pregnant at Assessment- Mean # of Days in Program is 394.97 Not Pregnant at Assessment- Mean # of Days in Program is 361.27

Dependent and Predictive Variables	Mean or %	Std. Deviation	N	Bivariate Relationship with Number of Days in the Program *
Days Between Assessment and Enrollment	22.02	21.836	3683	-.068 (p <.001) Significant negative correlation The higher the number of days between assessment and enrollment the lower the number of days in the program
Black	38%	.486	3683	F=6.387 (p <.012) Black-Mean # of Days in Program is 391.73 Not Black-Mean # of Days in Program is 376.15
Hispanic	28%	.448	3683	F=9.91 (p <.002) Hispanic-Mean # of Days in the Program is 397.29 Not Hispanic-Mean # of Days in Program is 376.25
White	30%	.460	3683	F=26.773 (p <.001) White-Mean # of Days in the Program is 358.72 Not White-Mean # of Days in the Program is 392.32
Participant Age at Enrollment	22.41	5.915	3683	.046 (.002) Significant positive correlation The older the participant, the higher the number of days in the program
Grade less than 12 at intake	54%	.499	3683	F=.049 (p < .824) Not significant
Number of Home Visits Completed on Level 1	17.18	12.519	3683	.626 (p <.001) Significant positive correlation The higher the # of home visits completed on Level 1, the higher the number of days in the program
Single Parent at Intake	74%	.436	3683	F=11.338 (p <.001) Single Parent-Mean # of Days in the Program is 376.11 Not Single-Mean # of Days in the Program is 399.51

* Based on Pearson Correlations or ANOVA F Statistic (Level of statistical significance)

The significant predictive variables and directions for the effects in the model were the same in this subgroup compared to the entire group of participants enrolled during 2003-04 Fiscal Year. The values of the unstandardized coefficients are below:

- Days between Enrollment and Closure= 195.544 +

  (9.398 * Number of HV Completed at Level I) +
  (-8.168 * Number of Children at Intake) +
  (49.580 * Pregnant at Assessment or 1) +
  (-1.048 * MOB HFFAT Score) +
  (-.347 * Days between Assessment and Enrollment) +
  (-15.441 * White or 1) +
  (14.315 * Black or 1)

Based on the "standardized" coefficients calculated for both the entire sample of those who enrolled in 2003-2004 and the subgroup of those who remained open or closed for reasons considered in the control of project staff, the strongest predictors of number of days in the program were number of home visits completed on Level 1 and number of children at intake. The higher the number of home visits completed on Level 1, the higher the number of days between enrollment and closure. The higher the number of children at intake, the lower the number of days between enrollment and closure.

Summary

In this summary, each question posed at the beginning of this chapter of the report is answered by referring to analyses cited and documented in the report. All of the analyses conducted as part of this study and presented in this chapter refer to HFF participants who enrolled during the 2003-2004 fiscal year, enrolled during the second half of the 2003-2004 fiscal year or a subgroup of these participants based on reasons for closure. The end of the study period for the analyses in this study was mid-July 2005.

Before presenting retention rates for HFF in this report, frequency distributions for closure reasons were examined. For all participants enrolling in the 2003-2004 fiscal year, the closure reasons with the highest percentages were "Moved out of Service Area" (MOOSA) (16.5 percent), "Not Interested" (14.6 percent), "Vanished (Lost Contact)" (9.9 percent) and "Parent School/Work Full-time" (8.3 percent). Looking at the frequency distributions for closure reasons across time in the program, two patterns emerged. The percentage closed due to "Not Interested" dropped from 37.2 percent for those who closed sometime within the first 3 months of their participation in the program to 29.1 percent for those who closed within the first 12 months of their participation in the program. The percentage that closed due to "Vanished (Lost Contact)" increased from 3.1 percent for those who closed in the first 3 months to 15.8 percent for those who closed during the first 12 months. Frequency distributions for closure reasons for subgroups of the entire enrollment sample based on when they closed were also reviewed. The retention subgroups with the highest percentages closing due to "MOOSA" were the subgroups closing before 3 months in the program and those closing between 6 and 9 months in the program. These percentages were 35.5 percent and 32.1 percent, respectively. The subgroup with the highest percentage closing for the reason "Vanished (Lost Contact)" closed from 9 to 12

months. This percentage was 24.15 percent. The subgroup with the highest percentage closing due to "Not Interested" included those who closed up to 3 months with the percentage being 37.2 percent. "MOOSA" and "Not Interested" were the predominant reasons for closing before 3 months after enrollment.

1. How successful is Healthy Families Florida at retaining families?

Based on retention rates presented in the HFF Five-year Evaluation Report (Williams, Stern & Associates, 2005), the analysis conducted by Healthy Families America (2004) and retention rates calculated in this study, retention in Healthy Families Florida compares favorably. The retention in Healthy Families Florida for this study for all participants enrolling during fiscal year 2003-2004 was 91.5 percent at 3 months, 79 percent at 6 months, 66.2 percent at 9 months and 56.4 percent at 12 months. These retention percentages are all higher than those recorded in the HFA analysis and the retention percentages in the HFF Five-year Evaluation Report. However, when considering that retention drops to just over half of the participants who enrolled 12 months earlier, there is still justification for continuing efforts to improve retention. Looking at variation in retention at 3, 6, 9 and 12 months across types of communities served did not indicate any statistically significant differences. Despite this absence of significant results, at 9 and 12 months the participant percentages retained in the rural areas were much lower than in the major cities suggesting that retention in rural areas might be more challenging after participants have been participating in the program longer than 6 months. The analysis also did not indicate statistically significant differences in retention rates across enrollment cohorts based on the quarter of enrollment during the 2003-2004 fiscal year. In other words, retention success remained relatively stable across enrollment cohorts.

2. What participant characteristics and programmatic experiences in Healthy Families Florida are related to whether or not families are retained at 3 months, 6 months, or 12 months?

Among the participant characteristics and program experiences included in this analysis, several were statistically significant in their relationships with 3 month retention, 6 month retention and 12 month retention. Number of children at intake was significantly associated with 3 month retention and 6 month retention. The higher the number of children at intake, the lower the retention. Single parents were less likely to be retained at 12 months. Black participants had higher retention at 3, 6 and 12 months while White participants had lower retention at all three time periods. Hispanics were more likely to be retained at 12 months. Older participants had higher retention at 12 months. Education (less than high school) was not significantly related to retention at 3, 6 or 12 months.

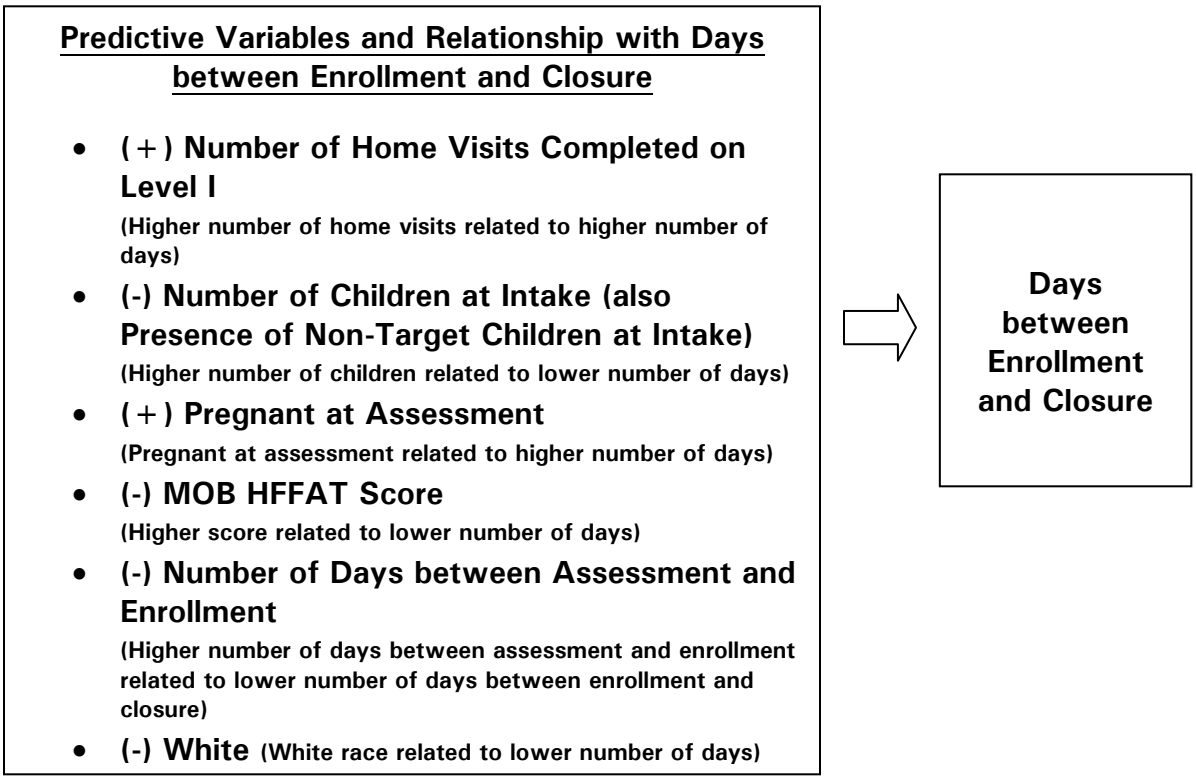
There were significant results in the analysis of the mother's *Healthy Families Florida Assessment Tool (HFFAT)* total score, individual items on the HFFAT and their statistical relationships with retention at 3, 6 and 12 months. HFFAT total scores varied significantly across categories for those retained and those not retained at 6 and 12 months. Those retained had lower HFFAT scores. When looking at individual items on the HFFAT, there were several that had a significant association with one of the three retention rates (3, 6, or 12 months) and three concerns that were significantly associated

with all three retention rates. These concerns were little or no prenatal care (< 5 visits) or poor compliance with treatment/medication, continued smoking/tobacco use and limited awareness with discipline options. Participants with any of these concerns were less likely to be retained. The final set of relationships in this analysis included pregnant at assessment, number of home visits completed during Level 1 and retention at 3, 6 and 12 months. Participants who were pregnant at assessment had higher retention at 3, 6 and 12 months. Those with a higher number of home visits on Level 1 had higher retention at 3, 6 and 12 months.

3. What participant characteristics and programmatic experiences in Healthy Families Florida are related to the number of days in the program?

The answer to this question was based on the development and testing of a conceptual model that included several predictive factors and one dependent variable, the number of days between the enrollment date and the closure date or end of the study period. While tests of bivariate relationships were conducted for each predictor and number of days in the program, the primary emphasis was a multivariate analysis in which the variation in the predictors was controlled in the determination of the significance of each. Relying on stepwise regression to identify the "best fit" model, the statistically significant or "best" predictors are specified in Figure 7.

Figure 7: "Best Fit" Model for Predicting Days between Enrollment and Closure



The significant relationships in Figure 7 indicate the following:

- The higher the number of home visits on Level 1 the higher the number of days in the program
- The higher the number of children at intake the lower the number of days in the program
- If a participant is pregnant at assessment, the higher the number of days in the program
- The higher the HFFAT score of a participant the lower the number of days in the program
- The higher the number of days between assessment and enrollment the lower the number of days in the program
- If a participant is White, the lower the number of days in the program

This analysis of retention of participants and families in Healthy Families Florida was valuable for a variety of reasons. While there were still several findings that were inconsistent across studies, there were a few findings in this analysis (bivariate or multivariate) that were consistent with earlier findings in the analysis of HFF participant data or in one other analysis of participant data from home visiting programs preventing child abuse and neglect. Using these criteria, the predictors identified as significant and an explanation of the specific bivariate relationships are listed below:

- *Black participants have higher retention*
- *Hispanic participants have higher retention*
- *White participants have lower retention and lower number of days in the program**
- *Prenatal enrollment is related to higher retention and higher number of days in the program (based on pregnant at assessment in the HFF analysis)**
- *A higher number of children at intake is related to lower retention and lower number of days in the program**
- *Older participants have higher retention (12 month retention in HFF analysis)*
- *Single parent status related to lower retention (12 months) and lower number of days in the program*
- *A higher number of completed home visits is related to higher number of days in the program (completed home visits on Level 1 in the HFF analysis)**
- *A higher number of days between assessment and enrollment is related to lower number of days in the program**
- *A higher HFFAT total score for the mother is related to lower retention and lower number of days in the program**
- *Individual HFFAT concerns related to lower retention were active substance abuse in the home (6 months), history of alcohol/substance abuse (12 months), MOB/SO committed one or more victimless crimes (12 months), little or no prenatal care or poor compliance with treatment/medication (3, 6 and 12 months), continued smoking/tobacco use (3, 6 and 12 months), verbalized unrealistic expectations about child development (3 months) and limited awareness of discipline options (3, 6 and 12 months)*

- *Individual HFFAT concerns related to high retention were inadequate income/housing (12 months) and suicidal ideation/attempted suicide (3 months)*

The asterisk (*) next to the predictors listed above indicates that the significant relationship was identified in a multivariate as well as a bivariate analysis and should be considered a more consistent predictor. New predictors identified in this analysis were number of children at intake and several individual HFFAT concerns. It is also important to note that several factors were not statistically significant. Examples of these include education level of the mother and several HFFAT individual concerns that refer to experience with domestic violence in the home, maternal depression, or experience with abuse or neglect as a child. If analysis of HFF participant data is conducted on retention and related factors in the future, consistency across findings should continue to be considered. Any replication of findings will add confidence to corresponding changes and improvements to the program. Future analyses should also consider new factors not included in previous tests of statistical significance.

Chapter IV
Review and Analysis of Information on Healthy Families Florida Participants Who Left the Program*

The purpose of the fourth chapter of research on engagement and retention was to learn more about people who are leaving the program due to completion or who leave for various reasons prior to program completion. The families studied in this chapter include those participants in Healthy Families Florida (HFF) who closed between December 1, 2005 and March 23, 2006. The three main research questions answered in this chapter follow, along with a brief explanation of the approach implemented to answer each question. **Please note that frequencies have been rounded to the nearest whole percent throughout this chapter of the report.*

Who is leaving the program?

For this analysis, a number of demographic variables, such as age, race, education level, marital status, timing of assessment, number of children and the type of community in which closed participants reside were included. Risk for child abuse and neglect, as indicated by specific items on the *Healthy Families Florida Assessment Tool (HFFAT)*, as well as by the total score on the HFFAT, were examined. Finally, a number of variables related to closed participants' experiences with Healthy Families Florida, such as the length of time from assessment to enrollment, the number of home visits completed on Level 1, the length of time on program levels and the overall length of time in the program were reviewed.

Why are people leaving the program?

The frequency of families closed due to each closure reason was reviewed. Seven "closure reasons groups" were formed in order to conduct analyses that would answer the third research question.

What distinguishes people closing for different reasons?

Statistical relationships between demographic, abuse and neglect risk and service experience variables mentioned above and closure reason were tested to determine if any significant differences exist between the closure reason groups.

Characteristics of Participants Who Left the Program

Demographic Characteristics

Our sample of HFF closed participants consisted of 748 primary participants from all HFF projects who left the program between December 1, 2005 and March 23, 2006. Based on the definitions of community types mentioned previously (p. 34), almost half (49 percent) of closed participants in this sample received services from Healthy Families projects located within small city communities. Over a fourth (26 percent) of closed participants received services from Healthy Families projects serving major cities. Thirteen percent received services from HFF projects serving mid-sized city communities and 12 percent were served by HFF projects serving rural communities. The majority of closed participants in this sample were female (99 percent), with five male participants comprising the remaining 1 percent of the

sample. The average age at time of closure was 24 years, with a range from 14 to 63 years. Forty-three percent identified their race as Black (non-Hispanic), 29 percent as White (non-Hispanic) and 26 percent as Hispanic. The remaining 2 percent of participants identified as Other, Multi/bi-racial, Native American or Asian or Pacific Islander (non-Hispanic). At the time of intake, the highest level of education completed was less than 12th grade for 48 percent of closed participants in the sample. Thirty-four percent had completed their high school diploma or certificate, 6 percent their GED, 2 percent vocational high school or college and 11 percent some college. Thirty-five (10 percent) of the 355 closed participants who entered the program with less than a high school education had improved their education level to high school diploma, GED or beyond by the time they closed from the program. Sixty-one percent of the sample was pregnant at the time of assessment and 78 percent was single. The average number of children was one, with a range from zero to 14 children. Almost half (47 percent) of closed participants had more than one child.

Risk for Child Abuse and Neglect

The *Healthy Families Florida Assessment Tool (HFFAT)* is used to determine eligibility for the program based on risk for child abuse and neglect. Assessments are considered positive, with the family being at risk of child abuse and neglect, when a parent or significant other scores 13 or higher on the HFFAT. If neither score is 13 or higher, a family can still be deemed eligible for the program as a "clinical positive" based on information from a professional source, parent or guardian that would have scored the family into the program if the parent had revealed the information. This decision can only be made by a supervisor and factors justifying the decision must be documented in the participant file. HFFAT scores were available for all but ten of the 748 participants in this sample. The average HFFAT score was 25, with a range from 6 to 68. Data regarding specific items on the HFFAT were only available for 553 closed participants in this sample, as data for individual items were not entered into the HFF Data System prior to December 23, 2003. For purposes of this study, similar or related HFFAT items were combined in order to form a total of eight indicators (abuse and neglect risk factors). Four hundred and seventy-four (86 percent) of the 553 participants who had HFFAT item information available in the data system identified positively on at least one of the following eight selected groupings of abuse and neglect risk factors from the HFFAT:

- 43 percent experienced abuse and/or neglect as a child
- 37 percent experienced or had a fear of violence in relationships
- 33 percent reported substance abuse not resulting in treatment or substance abuse present by someone in the household other than the mother of the baby (MOB)
- 32 percent had a childhood caregiver who abused substances or was mentally unstable
- 28 percent were experiencing maternal depression
- 23 percent witnessed domestic violence as a child or adolescent
- 23 percent were treated or hospitalized for substance abuse or mental illness
- 20 percent committed violent or criminal behavior

Service Experience

An average of 40 days passed from the time of assessment to enrollment in the program for these participants. Level 1 home visit data was available for 459 closed participants, who completed an average of 23 visits while on Level 1, with a range of one to 175 visits. The average length of time in the program was approximately one and a half years (555 days), with a range from nine days to approximately five and a half years (2035 days). Almost two-fifths of closed participants (38 percent) were on Level X at the time of closure and almost a third (32 percent) was on Level 1 or a special status of Level 1.

Table 21: Level and Home Visit Information

Level	Participants on Level at Closure	Participants with at Least One Completed Home Visit on Level	Average # of Months on Level*	Average Number of Completed Home Visits on Each Level
Level 1	210 (28%)	459	8.8	23
Level 1-E	13 (2%)	66	8.9	15
Level 1-P	5 (1%)	299	4.8	10
Level 1-SS	4 (1%)	14	7.2	24
Level 2	75 (10%)	269	10.0	20
Level 3	38 (5%)	167	11.2	15
Level 4	116 (16%)	80	10.5	13
Level X	287 (38%)	101	6.0	10

*Based on dates of first and last home visits on level

Finally, for purposes of this study and due to the small number of families closed for some of the closure reasons, all closure reasons were condensed into a total of seven closure reason groups. The following closure reasons were of interest for this study and had adequate numbers of closed participants to conduct analyses: "Moved Out of Service Area" (MOOSA), "Vanished (Lost Contact)," "Not Interested," "Completed HFF," "Other" and "Parent School/Work Full-Time." Due to small numbers of participants closed for each of the remaining reasons, all other closure reasons were collapsed into a seventh and final group, entitled "All Remaining Reasons." As displayed in Table 22, the largest closure reason group consisted of those participants closing due to "Moved Out of Service Area" (MOOSA) (24 percent), followed by "Vanished (Lost Contact)" (20 percent), "Not Interested" (18 percent), "Completed HFF" (15 percent), "Parent School/Work Full-Time" (11 percent), "Other" (7 percent) and "All Remaining Closure Reasons" (6 percent). Descriptions of each closure reason appear in Table 23.

Table 22: Frequency Distribution for Closure Reason Groups

Closure Reason Group	Number of Closed Participants	Percent of Sample
Moved out of Service Area (MOOSA)	182	24%
Vanished (Lost Contact)	146	20%
Not Interested	131	18%
Completed HFF	112	15%
Parent in School/Work Full-Time	84	11%
Other	52	7%
All Remaining Closure Reasons (includes those closed due to the following reasons)	41	6%
o Child Removed by CPS	15	2.0%
o Referred to a NON-HFF Healthy Families Program	5	0.7%
o Child Adopted Out	4	0.5%
o Transferred to Another HFF Site	4	0.5%
o Refused New FSW	4	0.5%
o Target Child Miscarried/ITOP/Died	3	0.4%
o Aged Out	3	0.4%
o Parent Incarcerated	2	0.3%
o Primary Participant Died	1	0.1%

Table 23: Descriptions of HFF Closure Reasons

Closure Reason	Description
Moved out of Service Area (MOOSA)	This option is used when the participant moves out of the site's service area.
Vanished (Lost Contact)	The family cannot be located after 90 days of outreach has been provided.
Not Interested	A participant is not interested in remaining involved in the program.
Completed HFF Program	The HFF program is completed when the participant has completed Level 4.
Parent in School/Work Full-time	A participant is unable to participate in the program due to the demands of attending school/work full-time.
Other	The reason the family wishes to close is provided. No reason that is already listed or is associated with a reason listed should be entered as "Other."
Parent Incarcerated	The primary participant is incarcerated.
Target Child Miscarried/ITOP/Died	The target child died, or the mother miscarried or terminated her pregnancy.
Referred Out	The participant would be better served through other community resources/programs. The participant is referred to a more appropriate service.
Child Adopted Out	The target child was adopted out of the family.
Child Removed by CPS	The target child is removed from the family by CPS and there are no immediate reunification plans.
Referred to a NON-HFF Healthy Families Program	A participant moves to another state that has a Healthy Families program
Transferred to Another HFF Site	A participant moves to another HFF site in Florida and is enrolled into their HFF program.
Primary Participant Died	The primary participant has died.
Aged Out	A family has not completed Level 4 but has been in the program for five years after the birth of the baby.
Refusing New FSW	A participant is not interested in remaining in the program due to a change in FSW.

Characteristics of Participants in Closure Reason Groups

"Moved out of Service Area" (MOOSA) Closure Reason Group

A total of 182 primary participants closed due to "Moved out of Service Area" (MOOSA). 181 were female and one was male. Over half (53 percent) received services from an HFF project serving a small city or town. One-fourth (25 percent) received services from a project serving a major city, 12 percent from a project serving a rural community and 10 percent from a project serving a mid-sized city. The average age of these closed participants was 23 years, with a range from 15 to 44 years. White was the most common race identified by this group (41 percent), followed by Hispanic (32 percent), Black (25 percent) and those identifying with another race (2 percent). At intake, the majority of these closed participants had completed high school or beyond, with 34 percent reporting a high school diploma or certificate as their highest level of educational attainment, 11 percent some college, 10 percent a GED and one percent vocational training. The remaining 43 percent reported less than a 12th grade education. At the point of closure from the program, three of these participants had improved their highest level of educational achievement to at least the high school level. At intake, 63 percent of participants closed due to moving out of the service area were pregnant and 77 percent were single. Participants had an average of one child at the time of intake, with a range from zero to nine children. Forty five percent of participants closed due to "MOOSA" had at least one child in addition to the target child. A summary of demographic information about participants in the sample closed due to "MOOSA" is presented in Table 24.

Table 24: Demographic Information: Entire Sample and "MOOSA" Group

	Entire Sample	MOOSA
Number of Closed Participants	748 closed participants	182 closed participants
Major City	26%	25%
Mid-sized City	13%	10%
Small City or Town	49%	53%
Rural Community	12%	12%
Female	99%	99%
Male	1%	1%
Mean Age	24 years	23 years
Black	43%	25%
White	29%	41%
Hispanic	26%	32%
Other	2%	2%
Less than High School-Intake	48%	43%
Pregnant at Assessment	61%	63%
Single at Intake	78%	77%
Mean Number of Children	1 child	1 child
% with More than One Child	47%	45%

The average HFFAT score for mothers in this group was 25, with a range from eight to 65. Based on data for 163 closed participants in the "MOOSA" group for whom HFFAT item

data are available, the following is the prevalence of the following eight selected groupings of abuse and neglect risk factors from the HFFAT among participants in this sample who closed due to ”MOOSA”:

- 47 percent experienced abuse and/or neglect as a child
- 39 percent reported substance abuse not resulting in treatment or substance abuse present in the home by an adult other than the mother of the baby
- 36 percent experienced or feared violence in relationships
- 31 percent had a caregiver during childhood who abused substances or was mentally unstable
- 29 percent were treated or hospitalized for substance abuse or mental illness
- 25 percent were experiencing maternal depression
- 22 percent witnessed domestic violence as a child/adolescent
- 17 percent committed violent and/or criminal behavior

The average number of days between assessment and enrollment in the program was 40 days. Participants closed due to “MOOSA” received an average of 18 home visits while on Level 1, with a range of one to 76 visits. The average length of time in the program was slightly less than one year (350 days), with a range of 13 days to approximately three years and ten months (1408 days). Information regarding level at closure, time spent on each level and the number of home visits completed on each level appears in Table 25.

Table 25: Level and Home Visit Information: “MOOSA”

Level	Participants on Level at Closure	Participants with at Least One Completed Home Visit on Level	Average # of Months on Level*	Average Number of Completed Home Visits on Level
Level 1	85 (47%)	94	6.3	18
Level 1-E	4 (2%)	8	7.6	12
Level 1-P	0 (0%)	67	4.8	9
Level 1-SS	1 (1%)	3	9.6	35
Level 2	35 (19%)	49	6.1	14
Level 3	19 (10%)	16	8.2	13
Level 4	2 (1%)	1	1.2	1
Level X	36 (20%)	18	3.5	9

*Based on dates of first and last home visits on level

"Vanished (Lost Contact)" Closure Reason Group

A total of 146 primary participants closed due to "Vanished (Lost Contact)" were female and one was male. Slightly over a third (35 percent) received services from an HFF project serving a small city, while almost a third (32 percent) received services from a project serving a major city. One fifth (20 percent) of these closed participants received services from a project serving a mid-sized city and 13 percent received services from a project serving a rural community. The average age at the time of closure for these participants was 23 years, with a range from 14 to 42 years. Black was the most commonly identified race in this closure group (56 percent), followed by Hispanic (23 percent) and White (19 percent). The remaining 2 percent identified with another race. The majority (55 percent) of closed participants in this group reported less than high school education as their highest level of education completed at the time of intake. Twenty-nine percent had earned their high school diploma or certificate, 9 percent had attended college, 6 percent had received their GED and 1 percent had completed vocational training. Of those who had not completed at least 12th grade or equivalent at the time of intake, five had improved their education level by the time of closure. Fifty four percent of the closed participants in this group were pregnant at the time of intake and 84 percent were single. The average number of children at intake was one child, with a range from zero to seven children. Forty eight percent of primary participants had at least one child in addition to the target child. A summary of demographic information about participants in the sample closed due to "Vanished (Lost Contact)" is presented in Table 26.

Table 26: Demographic Information: Entire Sample and "Vanished (Lost Contact)" Group

	Entire Sample	Vanished (Lost Contact)
Number of Closed Participants	748 closed participants	146 closed participants
Major City	26%	32%
Mid-sized City	13%	20%
Small City or Town	49%	35%
Rural Community	12%	13%
Female	99%	99%
Male	1%	1%
Mean Age	24 years	23 years
Black	43%	56%
White	29%	19%
Hispanic	26%	23%
Other	2%	2%
Less than High School-Intake	48%	55%
Pregnant at Assessment	61%	54%
Single at Intake	78%	84%
Mean Number of Children	1 child	1 child
% with More than One Child	47%	48%

The average HFFAT score for mothers in this group was 24, with a range from nine to 68. Based on data for 117 closed participants in the "Vanished (Lost Contact)" group for whom HFFAT item data are available, the following is the prevalence of eight selected groupings of abuse and neglect risk factors from the HFFAT among participants in this sample who closed due to "Vanished (Lost Contact)":

- 35 percent experienced abuse and/or neglect as a child
- 33 percent experienced or had a fear of violence in relationships
- 32 percent reported substance abuse not resulting in treatment or substance abuse present in the home by an adult other than the mother of the baby
- 28 percent were experiencing maternal depression
- 27 percent had a caregiver during childhood who abused substances or was mentally unstable
- 23 percent committed violent and/or criminal behavior
- 21 percent witnessed domestic violence as a child/adolescent
- 15 percent were treated or hospitalized for substance abuse or mental illness

There was an average of 56 days between assessment and enrollment in the program. Participants received an average of 20 home visits while on Level 1, with a range from one to 110 visits, and were in the program an average of approximately one year and four months (491 days). The majority (96 percent) of these participants were on Level X at the time of closure. Information regarding level at closure, time spent on each level and the number of home visits completed on each level appears in Table 27.

Table 27: Level and Home Visit Information: "Vanished (Lost Contact)"

Level	Participants on Level at Closure	Participants with at Least One Completed Home Visit on Level	Average # of Months on Level*	Average Number of Completed Home Visits on Level
Level 1	2 (1%)	106	8.0	20
Level 1-E	0 (0%)	15	11.5	12
Level 1-P	1 (1%)	56	4.1	8
Level 1-SS	0 (0%)	0	N/A	N/A
Level 2	1 (1%)	48	7.9	17
Level 3	2 (1%)	20	7.5	12
Level 4	0 (0%)	2	0.3	1
Level X	140 (96%)	21	4.5	9

*Based on dates of first and last home visits on level

"Not Interested" Closure Reason Group

A total of 131 participants closed due to "Not Interested" were female and one was male. Forty five percent of these closed participants received services from an HFF project serving a small city or town. Almost a third (32 percent) was served by a project serving a major city. Fifteen percent received services from a project serving a mid-sized city and 8 percent from a project serving a rural community. The average age was 23 years, with a range from 14 to 49 years. Fifty two percent identified themselves as Black, 24 percent as White, 21 percent as Hispanic and the remaining 3 percent as other races. At the time of intake, half of these participants reported their highest level of education as less than high school. Thirty four percent had earned their high school diploma or certificate, 10 percent had attended college, 4 percent received their GED and 3 percent had received vocational training. By the time of closure, one participant with less than high school education at intake had improved their education level to at least high school. At the time of intake, 64 percent of these mothers were pregnant and 82 percent were single. Participants had an average of one child at intake, with a range from zero to 14 children. Half had at least one child in addition to the target child. A summary of demographic information about participants in the sample closed due to "Not Interested" is presented in Table 28.

Table 28: Demographic Information: Entire Sample and "Not Interested" Group

	Entire Sample	**Not Interested**
Number of Closed Participants	748 closed participants	131 closed participants
Major City	26%	32%
Mid-sized City	13%	15%
Small City or Town	49%	45%
Rural Community	12%	8%
Female	99%	99%
Male	1%	1%
Mean Age	24 years	23 years
Black	43%	52%
White	29%	24%
Hispanic	26%	21%
Other	2%	3%
Less than High School-Intake	48%	50%
Pregnant at Assessment	61%	64%
Single at Intake	78%	82%
Mean Number of Children	1 child	1 child
% with More than One Child	47%	50%

The average HFFAT score for mothers in this group was 25, with a range from 11 to 67. Based on data for 113 closed participants in the "Not Interested" group for whom HFFAT item data are available, the following is the prevalence of selected groupings of abuse and neglect risk factors from the HFFAT among participants in this sample who closed due to "Not Interested:"

- 43 percent experienced abuse and/or neglect as a child
- 34 percent reported substance abuse not resulting in treatment or substance abuse present in the home by an adult other than the mother of the baby
- 33 percent experienced or had a fear of violence in relationships
- 32 percent had a caregiver during childhood who abused substances or was mentally unstable
- 31 percent were experiencing maternal depression
- 24 percent witnessed domestic violence as a child/adolescent
- 17 percent were treated or hospitalized for substance abuse or mental illness
- 16 percent committed violent and/or criminal behavior

There was an average of 40 days from assessment to enrollment in the program. Participants closing due to "Not Interested" received an average of 18 home visits on Level 1, with a range from one to 91 visits. This group of closed participants spent an average of slightly over 11 months (340 days) in the program, with a range from one month (30 days) to approximately four and a half years (1666 days). Information regarding level at closure, time spent on each level and the number of home visits completed on each level appears in Table 29.

Table 29: Level and Home Visit Information: "Not Interested"

Level	Participants on Level at Closure	Participants with at Least One Completed Home Visit on Level	Average # of Months on Level*	Average Number of Completed Home Visits on Level
Level 1	50 (38%)	61	7.4	18
Level 1-E	2 (2%)	6	6.1	12
Level 1-P	0 (0%)	45	4.3	12
Level 1-SS	1 (1%)	2	1.0	5
Level 2	17 (13%)	22	8.3	19
Level 3	10 (8%)	12	9.2	10
Level 4	0 (0%)	0	N/A	N/A
Level X	51 (39%)	11	7.2	15

*Based on dates of first and last home visits on level

"Completed HFF Program" Closure Reason Group

Of the 112 HFF primary participants in the sample who completed the program, 110 were female and the remaining two were male. Over half (55 percent) of these closed participants

received services from an HFF project serving a small city or town. 29 percent received services from a project serving a major city, 13 percent from a project serving a rural community and 4 percent from a project serving a mid-sized city. The average age of participants at the time of closure was highest for this group of closed participants, at 28 years. Their ages ranged from 18 to 64 years. Almost half (49 percent) of the participants in this group were Black, 27 percent were Hispanic, 22 percent were White and 2 percent identified with other races. At the time of intake, 44 percent of these participants reported less than high school education, 38 percent had received their high school diploma or certificate, 13 percent had attended college, 4 percent had earned their GED and 2 percent had received vocational training. At the time of closure, 11 participants who initially had less than 12th grade education had improved their education level to at least high school or equivalent. At intake, 55 percent of participants in this group were pregnant and 68 percent were single. The average number of children at the time of intake was one, with a range from zero to six children. Forty four percent of those completing the program had at least one child in addition to the target child. A summary of demographic information about participants in the sample closed due to completion of the program is presented in Table 30.

Table 30: Demographic Information: Entire Sample and "Completed HFF Program" Group

	Entire Sample	**Completed HFF Program**
Number of Closed Participants	748 closed participants	112 closed participants
Major City	26%	29%
Mid-sized City	13%	4%
Small City or Town	49%	55%
Rural Community	12%	13%
Female	99%	98%
Male	1%	2%
Mean Age	24 years	28 years
Black	43%	49%
White	29%	22%
Hispanic	26%	27%
Other	2%	2%
Less than High School-Intake	48%	44%
Pregnant at Assessment	61%	55%
Single at Intake	78%	68%
Mean Number of Children	1 child	1 child
% with More than One Child	47%	44%

Completers had an average HFFAT score of 22, with a range from 13 to 54. HFFAT item information was available for only eight program completers (7 percent of completers in the sample), as most entered the program before HFFAT item information began being entered into the HFF Data System. The following is the prevalence of selected groupings of abuse and neglect risk factors from the HFFAT for these eight completers:

- 25 percent were experiencing maternal depression
- 25 percent witnessed domestic violence as a child/adolescent
- 25 percent were treated or hospitalized for substance abuse or mental illness
- 13 percent experienced abuse and/or neglect as a child
- 13 percent experienced or had a fear of violence in relationships
- 13 percent had a caregiver during childhood who abused substances or was mentally unstable
- 13 percent committed violent and/or criminal behavior
- None (0 percent) reported substance abuse not resulting in treatment or substance abuse present in the home by an adult other than the mother of the baby

There was an average of 21 days between assessment and enrollment in the program. Participants in this group received an average of 33 home visits while on Level 1 of the program, with a range from one to 124 visits. Completers spent an average of almost four years (1442 days) in the program. All completers closed the program on Level 4. Information regarding level at closure, time spent on each level and the number of home visits completed on each level appears in Table 31.

Table 31: Level and Home Visit Information: "Completed HFF Program"

Level	Participants on Level at Closure	Participants with at Least One Completed Home Visit on Level	Average # of Months on Level*	Average Number of Completed Home Visits on Level
Level 1	0 (0%)	107	12.2	33
Level 1-E	0 (0%)	24	9.6	19
Level 1-P	0 (0%)	52	7.5	17
Level 1-SS	0 (0%)	3	20.3	54
Level 2	0 (0%)	110	13.4	25
Level 3	0 (0%)	108	12.7	16
Level 4	112 (100%)	76	11.1	14
Level X	0 (0%)	25	8.4	13

*Based on dates of first and last home visits on level

"Other" Closure Reason Group

All of the 52 participants in this sample citing "Other" reasons for closure were female. Sixty five percent of these closed participants received services from an HFF project serving a small city or town. Seventeen percent received services from a project serving a major city, 12 percent from a project serving a mid-sized city and 6 percent from a project serving a rural community. The average age of these participants was 23 years, with a range from 16 to 50 years. Fifty two percent were Black, 39 percent White, 8 percent Hispanic and 2 percent identified with other races. At the time of intake, 44 percent of these closed participants had an education level below 12th grade. Thirty five percent had received a high school diploma or certificate, 12 percent had attended college, 8 percent received their GED and 2 percent had received vocation training. Of those participants with less than 12th grade completed at intake, two improved their education level by the time of closure from the program. Sixty one percent of participants closing due to "Other" reasons were pregnant at the time of assessment and 84 percent were single. Participants had an average of one child at intake, with a range from zero to four children. Forty four percent had at least one child in addition to the target child. A summary of demographic information about participants in this sample closed due to "Other" reasons is presented in Table 32.

Table 32: Demographic Information: Entire Sample and "Other" Group

	Entire Sample	Other
Number of Closed Participants	748 closed participants	52 closed participants
Major City	26%	17%
Mid-sized City	13%	12%
Small City or Town	49%	65%
Rural Community	12%	6%
Female	99%	100%
Male	1%	0%
Mean Age	24 years	23 years
Black	43%	52%
White	29%	39%
Hispanic	26%	8%
Other	2%	2%
Less than High School-Intake	48%	44%
Pregnant at Assessment	61%	61%
Single at Intake	78%	84%
Mean Number of Children	1 child	1 child
% with More than One Child	47%	44%

The average HFFAT score for mothers in this group of closed participants was 28, with a range from six to 64. Based on data for 48 closed participants in the "Other" group for whom HFFAT item data are available, the following is the prevalence of eight selected groupings of abuse and neglect risk factors from the HFFAT among participants in this sample who closed due to "Other" reasons:

- 54 percent experienced or had a fear of violence in relationships
- 52 percent experienced abuse and/or neglect as a child
- 38 percent had a caregiver during childhood who abused substances or was mentally unstable
- 35 percent witnessed domestic violence as a child/adolescent
- 33 percent reported substance abuse not resulting in treatment or substance abuse present in the home by an adult other than the mother of the baby
- 33 percent committed violent and/or criminal behavior
- 25 percent were experiencing maternal depression
- 25 percent were treated or hospitalized for substance abuse or mental illness

There was an average of 28 days between assessment and enrollment in the program. These participants received an average of 21 home visits while on Level 1, with a range from five to 122 visits. The average amount of time spent in the program by this group of participants was a little over one year (371 days), with a range from 12 days to over five years (1870 days). Information regarding level at closure, time spent on each level and the number of home visits completed on each level appears in Table 33.

Table 33: Level and Home Visit Information: "Other"

Level	Participants on Level at Closure	Participants with at Least One Completed Home Visit on Level	Average # of Months on Level*	Average Number of Completed Home Visits on Level
Level 1	21 (40%)	27	8.8	21
Level 1-E	1 (2%)	4	5.9	8
Level 1-P	1 (2%)	25	2.5	5
Level 1-SS	0 (0%)	3	2.2	12
Level 2	8 (15%)	8	7.2	14
Level 3	2 (4%)	2	9.1	9
Level 4	0 (0%)	0	N/A	N/A
Level X	19 (37%)	6	11.2	14

*Based on dates of first and last home visits on level

"Parent School/Work Full-Time" Closure Reason Group

All of the 84 participants who closed due to full-time school or work were female. Forty eight percent of these closed participants received services from an HFF project serving a small city or town. Sixteen percent received services from a project serving a major city and 16 percent from a project serving a mid-sized city. The remaining 21 percent received services from a project serving a rural community. The average age was 25 years, with a range from 14 to 39 years. Regarding race, 36 percent were Black, 32 percent Hispanic, 29 percent White and 4 percent were identified as other races. At the time of intake, 38 percent of this group reported an education level less than 12th grade. Thirty nine percent had received a high school diploma or certificate, 18 percent had attended college, 4 percent received their GED and 1 percent had received vocational training. Of those participants with less than 12th grade education at intake, eight had improved their education level to high school, its equivalent or beyond by the time of closure from the program. At the time of intake, 68 percent of mothers in this group were pregnant and 72 percent were single. The average number of children at intake was one child, with a range from zero to four children. Forty four percent had at least one child in addition to the target child. A summary of demographic information about participants in this sample closed due to full-time school or work is presented in Table 34.

Table 34: Demographic Information: Entire Sample and "Parent School/Work Full-Time" Group

	Entire Sample	**Parent School/ Work Full-Time**
Number of Closed Participants	748 closed participants	84 closed participants
Major City	26%	16%
Mid-sized City	13%	16%
Small City or Town	49%	48%
Rural Community	12%	21%
Female	99%	100%
Male	1%	0%
Mean Age	24 years	25 years
Black	43%	36%
White	29%	29%
Hispanic	26%	32%
Other	2%	4%
Less than High School-Intake	48%	38%
Pregnant at Assessment	61%	68%
Single at Intake	78%	72%
Mean Number of Children	1 child	1 child

	Entire Sample	Parent School/ Work Full-Time
% with More than One Child	47%	44%

Mothers in this group had an average HFFAT score of 24, with a range from seven to 64. Based on data for 71 participants in the "Parent School/Work Full-time" group for whom HFFAT item data are available, the following is the prevalence of eight selected groupings of abuse and neglect risk factors from the HFFAT among participants in this sample who closed due to full-time school or work:

- 45 percent experienced abuse and/or neglect as a child
- 41 percent experienced or had a fear of violence in relationships
- 34 percent had a caregiver during childhood who abused substances or was mentally unstable
- 30 percent were experiencing maternal depression
- 28 percent reported substance abuse not resulting in treatment or substance abuse present in home by an adult other than mother of the baby
- 23 percent were treated or hospitalized for substance abuse or mental illness
- 21 percent witnessed domestic violence as a child/adolescent
- 16 percent committed violent and/or criminal behavior

There was an average of 27 days from assessment to enrollment in the program. The average number of home visits received while on Level 1 of the program by participants in this group was 20 visits, with a range of one to 61 visits. These participants were in the program for an average of slightly over one year and one month (397 days), with a range from 9 days to four years and seven and a half months (1699 days). The majority of participants in this group closed on Level 1 (42 percent) or Level X (42 percent). Information regarding level at closure, time spent on each level and the number of home visits completed on each level appears in Table 35.

Table 35: Level and Home Visit Information: "Parent School/Work Full-Time"

Level	Participants on Level at Closure	Participants with at Least One Completed Home Visit on Level	Average # of Months on Level*	Average Number of Completed Home Visits on Level
Level 1	35 (42%)	39	6.9	20
Level 1-E	5 (6%)	7	6.1	14
Level 1-P	0 (0%)	34	2.4	6
Level 1-SS	1 (1%)	0	N/A	N/A
Level 2	5 (6%)	21	8.2	15
Level 3	3 (4%)	6	6.7	7

Level	Participants on Level at Closure	Participants with at Least One Completed Home Visit on Level	Average # of Months on Level*	Average Number of Completed Home Visits on Level
Level 4	0 (0%)	0	N/A	N/A
Level X	35 (42%)	14	3.6	7

*Based on dates of first and last home visits on level

"All Remaining Closure Reasons" Group

All 41 participants closing due to the remaining closure reasons were female. Sixty one percent received services from an HFF project serving a small city or town. Fifteen percent received services from a project serving a major city, 12 percent from a project serving a rural community and 12 percent from a project serving a mid-sized city. The average age at closure for this group of participants was 25 years, with a range from 16 to 40 years. Thirty nine percent of these participants reported their race as White, 32 percent as Hispanic and 29 percent as Black. At the time of intake in the program, 66 percent reported less than 12th grade education, 24 percent had received their high school diploma or certificate, 7 percent had earned their GED and 2 percent had attended college. At the time of closure from the program, five of the participants who initially had less than 12th grade education had improved their education level to at least the high school level by the time they closed from the program. Sixty eight percent of mothers in this group were pregnant at the time of intake and 75 percent were single. They had an average of one child at intake, with a range from zero to five children. Fifty four percent had at least one child in addition to the target child. A summary of demographic information about participants in this sample closed due to all remaining reasons is presented in Table 36.

Table 36: Demographic Information: Entire Sample and "All Remaining Closure Reasons" Group

	Entire Sample	All Remaining Closure Reasons
Number of Closed Participants	748 closed participants	41 closed participants
Major City	26%	15%
Mid-sized City	13%	12%
Small City or Town	49%	61%
Rural Community	12%	12%
Female	99%	100%
Male	1%	0%
Mean Age	24 years	25 years
Black	43%	29%
White	29%	39%
Hispanic	26%	32%

	Entire Sample	All Remaining Closure Reasons
Other	2%	0%
Less than High School-Intake	48%	66%
Pregnant at Assessment	61%	68%
Single at Intake	78%	75%
Mean Number of Children	1 child	1 child
% with More than One Child	47%	54%

The average HFFAT score for mothers in this group was 28, with a range from seven to 61. Based on data for 33 participants in the "All Remaining Closure Reasons" Group for whom HFFAT item data are available, the following is the prevalence of eight selected groupings of abuse and neglect risk factors from the HFFAT among participants in the "All Remaining Closure Reasons" group:

- 49 percent experienced abuse and/or neglect as a child
- 46 percent experienced or had a fear of violence in relationships
- 36 percent had a caregiver during childhood who abused substances or was mentally unstable
- 33 percent were treated or hospitalized for substance abuse or mental illness
- 30 percent were experiencing maternal depression
- 30 percent reported substance abuse not resulting in treatment or substance abuse present in the home by an adult other than the mother of the baby
- 24 percent committed violent and/or criminal behavior
- 21 percent witnessed domestic violence as a child/adolescent

The average number of days from assessment to enrollment in the program was 58 days. The average number of visits completed while on Level 1 of the program was 35 visits, with a range from one to 175 visits. Closed participants in this group spent an average of one year and almost five months (510 days) in the program, with a range from 14 days to over five years and two months (1900 days). Information regarding level at closure, time spent on each level and the number of home visits completed on each level appears in Table 37.

Table 37: Level and Home Visit Information: "All Remaining Closure Reasons"

Level	Participants on Level at Closure	Participants with at Least One Completed Home Visit on Level	Average # of Months on Level*	Average Number of Completed Home Visits on Level
Level 1	17 (42%)	25	13.2	35

Level	Participants on Level at Closure	Participants with at Least One Completed Home Visit on Level	Average # of Months on Level*	Average Number of Completed Home Visits on Level
Level 1-E	1 (2%)	2	9.5	20
Level 1-P	3 (7%)	20	7.9	15
Level 1-SS	1 (2%)	3	0.9	6
Level 2	9 (22%)	11	12.0	25
Level 3	2 (5%)	3	16.3	28
Level 4	2 (5%)	1	2.8	2
Level X	6 (15%)	6	8.0	6

*Based on dates of first and last home visits on level

Differences between Closure Reason Groups

Demographic Differences

Chi-square analyses were conducted in order to determine if any significant associations exist for this sample between closure reason and the type of community in which a closed participant was served. The highest percentages of participants closed due to "Not Interested" were served by HFF projects in major cities and mid-sized cities, while the lowest percentage of participants closed due to "Not Interested" were served by HFF projects in rural communities. The highest percentage of participants who closed due to "Vanished (Lost Contact)" were served by HFF projects in mid-sized cities, while the lowest percentage of participants closed due to "Vanished (Lost Contact)" were served by HFF projects in small cities or towns. The highest percentage of participants closed due to "Parent School/Work Full-Time" were served by HFF projects in rural communities, while the lowest percentage of participants closed due to "Parent School/Work Full-Time" were served by HFF projects in major cities. The lowest percentage of participants closed due to completion of the program received services from HFF projects serving mid-sized cities. The highest percentage of participants closed due to "Other" reasons was served by HFF projects in small cities or towns.

Analyses also identified several significant associations between participant characteristics and closure reason groups. Race was found to be significantly related to closure reason, with the most notable difference among participants who closed the program due to "Moved out of Service Area" (MOOSA). This group had the highest percentage of White participants (41 percent) and Hispanic participants (32 percent) of all seven groups, yet the lowest percentage of Black participants (25 percent). "Vanished (Lost Contact)" is the closure group with the highest percentage of closed participants who are Black (56 percent). This closed participant group also contained the lowest percentage of White participants of all groups (19 percent). The "Other" group contained the lowest percentage of participants identified as Hispanic of all seven groups, with only 8 percent identified as Hispanic. The percentage of participants within each group who identified themselves with other races was very small in each

group, with the largest (4 percent) being the group of participants who closed due to full-time work or school commitments. The "All Remaining Closure Reasons" group did not contain any participants who identified their race as something other than Black, White or Hispanic.

The majority of participants in each of the seven closure reason groups were single at the time of intake. Yet variation in the percentage of participants in each group who were single at the time of intake was noted and analysis revealed a significant association between single marital status and closure reason group. The program completers group had the lowest percentage of single parents at intake (68 percent), while the group of participants closed due to "Vanished (Lost Contact)" had the highest percentage (84 percent). Program completers had higher odds of being married at intake than all other closed participants (odds ratio, 1.85), while those closed due to "Vanished (Lost Contact)" had higher odds of being single at intake (odds ratio, 1.67).

The highest level of education completed by participants at the time of closure was found to be significantly associated with closure reason group, although education level at intake was not. The group with the highest percentage of closed participants with less than a 12^{th} grade education at the time of closure is the "All Remaining Closure Reasons" group (54 percent). The group of participants closing due to full-time work or school had the lowest percentage of participants with less than a 12^{th} grade education (29 percent). Participants closing due to full-time work or school had the highest percentage of individuals with at least some vocational or college education completed (21 percent), while participants in the "All Remaining Closure Reasons" group had the lowest (10 percent).

The final significant association between closure group and participant level factors is related to the age of the participant at the time of closure from the program. The average age of participants who closed due to program completion was 28 years while the lowest average age is for participants in the "Vanished (Lost Contact)" group at 23 years. It was suspected that this association was likely due to the higher average age of participants who completed the program than participants closing for all other reasons since they have been participating in the program longer. Thus, the analysis was repeated without this group included. As expected, a significant association was no longer found between age at closure and closure reason.

Risk for Abuse and Neglect Differences

A one-way analysis of variance (ANOVA) revealed a significant difference in maternal HFFAT score between closure reason groups. The mean maternal HFFAT score for the entire sample was 25. The mean score for program completers was 22; while the mean score for those closed due to "Other" reasons and reasons included in the "All Remaining Closure Reasons" group was 28.

The next step was to use chi-square analyses and the calculation of odds ratios to determine if any significant associations exist between closure reasons and selected groupings of abuse and neglect risk indicators, based on HFFAT item responses. When comparing all seven closure reason groups with each other, no significant associations were noted between specific HFFAT risk factor indicators and closure reason groups. Due to a very small number of HFFAT records available for closed participants who completed the program (n=8), the analysis was repeated with this group of closed participants excluded. Among the six other groups of closed participants in this analysis, there is a significant association between closure reason and the presence of one of the HFFAT risk factors of interest: Maternal current or prior substance abuse

or mental illness requiring treatment or hospitalization. . A lower percentage of participants closed due to "Vanished (Lost Contact)" reported this risk factor (15 percent), while a higher percentage of participants in the "All Remaining Closure Reasons" group reported this risk factor (33 percent).

Analyses for four closure reason groups of interest were conducted, in order to gain a better understanding of who these individuals are and what makes them different from those closed due to other reasons. Four dichotomous variables were created, indicating whether or not a participant closed due to the reason of interest. These four variables are "Not Interested," "Vanished (Lost Contact)," "Other" and "MOOSA." Several significant relationships were found between certain risk factors and closure reason groups. Results are presented in Table 38.

Participants closing because they are "Not Interested" were not significantly more or less likely to have indicated the presence of any risk factor indicators. However, when each item from the HFFAT was analyzed individually, it was found that participants closed due to "Not Interested" had lower odds of having committed violence against another person (odds ratio, .52). Ten percent of these closed participants reported this concern, compared to 17 percent of all other closed participants in this sample.

"Vanished (Lost Contact)" participants had lower odds of experiencing current or prior mental illness or substance abuse requiring treatment or hospitalization than those closing due to all other reasons (odds ratio, 1.79). Fifteen percent of "Vanished (Lost Contact)" participants reported this risk factor, compared with 25 percent of those closing for all other reasons. This group of closed participants also had lower odds of experiencing abuse or neglect during childhood than closed participants in all other closure reason groups (odds ratio, 1.56). Thirty five percent of participants in the "Vanished (Lost Contact)" closure reason group reported this risk factor, compared with 46 percent of participants closing due to all other reasons.

Participants closing due to "Other" reasons had higher odds of having witnessed domestic violence during childhood or adolescence than participants in all other closure reason groups (odds ratio, 1.97). Thirty five percent of closed participants in this group reported this risk factor, as opposed to 22 percent of participants in all other closure reason groups. They also had higher odds of having committed violence against another person or engaging in criminal behavior (odds ratio, 2.22). Thirty three percent reported this risk factor as opposed to 18 percent of participants in all of the other closure reason groups. In order to understand whether this relationship was related more to violent or criminal behavior, an analysis was conducted for the item addressing violence toward others as well as the item regarding criminal activity. It appears that participants closed due to "Other" reasons had higher odds of reporting violence against others (odds ratio, 2.44) but lower odds of reporting criminal behavior (odds ratio, .58) as participants closing for all other reasons. Finally, participants closing due to "Other" reasons had higher odds of experiencing violence or having a fear of violence in their intimate partner relationships than all other participants (odds ratio, 2.13). Fifty four percent of these closed participants reported this risk factor as opposed to 36 percent of participants closing due to all other reasons. Regarding individual items, participants closing due to "Other" reasons had higher odds of reporting past abusive relationships, experiencing domestic violence or other abuse within the 12 months before assessment and to report a current physical response to anger than participants closing due to all other reasons. They had lower odds, however, of expressing a fear of violence within the home.

Participants closing due to "Moved out of Service Area" (MOOSA) had higher odds of reporting receipt of treatment or being hospitalized for either mental illness or substance abuse at the time of assessment or in the past than participants who closed for other reasons (odds ratio, 1.62). Twenty nine percent of participants who closed due to "MOOSA" reported this risk factor, compared with 20 percent of participants who closed for all other reasons. Participants who closed due to "MOOSA" also had higher odds of reporting current or recent substance abuse in the home by a member of their household or their own history of untreated substance abuse (odds ratio, 1.4). Thirty nine percent of closed participants in the "MOOSA" closure reason group reported this risk factor, compared to 31 percent of all other closed participants. These were the only significant differences in reported HFFAT risk factor indicators between closed participants in the "MOOSA" group and those in all other groups.

Table 38: HFFAT Risk Factor Indicators for "Not Interested," "Vanished (Lost Contact)," "Other" and "MOOSA" Groups

HFFAT Risk Factor Indicators (All Groups %)	Not Interested		Vanished (Lost Contact)		Other		MOOSA	
As a child or adolescent, witnessed domestic violence. (23%)	23.9%	NS	20.5%	NS	35.4%	*	22%	NS
As a child, had a caregiver who abused substances or was mentally unstable. (32%)	31.9%	NS	27.4%	NS	37.5%	NS	31%	NS
Experienced abuse and/or neglect as a child. (43%)	43.4%	NS	35.0%	*	52.1%	NS	47%	NS
As an adult, treated/hospitalized for substance abuse or mental illness. (23%)	16.8%	NS	15.4%	*	25.0%	NS	29%	*
Substance abuse by someone in the home other than MOB or substance abuse not resulting in treatment or hospitalization. (33%)	33.6%	NS	31.6%	NS	33.3%	NS	39%	*
Committed violence against another person and/or criminal behavior. (20%)	15.9%	NS	23.1%	NS	33.3%	*	17%	NS
Experienced maternal depression. (28%)	31.0%	NS	28.2%	NS	25.0%	NS	25%	NS
Experienced domestic violence as an adolescent or adult. (37%)	32.7%	NS	33.3%	NS	54.2%	*	36%	NS

* = significant ($p < .05$) NS = not significant

Service Experience Differences

Several significant relationships were identified between closure reason group and variables related to participants' experiences with the program. First, it appears that participants in different closure reason groups received a significantly different number of home visits while on Level 1 of the program. Participants who closed due to reasons compiled into the "All

Remaining Closure Reasons" category received the most home visits, with an average of 35 visits completed on Level 1. Participants closing due to "MOOSA" and "Not Interested" received the lowest number of home visits, with an average of 18 visits completed while on Level 1. The average number of completed visits on Level 1 for participants in the remaining five closure groups is as follows:

- 33 visits for HFF program completers
- 21 visits for "Other" closure reasons
- 20 visits for "Vanished (Lost Contact)"
- 20 visits for closure due to full-time work or school

A significant relationship exists for this sample between reason for closure from the program and the number of days a participant spent in HFF. Considering the structure of the program, those who closed due to completion of the program would be expected to have spent a longer period of time in the program. Thus, the analysis was repeated but with all completers excluded. The relationship between the two variables remained significant. Completers spent an average of almost four years in the program (1442 days); the longest amount of time of all closure reason groups. Those closing due to "Not Interested" spent the least amount of time in the program, with an average of slightly over eleven months (340 days). The average amount of time spent in HFF for the five additional closure group is as follows:

- 510 days, or almost one year and five months, for those closing due to "All Remaining Closure Reasons"
- 491 days, or almost one year and four months, for those closing due to "Vanished (Lost Contact)"
- 397 days, or approximately one year and one month, for those closing due to "Parent School/Work Full-Time"
- 371 days, or slightly over one year, for those closing due to "Other" reasons
- 350 days, or slightly under one year, for those closing due to "MOOSA"

Finally, a significant relationship was found between the HFF program level at closure and closure reason. The majority (96 percent) of participants closed due to "Vanished (Lost Contact)" were on Level X at the time of closure. All completers were on Level 4 (100 percent). For the remaining closure groups, there was more variation in program level at closure. The frequencies of participants on each program level at closure appear in Table 39.

Table 39: HFF Level at Closure

Closure Reason Group	Level 1	Level 1-P	Level 1-SS	Level 2	Level 3	Level 4	Level X	Level 1-E
MOOSA	47%	---	1%	19%	10%	1%	20%	2%
Vanished (Lost Contact)	1%	1%	---	1%	1%	---	96%	---
Not Interested	38%	---	1%	13%	8%	---	39%	2%

Closure Reason Group	Level 1	Level 1-P	Level 1-SS	Level 2	Level 3	Level 4	Level X	Level 1-E
Completed HFF	---	---	---	---	---	100%	---	---
Other	40%	2%	---	15%	4%	---	37%	2%
F/T School/Work	42%	---	1%	6%	4%	---	42%	6%
All Remaining Reasons	42%	7%	2%	22%	5%	5%	15%	2%

Summary

In this chapter, the analysis of closed participants provided information about families closing due to various reasons and revealed some differences between those closing for different reasons. The chapter began by presenting information about demographic, risk for child abuse and neglect and experience in HFF variables for the entire sample. Next, information about the reasons why families in the sample left HFF was presented. The most common closure reason was "Moved out of Service Area" (MOOSA) (24 percent), followed by "Vanished (Lost Contact)" (20 percent), "Not Interested" (18 percent), "Completed HFF" (15 percent), "Parent School/Work Full-time" (11 percent) and "Other" reasons (7 percent). Due to very small numbers of participants closing due to the remaining closure reasons that are closure reason options in the HFF Data System, those closed due to these reasons were grouped together to form a seventh and final group: "All Remaining Closure Reasons" (6 percent). Following in sequence, information on the same variables mentioned above was presented separately for each closure reason group. Comparison of data across closure reason groups and the entire sample provided an indication of how the closure group of interest compared to all closed participants in the sample. When testing the statistical relationships between several different factors and closure reasons, the following was learned:

Differences Across Size of Community Served

1. The highest percentages of participants closed due to "Not Interested" were served by HFF projects in major cities and mid-sized cities, while the lowest percentage of participants closed due to "Not Interested" were served by projects in rural communities.
2. The highest percentage of participants who closed due to "Vanished (Lost Contact)" were served by HFF projects in mid-sized cities, while the lowest percentage of participants closed due to "Vanished (Lost Contact)" were served by projects in small cities or towns.
3. The highest percentage of participants closed due to "Parent School/Work Full-Time" were served by HFF projects in rural communities, while the lowest percentage of participants closed due to "Parent School/Work Full-Time" were served by HFF projects in major cities.
4. The lowest percentage of participants closed due to completion of the program received services from HFF projects in mid-sized cities.
5. The highest percentage of participants closed due to "Other" reasons was served by HFF projects in small cities or towns.

Differences in Demographic Characteristics Across Closure Reason Groups

1. A higher percentage of those closed due to "MOOSA" were White while a lower percentage were Black.
2. A higher percentage of those closed due to "Vanished (Lost Contact)" were Black while a lower percentage were White.
3. A lower percentage of those closed due to "Other" reasons were Hispanic.
4. A lower percentage of participants who completed the program were single at intake, while a higher percentage of those closed due to "Vanished (Lost Contact)" were single.
5. A lower percentage of participants closed due to "Parent School/Work Full-Time" had less than a high school education at the time of closure.
6. Program completers had a significantly higher average age at the time of closure than all other closed participants.

Differences in Child Abuse and Neglect Risk Factors Across Closure Reason Groups

1. Participants closed due to "Other" or "All Remaining Closure Reasons" had the highest mean HFFAT score, while those who "Completed HFF" had the lowest.
2. Participants closed due to "Not Interested" had lower odds of having committed violence against another person than those closed for all other reasons.
3. Those closed due to "Vanished (Lost Contact)" had a lower odds of experiencing current or prior mental illness or substance abuse requiring treatment or hospitalization and lower odds of reporting abuse or neglect during their childhood.
4. Those closed due to "Other" reasons had higher odds of witnessing domestic violence during childhood or adolescence; having committed violence against another person; reporting abusive relationships and expressing a physical response to anger. They had lower odds of fearing violence in their home.
5. Those closed due to "Moved out of Service Area" (MOOSA) were more likely to report receiving treatment or being hospitalized for mental illness or substance abuse and current or recent substance abuse by another member of their household.

Differences in Program Experience Across Closure Reason Groups

1. Number of home visits completed on Level 1 was significantly related to closure reason, with those closed due to "MOOSA" and "Not Interested" receiving the fewest home visits and those in the "All Remaining Closure Reasons" group receiving the highest number of home visits.
2. Number of days in the program was significantly related to closure reason group, with those closed due to "Not Interested" having the shortest length of stay and those completing the program spending the longest period of time in the program.

Chapter V
Healthy Families Florida Closed Participant Survey

Closed participants or those who leave prior to program completion have been of interest in Healthy Families Florida for several years. In 2003, a telephone survey of Healthy Families Florida (HFF) closed participants or "early leavers" was conducted by Williams, Stern & Associates (2003) to obtain information regarding their satisfaction with the program. While that survey did not find any effects of program dosage on overall program satisfaction, there were differences identified. Former participants who had remained in the program longer were more likely to report higher satisfaction with their living situation, ability to manage stress, patience with their children, accessibility of services and knowledge about their children's behavior. Respondents reported satisfaction with their home visitor, information and help received from the program, home visits, having a person to talk with, pleasant staff and program activities/get-togethers. Areas in which respondents expressed dissatisfaction include their ability to get help or information, problems with the home visiting schedule, a perception of the program as intrusive, disliking their home visitor and having a change in their FSW.

To expand on the results based on the 2003 survey, as well as to find out more information about families closed due to "Not Interested" and "Other," a survey of closed HFF participants was conducted. The sample size for this survey was 183 and was taken from 748 closed participants whose closure date was between December 1, 2005 and March 23, 2006. The survey sample only included those with closure reasons listed as "Not Interested" or "Other." The 183 closed participants were included in the survey in order to gain a better understanding of their subjective experience with the program. Each closed participant meeting the criteria for this survey was mailed a packet that contained the following items:

- A letter explaining the purpose of the study and instructions for participation
- A questionnaire (English and Spanish versions were distributed to closed participants whose race was identified as Hispanic or Mixed/Other.)
- An entry card to be returned in order to participate in a drawing for a $100 gift card
- A pre-addressed, postage paid envelope to return questionnaire and entry card

Questionnaire items related to respondents' view of their program experience, home visitor characteristics, participant characteristics and reasons for early termination, as well as two additional items that address overall view of the program. Each item was developed based on a review of relevant literature in peer reviewed publications, the "Early Leavers" study conducted by Williams, Stern & Associates (2003) and feedback from HFF central and project staff. According to the Flesch-Kincaide Grade Level formula calculated in Microsoft Word, the questionnaire was at the 5^{th} grade reading level.

Survey Challenges

Despite the use of an incentive and pre-addressed/postage paid envelopes, the number of completed questionnaires received was 37 (20 percent) of the 183 closed participants included in the survey. Eighteen (10 percent) of the 183 questionnaires were returned by the USPS. Some reasons for non-delivery and return to the Ounce of Prevention Fund of Florida include insufficient address, nonexistent address, no longer living at address, unable to forward and

moved without leaving an address. Due to an inadequate number of completed questionnaires received, the results based on the completed questionnaires were not generalizable to the entire closed participant group and the value of statistical analyses using survey responses was limited. However, frequencies and other descriptive statistics for each questionnaire item, as well as responses to open-ended items, were reviewed and are presented below.

Respondent Demographic Characteristics and Program Involvement

The survey respondent group of 37 closed participants consisted of women with closure dates between December 1, 2005 and March 16, 2006. The average age of the women at closure was 24 years, with a range from 14 to 49 years. The respondents' highest level of education was recorded at the time of intake as well as at the time of closure from the HFF program. At the time of intake, 38 percent of the sample had less than a 12th grade education, 46 percent had a high school diploma or certificate, three percent had their GED, three percent had attended vocational school and 11 percent had attended at least some college classes. The percentage of those attending some college classes increased considerably among participants during their time in HFF. At the time of closure from HFF, 38 percent of the sample had less than a 12th grade education, 35 percent had their high school diploma or certificate, five percent had obtained their GED and 22 percent had attended some college classes.

The racial group that each participant identified with was recorded as well. The sample was made up of 43 percent Black (Non-Hispanic) women, 30 percent White (Non-Hispanic) women, 24 percent Hispanic women and three percent Multi/Bi-racial women. In addition to race, data were available on the ethnicity of each participant included in the sample. The ethnic make-up of the group is as follows: 38 percent African American, 24 percent Anglo/Western European, 14 percent Mexican, five percent Puerto Rican, three percent Guatemalan, three percent Haitian, five percent "Unknown" and eight percent "Other."

Women who were married at the time of intake made up only 17 percent of the sample, while 83 percent were single at the time of intake. The average number of children the participants had at the time of intake was one child, with a range from zero to eight children. Women who were pregnant at intake made up 65 percent of the sample, while 35 percent were not pregnant at the time of intake. Of the 24 women who were pregnant, data were available for 21 of them regarding pregnancy trimester at intake. Five women (24 percent) were in their first trimester at the time of intake. There were 11 women (52 percent) in their second trimester and five women (24 percent) in their third trimester. When survey respondents closed out their time in HFF, the age of the child that Healthy Families Florida was targeting for services was recorded. The results are as follows: 73 percent of the target children were less than one year old at the time of closure, 16 percent were one year old, five percent were two years old, three percent were three years old and three percent were four years old.

The number of home visits completed while survey respondents were on Level 1 of the HFF program was available for 17 of the respondents. Among this group, there was an average of 21 visits completed while on Level 1. Based on the entire sample (37 people), involvement with Healthy Families Florida ceased on different levels of service intensity. Overall, 46 percent closed on Level 1, 3 percent closed on Level 1-P, 11 percent closed on Level 2, 8 percent closed on Level 3 and 32 percent closed on Level X.

The average number of days in HFF for the survey respondent group was approximately one year (366 days), with a range of approximately one month (33 days) to a little over four and a half years (1666 days). The number of days was calculated from the intake date to the date the participant was closed out of the program. Regarding closure reasons, 73 percent of the sample closed out their involvement in HFF because they were "Not Interested" in the services provided by HFF. The remaining 27 percent reported "Other" reasons for ending their time with HFF.

Non-Respondent Demographics and Program Involvement

The study also included a review of demographic information for those who did not respond to the survey and for whom there were no questionnaire materials returned due to insufficient or incorrect address information. While the small number of respondents prevented analyses to determine any statistically significant differences between responders and those who did not respond, there appears to be some variation between these two groups in this sample. The most striking difference is regarding education level, with a much higher percentage of non-responders having less than a high school education at intake than those who returned questionnaires (52 percent vs. 38 percent). Difficulty reading or understanding the questionnaire and accompanying materials could potentially be one reason people in this group did not complete and return questionnaires.

The average length of time in the program was shorter for non-responders, who spent an average of ten months in the program. Responders were in the program an average of one year. Responders completed an average of 21 home visits while on Level 1 of the program, while non-responders received an average of 18 completed visits on Level 1. The percentage of families closed due to "Not Interested" and "Other" reasons was the same for both groups, at 73 percent and 27 percent, respectively.

Findings Based on Questionnaire Responses

Program Experience

For a series of five statements regarding program experiences, respondents were asked to describe their personal experience in the program by selecting one of five response options, ranging from "Strongly Disagree" to "Strongly Agree," with a "Neutral" response option included. The strongest agreement was in response to the statement "Healthy Families services were what I was told at the beginning," with 86 percent of respondents agreeing or strongly agreeing with this statement. While the majority of respondents agreed or strongly agreed with each statement, the item with the lowest percentage of respondents agreeing is "Healthy Families made my life better," with 58 percent of respondents agreeing or strongly agreeing with this item. Response frequencies for items related to program experiences appear in Table 40.

Table 40: HFF Closed Participant Survey: Items Related to Program Experience

Questionnaire Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Healthy Families services were what I was told at the beginning.	58%	28%	8%	6%	---
Healthy Families improved my relationship with my child.	51%	26%	14%	9%	---
Healthy Families helped me become a better parent.	50%	28%	14%	6%	3%
Healthy Families made my life better.	36%	22%	33%	6%	3%
The activities during home visits were helpful.	47%	33%	8%	8%	3%

On the survey questionnaire, respondents were given the opportunity to write additional suggestions or comments by completing the sentence "Healthy Families should _____." A total of 15 responses were provided. Some of the (paraphrased) suggestions and comments are as follows:

- Encourage more parents to participate because the program is helpful.
- Have more interesting activities to do with the child.
- Keep scheduled appointments.
- Make parent feel comfortable when visitor is in the home and interacting with the baby.
- Hire "more experienced and truthful" staff.
- "Keep up the good work."
- Ensure home visitors have things in common with participant.

Home Visitor Characteristics

A series of eight statements were included on the questionnaire in order to gain information regarding closed participants' views of their home visitor. As with program experience items, respondents indicated their opinion or reaction to these statements by selecting one of five response options. The item with the highest percent of respondents agreeing is "I trusted my home visitor," with 92 percent of respondents agreeing or strongly agreeing with this statement. The statement with the lowest percent of respondents agreeing relates to the timing of home visits: "My home visitor visited me at times that were good for my child and me." 81 percent of respondents agreed or strongly agreed with this item. Response frequencies for items related to home visitor characteristics appear in Table 41.

Table 41: HFF Closed Participant Survey: Items Related to Home Visitor Characteristics

Questionnaire Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I trusted my home visitor.	72%	19%	---	3%	6%
My home visitor cared about my child and me.	75%	14%	8%	---	3%
My home visitor was easy to talk to.	72%	17%	3%	6%	3%
My home visitor respected my opinions.	72%	17%	6%	3%	3%
It was easy to contact my home visitor.	61%	28%	3%	3%	6%
My home visitor listened to me.	74%	14%	6%	3%	3%
My home visitor visited me at times that were good for my child and me.	64%	17%	6%	6%	8%
It is best to have the same home visitor for all home visits.	75%	11%	11%	3%	---

Respondents were also asked to indicate whether or not they believe it is important to have a home visitor who is similar to them in various ways. The majority of respondents (89 percent) believed that it is important to have a home visitor who is similar to them regarding experience as a parent. None of the other characteristics had more than 16 percent of respondents indicating importance:

- 16 percent believed it is important to have a home visitor who is similar regarding age.
- 16 percent believed it is important to have a home visitor who is similar regarding where they live.
- 14 percent believed it is important to have a home visitor who is similar regarding race.
- 8 percent believed it is important to have a home visitor who is similar regarding education level.

Respondents were also given the opportunity to write any additional comments about their home visitor that they wanted to share. The majority discussed things they liked or appreciated about their home visitor describing them as nice, helpful, a strong listener, pleasant, competent, polite, supportive, caring, knowledgeable and funny. Other comments regarding home visitors are as follows:

- "The home visitor would usually just show up. She will not call before arriving. I was not pleased."

- "(Home visitor) would schedule an appointment and not show up, then the next week would call to see if she could come by, would expect me to drop everything or schedule an appointment for the next week and not show up again."
- "She lied on me to the D.C.F. and almost got my kids taken from me. That's why I stopped services in my home."
- "(Home visitor) didn't do well."

Participant Characteristics

Regarding items related to the participant's life and their decision to leave HFF, the item with the highest percentage of respondents agreeing or strongly agreeing was "I was too busy to participate," with 34 percent of respondents indicating agreement with this statement. The item with the lowest percentage of respondents agreeing was "I, and/or members of my household, did not want the home visitor in our home," with only three percent agreeing with this statement. There were three additional items with less than ten percent of respondents agreeing, suggesting that respondents did not view family and/or friends discouraging participation or being hesitant to share personal information with a home visitor as factors in their decision to leave the program. Response frequencies for items related to participant characteristics are presented in Table 42.

Table 42: HFF Closed Participant Survey: Items Related to Participant Characteristics

Questionnaire Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I was too busy to participate.	20%	14%	17%	26%	23%
My child and I did not need the services.	6%	11%	29%	29%	26%
I, and/or members of my household, did not want the home visitor in our home.	---	3%	9%	34%	54%
I did not want to share personal matters with my home visitor.	3%	3%	11%	34%	49%
My family told me that I should not participate.	3%	3%	3%	31%	60%
My friends told me that I should not participate.	3%	3%	---	34%	60%
I had enough support from family members.	12%	12%	15%	38%	24%
I had enough support from friends.	9%	11%	20%	29%	31%

Respondents were given the opportunity to write any additional reasons for discontinuing participation in Healthy Families. The most common themes were closed participants who felt

they were too busy to continue participation and those who decided to leave the program when faced with a change in FSW. Some additional reasons are as follows:

- Appointments not kept
- Not comfortable with home visitor
- Moved out of service area
- Family members did not want an FSW in the home
- "Because she lied on me and I don't trust her anymore."
- "Just not convenient at the time. I wish to get back in soon."
- "… I feel I didn't need help because me and my child are closer."
- "I did not stop services. My Healthy Family worker stop coming and the program did not replace the worker nor did they call."
- "I feel that my children and I had come to the height of our progress with Healthy Families."
- "I do not know what happened. My case worker never came back and I did not know if my visits were finished."

Overall Satisfaction

The majority of respondents appeared to be satisfied with Healthy Families Florida. Ninety two percent agreed that Healthy Families is a "good program," with no respondents expressing disagreement with this statement. Ninety one percent of respondents indicated that they would recommend the program to a friend. No respondents expressed disagreement with this item. Response frequencies for items related to overall satisfaction with the program appear in Table 43.

Table 43: HFF Closed Participant Survey: Items Related to Overall Satisfaction with Program

Questionnaire Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I would recommend Healthy Families to my friends.	72%	19%	8%	---	---
Healthy Families is a good program.	75%	17%	8%	---	---

Summary

While the response rate for this survey was lower than expected (20 percent), the survey of HFF closed participants' yielded useful information and set the stage for future efforts to collect information from HFF closed participants. Only families whose closure reason was "Not Interested" or "Other" were included in the survey, because there was an interest in learning

more about the experiences of these families with the program and about circumstances in their lives that might have led to their decision to close. Unfortunately, the small response rate did not allow for statistical analyses to be conducted that could be generalized to the entire group of participants who left for the reasons specified in this survey. Based on the responses received, these closed participants appeared to be satisfied overall with Healthy Families Florida. Regarding their experience with the program, the majority of respondents were satisfied with each aspect of program experience addressed with each survey item. The same pattern was seen with all items related to experience with their home visitor. Respondents indicated that they believe it is important to have a home visitor who has experience as a parent. Regarding personal reasons for closure, participants offered useful insight by way of their open-ended responses. Respondents indicated overall satisfaction with the program and agreed that they would recommend the program to a friend.

Chapter VI
"Ask the Experts": Engagement and Retention from the Perspective of Healthy Families Local Project Staff

Research presented in this chapter involved the use of a modified Delphi technique in order to learn more about engagement and retention in Healthy Families from front line project staff. The overall objective was to gain valuable insight from those who are interacting with Healthy Families Florida (HFF) participants and potential participants on a daily basis. The purpose of this research project was twofold:

- To determine the most common reasons families do not engage, or remain engaged, in Healthy Families Florida at all stages of program involvement (assessment, enrollment and retention) from the perspective of HFF project staff (family assessment workers, family assessment worker supervisors, family support workers, family support worker supervisors and program managers)
- To determine top suggestions, or "tips," that staff feel are most useful in encouraging engagement at each stage of program involvement (assessment, enrollment and retention)

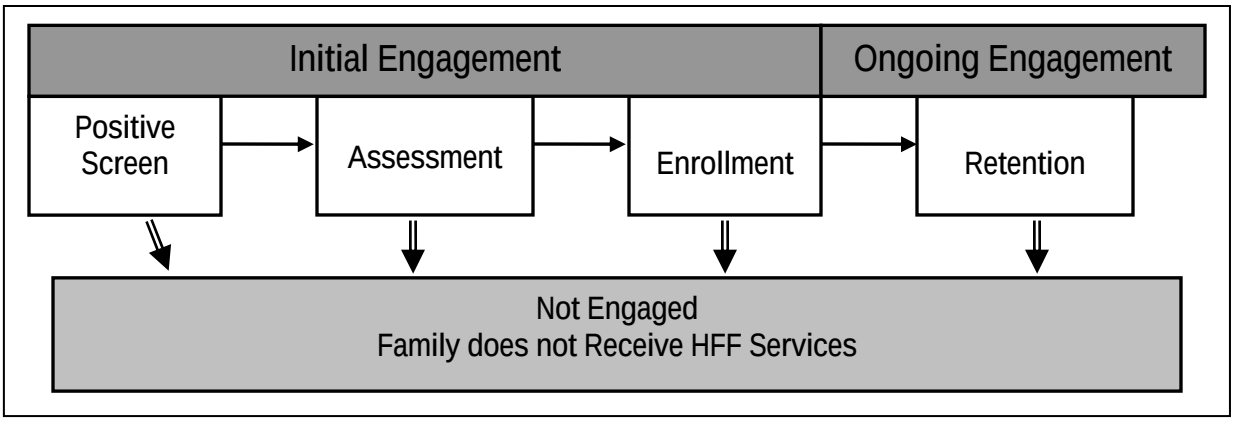
As mentioned above, engagement involves three distinct stages: Assessment, enrollment and retention. Assessment and enrollment, the first two stages, represent the *initial* engagement with the program and are explained below:

1. **Assessment** involves the time from screening to assessment to determine program eligibility and refers to families being interested in completing an assessment. The initial interaction with the family between screening and assessment is the primary focus.
2. **Enrollment** involves the time from assessment to enrollment in the program and refers to families agreeing to participate in Healthy Families and enrolling in the program.

The third and final stage of engagement, retention, refers to the *ongoing* engagement of a family in the program:

3. **Retention** begins with enrollment and refers to a family's continuation in the program through the levels. Interaction with the family after they have enrolled, during home visits and when providing other services are included.

Figure 8: Initial and Ongoing Engagement



Research Design and the Modified Delphi Procedure

A total of nine HFF projects of varying sizes and locations were selected to participate. Management at eight of these projects agreed to allow their project staff to participate. This resulted in a total of 79 HFF project staff included in this research:

- 14 Family Assessment Workers (FAW)
- 3 Family Assessment Worker Supervisors (FAWS)
- 44 Family Support Workers (FSW)
- 10 Family Support Worker Supervisors (FSWS)
- 8 Program Managers (PM)

A modified Delphi technique was used in order to obtain consensus among staff regarding top reasons families do not engage and are not retained and top tips to encourage engagement and retention. The Delphi technique is commonly described as a research method that includes the collection of qualitative data from a "panel of experts" multiple times in an iterative process for the purpose of reaching consensus on a set of policies or problems (Green, Jones, Hughes & Williams, 1999; Powell, 2003). The rounds of data collection allow respondents to first offer and then refine their opinions. The technique promotes discussion and facilitates judgment among the expert panel. To achieve the purposes articulated above, three rounds of data collection were included in this implementation of the modified Delphi technique. Each round is explained below.

Delphi Round 1

For the first round, staff at participating projects received a questionnaire allowing them to list any reasons they think families do not engage in the program, as well as tips that they feel are successful and important when attempting to engage families. A total of 39 completed questionnaires were received from staff in the following positions:

- 10 FAWs
- 3 FAW Supervisors
- 18 FSWs
- 3 FSW Supervisors
- 5 Program Managers

Delphi Round 2

The second round of data collection involved five separate conference call discussions, one for each staff position, with the intent of having each staff group reach consensus on a "top five" set of reasons families do not engage and are not retained and a "top five" set of tips to encourage engagement and retention. Prior to the calls, staff were provided a list of all reasons and tips submitted during round one by other HFF project staff functioning in the same position (i.e., FSWs received a list of all reasons and tips submitted by FSWs from all participating projects). Staff discussed the lists during the calls until they were able to achieve consensus on a set of top reasons and tips. Sixteen HF project staff participated in the calls:

- 6 FAWs
- 2 FAW Supervisors
- 3 FSWs
- 2 FSW Supervisors
- 3 Program Managers

After the conference calls, all top reasons and top tips for each stage of engagement (assessment, enrollment and retention) were compiled. Thus, results from round two included a set of top reasons and tips for assessment, a set for enrollment and a set for retention.

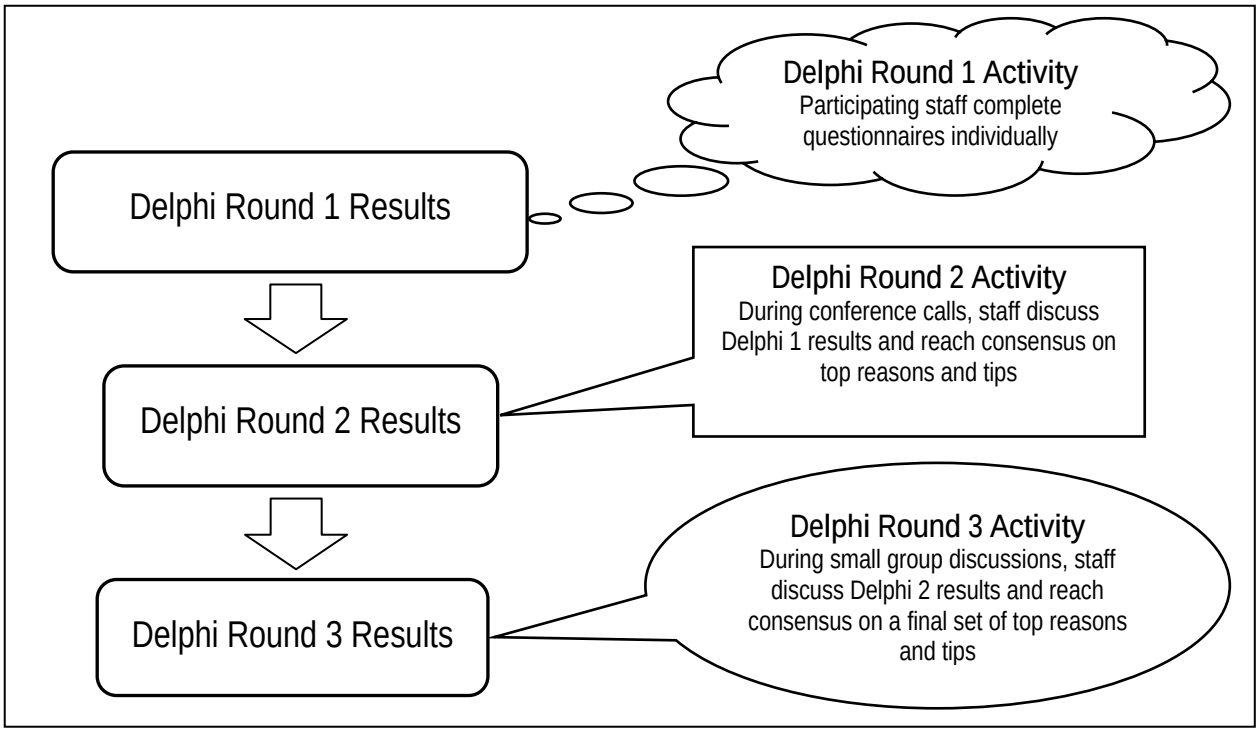
Delphi Round 3

For the third and final round of data collection, HFF project staff participated in face-to-face group discussions about top reasons and tips identified during round two. Each of the nine groups discussed one stage of engagement: Assessment, enrollment or retention. This was an opportunity to further refine the top reasons and tips by determining a final set of top reasons and tips for assessment, enrollment and retention, as agreed upon by staff in a variety of positions. Eighty nine staff from various HF projects and positions participated in this round of data collection during the HFF Program Managers' Meeting on July 20, 2006 in Tampa, Florida. The number of participants functioning in each staff position is as follows:

- 3 FAWs
- 15 FAW Supervisors
- 24 FSW Supervisors
- 38 Program Managers
- 12 Assistant Program Managers or Assistant Directors
- 4 Lead Entity Administrative Staff

Figure 3 on the following page presents the progression through each round of data collection used in this modified Delphi procedure.

Figure 9: Modified Delphi Procedure



Results in Each Round of the Modified Delphi Procedure

Delphi Round One

Staff provided a total of 330 reasons and 269 tips during the first round of data collection. In order to organize these reasons and tips, a categorization scheme was developed involving the creation of major categories, each containing subcategories, to describe all reasons and tips. Each individual reason and tip can be found in Tables 1 through 6 of Appendix VI. Reasons were placed into five major categories based on themes or ideas mentioned in staff questionnaire responses:

- Factors in the Individual's Life

  Reasons related to situations or things going on in the potential or current participant's life that may prevent engagement, such as family members or friends who discourage participation in the program or the occurrence of violence in the home

- No Need for Program

  Reasons indicating that individuals do not see any personal need for, or potential benefits from, program participation (potential participants and current participants may feel that they already have adequate support from friends and family or may want or need services that HFF does not offer)

- Program Procedures

  Reasons suggesting that program policies, structure (i.e. number of home visits required, leveling criteria, etc.) or activities may hinder engagement

- Staff

  Reasons referring to individual staff member personality characteristics and demeanor, reliability and flexibility of staff, or a change in a family's assigned home visitor during program participation

- View of Program

  Distinguished from "no need for program" responses in that these reasons refer to an individual's overall view of the program, rather than considering the program and determining that they and their family have no personal need. These reasons relate to viewing program participation as being an invasion of one's privacy or associating HFF with other agencies and programs.

Tips were organized into four major categories based on the following common themes:

- Description of Program

  Tips to better inform families about HFF by increasing knowledge about the program, addressing negative stigma that potential participants may attach to the program, being clear and honest about program requirements, distinguishing Healthy Families Florida from other agencies and programs and emphasizing potential benefits from participation

- Offer Incentive

  Tips to meet the needs of families by providing referrals, information or tangible items such as gift-giveaways, baby items, diaper bags, or assistance with meeting basic needs (electric, shelter, etc.) relevant to their situation and needs

- Program Procedures

  Tips recommending changes in program activities, policies and procedures, such as increasing correspondence with families, completing visits outside of the home, having a central location for assessments, making the program fun, keeping the program personally meaningful, increasing publicity efforts, collaborating with referral sources, changing positive screen requirements, providing the name of referral sources, engaging mothers prenatally, contacting mothers at providers' offices, decreasing time between assessment and enrollment, allowing FAWs to enroll families at assessment, providing more skill development for workers and more time shadowing seasoned employees

- Staff

  Tips related to staff interaction with families or staffing/personnel issues, such as being courteous, non-judgmental, receptive, engaging, helpful, respectful, excited, enthusiastic, concerned, positive, natural, reassuring and motivated; encouraging participation of both the mother and father of the baby; addressing all questions/comments; not pressuring families; making visits personally meaningful and remaining sensitive to issues in the home. Related to staffing/personnel issues, tips relate to hiring procedures, involving the family with staff beyond their regular home visitor (such as high-risk specialists, supervisors and program managers) and better transitioning to new FSWs. Tips also suggest ensuring reliability and flexibility when scheduling visits and meeting families' needs.

These major categories were relevant in compiling reasons and tips for each stage of the engagement process, although variation among suggested reasons and tips for each stage led to the creation of more specific categories, or "subcategories," that each fall under one of the major categories. Tables 44 and 45 provide an overview of these major and sub categories and their relevance at assessment, enrollment and/or retention, as well as the position(s) of staff that provided reasons or tips for each category.

Table 44: Delphi Round 1: Reasons Families Do Not Engage in HFF

MAJOR CATEGORY	SUBCATEGORY	Assessment			Enrollment			Retention		
		FAW	FAW Sup.	PM	FSW	FSW Sup.	PM	FSW	FSW Sup.	PM
Factors in Individual's Life	Child Removed									✓
	Discouraged by Family/Friends		✓		✓	✓	✓	✓		✓
	Domestic Violence		✓	✓	✓		✓	✓	✓	✓
	Legal Issues	✓	✓	✓		✓		✓		✓
	Family not Involved	✓								
	Home Life/Living Situation	✓	✓	✓				✓	✓	✓
	Lack of Trust				✓					
	Too Busy	✓	✓	✓	✓	✓	✓	✓	✓	✓
No Need for Program	Adequate Knowledge	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Adequate Support	✓	✓	✓			✓	✓	✓	
	Already Receiving Services	✓								
	Bored							✓	✓	✓
	Want Services not Provided by HFF	✓			✓		✓	✓	✓	

MAJOR CATEGORY	SUBCATEGORY	Assessment			Enrollment			Retention		
		FAW	FAW Sup.	PM	FSW	FSW Sup.	PM	FSW	FSW Sup.	PM
Program Procedures	Activities/Services									✓
	Presentation of Program			✓		✓	✓			
	Program Structure							✓		✓
	Screening/Referral Process			✓						
	Timeframe				✓		✓			
Staff	Change in FSW							✓		✓
	Staff Demeanor/ Personality				✓	✓		✓	✓	✓
	Staff Knowledge							✓		
	Staff Flexibility							✓		✓
	Staff Reliability							✓	✓	✓
View of Program	Associate HFF with Other Agencies or Programs	✓	✓	✓	✓	✓	✓	✓		
	Invasion of Privacy	✓	✓	✓	✓	✓	✓			
	Lack of Knowledge about Program	✓		✓	✓	✓	✓			
	Negative Feedback about Program from Other Participants	✓								
	Stigma	✓	✓	✓	✓	✓				
	Too Much Time Required	✓	✓		✓	✓				
Other	Questionnaire responses that were unclear and could not be clarified during conference calls.	✓				✓				

Looking at assessment, enrollment and retention combined, almost half of the 29 subcategories contain reasons from staff in at least four of the five positions. There were eight subcategories that contained reasons provided by staff at all five levels (FAW, FAW supervisor, FSW, FSW supervisor and program manager). These include reasons related to legal issues, the family's home life/living situation, a potential or current participant feeling that they are too busy to participate, believing that they already have adequate knowledge about parenting or available resources, already having an adequate support system, associating HFF with other agencies or programs, viewing the program as an invasion of privacy and attaching a stigma to the program and participants served. For assessment, 11 of the 19 subcategories containing responses included reasons from at least two of the three staff positions providing input. For enrollment this figure was 13 of 17 and for retention it was 14 of 18. The most consistency across staff positions was seen with reasons related to retention. Assessment had a higher proportion of reasons suggested by only one position.

Table 45: Delphi Round 1: Tips for Encouraging Engagement in HFF

MAJOR CATEGORY	SUBCATEGORY	Assessment			Enrollment			Retention		
		FAW	FAW Sup.	PM	FSW	FSW Sup.	PM	FSW	FSW Sup.	PM
Description of Program	Address Stigma	✓								
	Be Honest				✓					
	Distinguish from other Agencies/Programs	✓								
	Emphasize Benefits	✓		✓	✓	✓				
	General Information about Program	✓			✓	✓	✓	✓	✓	
Offer Incentive	Tangible Item(s)	✓	✓	✓	✓	✓	✓	✓		
	Resources/Referrals/ Information	✓		✓	✓	✓		✓		✓
Program Procedures	Activities/Services				✓		✓	✓	✓	✓
	Correspondence	✓	✓		✓		✓	✓	✓	✓
	Location	✓	✓					✓		
	Make Program Fun			✓	✓			✓		✓
	Program Structure							✓	✓	
	Publicity	✓		✓	✓			✓		
	Screening/Referral Process	✓	✓	✓						
	Specifics				✓					

MAJOR CATEGORY	SUBCATEGORY	Assessment			Enrollment			Retention		
		FAW	FAW Sup.	PM	FSW	FSW Sup.	PM	FSW	FSW Sup.	PM
Program Procedures (continued)	Timeframe	✓			✓	✓	✓			
	Training	✓		✓	✓	✓	✓	✓	✓	✓
Staff	Interaction with Family/Demeanor	✓		✓	✓	✓	✓	✓	✓	✓
	Staffing						✓	✓	✓	✓
	Staff Flexibility	✓		✓	✓		✓	✓	✓	✓
	Staff Reliability	✓			✓			✓	✓	✓

The four major categories mentioned previously were relevant in compiling tips for each stage of the engagement process, although some variation among suggested tips for each of the three stages was noted. Thus, 21 subcategories were created based on survey responses to summarize, organize, understand and compare tips for engaging families in the program at assessment, enrollment and retention. Two of these subcategories contained tips for engaging families at each of the three stages of the engagement process, suggested by staff members in all five positions. These categories are providing families with tangible items and increased correspondence with families (letters, phone calls, more creative outreach). Eight subcategories contained tips suggested by staff in four of the five positions. These include emphasizing the benefits of the program; providing general information about the program; offering resources, referrals or helpful information to meet the family's needs and tips related to the timing of assessment and enrollment, staff training, staff interaction with families, staff flexibility when scheduling visits and the reliability of staff. The most consistency across staff positions was seen with tips related to retention. Staff in two of the three positions proving input suggested tips in 11 of the 14 subcategories containing tips for retaining families.

Delphi Rounds Two and Three

Results from the second and third rounds of data collection (Delphi Round 2 and Delphi Round 3) are presented in the following text. Results are presented in three sections: one for each stage of the engagement process. Thus, the first section reviews the reasons and tips identified as "top reasons" and "top tips" for initial engagement at assessment. Results from the second Delphi activity (conference calls) are presented first. This is followed with the final set of top reasons and top tips, as agreed upon by staff during the third and final round of data collection during the HFF Program Managers' Meeting. The same format is used in presenting results for initial engagement at enrollment and ongoing engagement after enrollment (retention).

Initial Engagement: Assessment Reasons

A total of fifteen "top reasons" were identified by project staff (FAWs, FAW supervisors and program managers) during the **second round of data collection** (**Delphi Round 2)** as being the most important or most common reasons why families do not agree to be assessed for program eligibility. Reasons from four of the five major categories were identified as top

reasons. "Staff" was the only major category not containing any top reasons. Most top reasons relate to a person's view of Healthy Families or a belief that they have no personal need for services offered by HFF. Project staff in all three positions selected such reasons.

Table 46: Delphi Round 2: Top Assessment Reasons by Staff Position

Category	FAW	FAW Supervisor	Program Manager	TOTAL
FACTORS IN INDIVIDUAL'S LIFE				2
Discouraged by Family/Friends		1		
Too Busy	1			
NO NEED FOR PROGRAM				6
Adequate Knowledge		1	2	
Adequate Support		1	1	
Already Receiving Services	1			
PROGRAM PROCEDURES				1
Screening/Referral Process			1	
VIEW OF PROGRAM				6
Associate HFF with other Agencies or Programs	1		2	
Invasion of Privacy	1			
Stigma		1	1	
ALL CATEGORIES				15

Two of the top reasons for not being assessed relate to factors in the individual's life: Mothers discouraged from participating by their significant other and parents who feel that they are too busy with work or school commitments to allow for weekly home visits.

Six top reasons involve parents not seeing any personal need for the program. FAW supervisors and program managers suggest that parents may believe that they know enough or know "everything they need to know" about parenting through prior experience as a parent or from receiving prenatal care. They also mentioned that mothers might feel that they have an adequate support system already in place. FSW supervisors mentioned that this is relevant to some mothers who screen positive based solely on being single, but have plenty of support from family members. Another reason related to parents seeing no personal need for the program (suggested by FAWs) is that the parent may already be receiving services from another agency (for example, Healthy Start).

Program managers also identified automatically screening positive based solely on being single as a top reason why parents do not agree to be assessed. They mentioned that this results

in too many parents being referred for assessment who "do not really need" Healthy Families services. This was the only reason related to program procedures that was selected as a top reason.

Finally, the "view of the program" category contained six top reasons. FAWs and program managers suggested that families confusing HFF with other agencies or programs, such as DCF or Healthy Start, is a top reason why families do not agree to be assessed. FAWs suggested that families may be uncomfortable with the idea of "strangers" or "visitors" entering their home and that this may be due to a fear that Healthy Families staff will be "investigating" them and will report them to DCF. Finally, FAW supervisors and program managers felt that parents may attach a certain stigma to the program and its participants; viewing the program as intended solely for individuals with low income or education or those labeled as "abusers" or "bad parents."

None of the three groups (FAWs, FAW supervisors and program managers) stuck to one major category when selecting top reasons why families are not assessed. They each identified top reasons in three of the five major categories, although the specific themes in their responses did vary by position and thus are categorized within different subcategories. FAWs and FAW supervisors did not identify any top reasons in the same subcategory, yet their choices for top reasons all fell within the same major categories. Program managers' selections were the same as FAWs for one subcategory and the same as FAW Supervisors for three subcategories.

Table 47: Delphi Round 2: Reasons People Who Are Offered an Assessment Are Not Assessed

(Delphi Round 1 statements appear in quotes, followed by any additional comments made during Delphi Round 2)

SUBCATEGORY	FAW	FAWS	PM
FACTORS IN INDIVIDUAL'S LIFE			
Discouraged by Family/Friends		"Their SO does not want someone in the house after work." Agree this is a reason, although mothers do not always say this directly.	
Too Busy	"Working full-time and going to school full-time, not time to accommodate intense weekly home visits." Very common.		

SUBCATEGORY	FAW	FAWS	PM
NO NEED FOR PROGRAM			
Adequate Knowledge		"They think they know enough." Some of the women already have pre-natal care or have other children and think they are experienced as a mother.	"People think they know everything they need to know about raising a child." This does figure into their decision. "They don't understand that it's bigger than that one piece."
			"They feel they have enough support and knowledge from friends and family."
Adequate Support		"Have a strong support system already in place." Many mothers assessed are screening into the assessment because they are single – need to have other risk factors. Their support system can consist of any family member(s).	"They feel they have enough support and knowledge from friends and family."
Already Receiving Services	"They are already receiving other services from other agencies and this would be duplication." Common reason, with HS being an example of other services. Could be rare in certain areas (i.e., rural areas)		
PROGRAM PROCEDURES			
Screening/Referral Process			"Automatically screening in based on 'single.' " Too many for assessment who do not really need the services.

SUBCATEGORY	FAW	FAWS	PM
VIEW OF PROGRAM			
Associate HFF with other Agencies or Programs	"They confuse us with the Department of Children and Families (DCF)." Confusion is very common. One FAW noted that there is a negative connotation associated with DCF, but not with Healthy Start.		"Confuse us with other "Healthy" programs." Healthy Start and Healthy Kids and they can't keep the programs straight (especially right after delivering).
			"They don't trust people, especially people associated with state agencies." Mentioned the caller ID—which is the State of Florida.
Invasion of Privacy	"They don't feel comfortable having strangers/visitors come into their home." Potential participants might stress this at assessment. They may be afraid that we are investigating and that DCF will be called.		
Stigma		"Label of lower income and lack of education." One mentioned that a potential participant also saw reference to child abuse and neglect on the HFF website and did not want an assessment because of that. Also mentioned that some ask if they are being offered an assessment because they are receiving Medicaid.	"They might assume services are for "other people" (lower socioeconomic class, "abusers," "bad parents," etc.)" Occurs frequently in the hospital. Screen into the program because they are single but they don't really need the services. The program is viewed as one for lower SES and others without a support system.

The **final round of data collection (Delphi Round 3)** brought together staff functioning in different positions within Healthy Families Florida to reach final consensus on a set of top reasons why families do not agree to be assessed. 30 staff participated in one of three small

group discussions regarding initial engagement at assessment. Top reasons relate to an individual not seeing a personal need to participate in Healthy Families and to potential participants feeling uncomfortable about someone they do not know entering their home.

Table 48: Delphi Round 3: Top Two Reasons People Who Are Offered an Assessment Are Not Assessed

NO NEED FOR PROGRAM	
Adequate Knowledge Adequate Support	"They feel they have enough support and knowledge from friends and family."
VIEW OF PROGRAM	
Invasion of Privacy	"They don't feel comfortable having strangers/visitors come into their home."

Initial Engagement: Assessment Tips

A total of 13 top tips were identified by project staff (FAWs, FAW supervisors and program managers) during the **second round of data collection (Delphi Round 2)** as being the most useful tips for encouraging families to be assessed for HFF program eligibility. Top tips fell within nine subcategories. These tips were fairly evenly distributed across all four major categories, with "staff" containing four top tips and the remaining major categories each containing three top tips. None of the major categories contains a top tip identified by project staff in each of the three positions, although each has at least one top tip identified by staff in two positions.

Table 49: Delphi Round 2: Top Assessment Engagement Tips by Staff Position

Category	FAW	FAW Supervisor	Program Manager	TOTAL
DESCRIPTION OF PROGRAM				3
Emphasize Benefits	1		1	
General Information about Program	1			
OFFER INCENTIVE				3
Tangible Item(s)		2		
Resources/Referrals/Helpful Information			1	
PROGRAM PROCEDURES				3
Correspondence		1		
Publicity	1			
Screening/Referral Process		1		

Category	FAW	FAW Supervisor	Program Manager	TOTAL
STAFF				4
Interaction with Family/ Demeanor	1		1	
Staff Flexibility	1		1	
ALL CATEGORIES				13

Three top tips refer to the way the program is described by FAWs to potential participants. Staff suggests that FAWs emphasize and stress the benefits of the program when talking with potential participants. They pointed out the importance of staff believing in the program and conveying their enthusiasm for the program to potential participants. Staff also recommends that FAWs ensure that potential participants understand that participation in the program is completely voluntary.

Two top tips suggest that families be offered tangible items, such as parenting magazines, free samples, coupons or gifts. Staff explained that offering material items is a good way to "get in the door" initially and that free packets with items mentioned above are offered by companies such as New Parent, Baby Talk, American Baby and Lamaze. One top tip encourages staff to provide needed referrals. Staff discussed the importance of providing referrals when helping families become acclimated into their community.

Three top tips relate to program procedures. Staff felt that written correspondence with families should occur when unable to make contact by telephone. They also suggest sending a reminder postcard that lists the date and time of the family's appointment with the FAW. Staff recommends that Healthy Families Florida engage in more promotion and publicity of the program to engage more potential participants who may not be aware of the program. It was suggested that HFF no longer use single marital status as an automatic positive screen factor, as staff felt that many single mothers who screen positive based solely on this criteria have adequate support systems in place and thus may not need HFF services.

Four top tips relate to staff interaction with families as well as staff flexibility when scheduling visits with families. It was suggested that staff be courteous, non-judgmental, engaging and enthusiastic when interacting with families.

There were no subcategories containing a top tip from all three staff positions, while enrollment and retention had at least one subcategory containing a top tip from staff in all three positions. Yet, some similarity was noted among staff groups. The most similarity in top tips suggested by staff in different positions was between FAWs and program managers. Suggested top tips from both groups include tips in the same two major categories and three subcategories. FAWs and program managers both identified as a top tip emphasizing benefits of the program to potential participants, with FAWs suggesting that staff inform mothers about services available to reduce stress and program managers emphasizing that staff must explain all the program has to offer and do so with enthusiasm. FAWs and program managers both suggest that staff be flexible when scheduling visits and be attentive to their interaction style and demeanor when talking with families.

FAW supervisors had only one top tip within the same major category, and none within the same subcategory, as either FAWs or program managers. Their top tips relate to offering tangible incentives to potential participants, written correspondence after phone calls and no longer using single as an automatic positive screen factor.

Table 50: Delphi Round 2: Tips for Engaging Families at Assessment

(Delphi Round 1 statements appear in quotes, followed by any additional comments made during Delphi Round 2)

SUBCATEGORY	FAW	FAW Supervisor	PM
DESCRIPTION OF PROGRAM			
Emphasize Benefits	"By letting them (MOB) know that they can get supportive services to help reduce stress."		"Offer something that is so important that no one could turn it down." Staff not sure exactly what this refers to but FAWs need to communicate that the program is great. The FAW must believe in the program and reflect this in his or her tone and excitement.
General Information about Program	"Reassure families that even though we are intense, we are voluntary."		
OFFER INCENTIVE			
Tangible Item(s)		"Free gift/samples/coupons/ information." Helps them to "get in the door." Discussion about the specific items included – refer to Baby Talk, New Parent, American Baby and Lamaze, which have free packets available (including a magazine, detergent, soap, breast feeding pads …).	
		"Incentives for the families." Each woman assessed receives a coupon for a consignment store. Another project has a point system for earning points when participant present for appointments – refers more to tip for retention after enrolled.	

SUBCATEGORY	FAW	FAW Supervisor	PM
OFFER INCENTIVE continued			
Resources/Referrals/ Helpful Information			"Helping them get connected with other community resources/services." For Hispanics, this was considered very important to help them get acclimated into the community (resource packets from the United Way, for example).
PROGRAM PROCEDURES			
Correspondence		"Written correspondence with pamphlet/letter of invitation." Explained that this is done when a cold call is not successful in resulting in an assessment. The other interpretation of this tip is to send a postcard with a telephone number for the FAW and their appointment date/time after scheduling the assessment to remind the woman she has an appointment. This works best when the actual appointment day is more than a couple of days from the time the appointment is made.	
Publicity	"Let more people know who we are and what we do, maybe promote, advertise, public presentations, get our program out there." A lot of potential participants do not know who we are and what we do. Some suggested avenues include doctors' offices, Healthy Start and more brochure distribution.		

SUBCATEGORY	FAW	FAW Supervisor	PM
PROGRAM PROCEDURES continued			
Screening/ Referral Process		"Change to screening tool where just being single is not automatic positive – must be single and something else (under 18 years old or over 18 and no diploma or GED)." Want the post-natal screen (which they conduct) to be more discriminating. Being single is usually the only criterion used for assessment and staff thought there should be more than one risk factor on the screen used for conducting an assessment. Many single women have adequate support and do not need HFF.	
STAFF			
Interaction with Family/ Demeanor	"Be courteous, non-judgmental and receptive on the phone." All agreed that this is a given.		"Engaging FAW." FAWs need to be excited, warm, friendly, focused on the mothers – ask questions about her. Make the program fun, interesting and personally meaningful.
Staff Flexibility	"Flexible time with staff."		"Being assured that there is flexibility in scheduling visits."

As noted during the discussion of top assessment reasons, 30 Healthy Families staff reached consensus on a set of final assessment top reasons and tips during the **third and final round of data collection (Delphi Round 3)**. Two of the three top tips suggest that offering potential participants some form of incentive, either by providing something tangible or linking families with needed resources, will help encourage more families to be assessed for program eligibility. The third top tip suggests that FAWs who are engaging when interacting with potential participants can help improve engagement at assessment.

Table 51: Delphi Round 3: Top Three Tips for Engaging Families at Assessment

OFFER INCENTIVE	
Tangible Item(s)	"Free gift/samples/coupons/ information."
Resources/Referrals/Helpful Information	"Helping them get connected with other community resources/services."
STAFF	
Interaction with Family/ Demeanor	"Engaging FAW."

Staff identified a corresponding tip for only one of the two top reasons why people do not agree to complete an assessment. Staff indicated that families feeling that they have enough knowledge and support is a top reason for lack of engagement, but did not provide any tips that directly address this reason. Related to the second top reason, families not being comfortable with visits taking place in their home, staff recommends that FAWs be engaging when interacting with families, which could make families feel more comfortable with the idea of having a stranger enter their home.

Initial Engagement: Enrollment Reasons

During the **second round of data collection (Delphi Round 2)**, project staff (FSWs, FSW supervisors and program managers) identified a total of 15 "top reasons" why people who have been assessed and determined to be eligible for Healthy Families Florida do not enroll in the program. Top reasons were identified in all five major categories. "Factors in individual's life" contained the most top reasons (six), followed by "no need for program," with 4 top reasons identified. The only major category including top reasons submitted by project staff in all three positions is "factors in individual's life."

Table 52: Delphi Round 2: Top Enrollment Reasons by Staff Position

Category	FSW	FSW Supervisor	Program Manager	TOTAL
FACTORS IN INDIVIDUAL'S LIFE				6
Discouraged by Family/Friends	1	1		
Domestic Violence	1		1	
Too Busy	1	1		

Category	FSW	FSW Supervisor	Program Manager	TOTAL
NO NEED FOR PROGRAM				4
Adequate Knowledge	3	1		
PROGRAM PROCEDURES				1
Timeframe			1	
STAFF				1
Staff Demeanor/Personality	1			
VIEW OF PROGRAM				3
Lack of Knowledge about Program			1	
VIEW OF PROGRAM				
Invasion of Privacy		1	1	
ALL CATEGORIES				15

Six reasons related to factors in the individual's life were selected as top reasons. These reasons include being discouraged by family or friends with whom the potential participant lives, experiencing domestic violence or being too busy with work or school to enroll and participate in the program.

Project staff identified four top reasons for not enrolling that relate to individuals seeing no personal need for the program. All of these reasons address a parent's belief that they have adequate knowledge about parenting and thus do not need to participate in the program. During the conference call, FSWs mentioned that this occurs with parents who have multiple children. They also explained that this occurs when younger mothers live with the grandmother of the baby, who may not want the mother to participate in the program. They mentioned that there are exceptions to this when mothers enroll despite the grandmother's wishes.

Program managers were the only staff to suggest a top reason related to program procedures as being a "top reason" why families do not enroll in the program. They felt that too long of a time period passing from assessment to enrollment is the "biggest issue" preventing enrollment in the program.

FSWs were the only staff group to identify a "staff"-related top reason. They explained that potential participants must feel comfortable with the staff member who presents the program. FSWs felt that many factors influence an individual's comfort level with staff, such as the staff member's personality and their choice of wording when interacting with the family.

Finally, FSW supervisors and program managers identified several top reasons related to a potential participant's view of the program. Both groups explained that parents may view the program as a potential invasion of their privacy, referring to the fact that visits take place within the home and that potential participants may be living with others. Also related to "view of the program," program managers explained that parents might be unfamiliar with Healthy Families Florida and the services provided by the program. They also discussed the importance of the FSW doing a good job when presenting the program and its benefits and indicated that this is often difficult for new staff.

As with assessment, there were no subcategories that contained a top reason suggested by each of the three staff groups. FSWs and FSW supervisors had the most similarity in suggested reasons of the three project staff groups. They both identified top reasons from three of the same subcategories, while program managers only identified reasons from one subcategory in common with each of the other two groups. FSWs and FSW supervisors both suggested that living with others who do not want home visits to occur ("discouraged by family/friends"), being "too busy" to participate and feeling one has "adequate knowledge" about parenting are among the most common reasons why families do not enroll in Healthy Families Florida. Program managers identified two top reasons not suggested by FSWs or program managers: Too much time between assessment and enrollment and a lack of knowledge about the program.

Table 53: Delphi Round 2: Reasons People Who Are Eligible for Healthy Families Do Not Enroll

(Delphi Round 1 statements appear in quotes, followed by any additional comments made during Delphi Round 2)

SUBCATEGORY	FSW	FSWS	PM
FACTORS IN INDIVIDUAL'S LIFE			
Discouraged by Family/ Friends	"They move in with other family member and they don't want people to come to their home." Participants move from place to place with some criminal activity.	"Unstable living situations (living with others who are not receptive to home visits)." Refers mostly to illegal families and cohabitation. Sometimes landlords will not allow outsiders to visit them due to the poor living conditions.	
Domestic Violence	"Past or present abusive relationship."		"Domestic violence."
Too Busy	"Busy working and/or going to school."	"They work or go to school full-time." Commented that there is the possibility of referring to Level 1E.	

SUBCATEGORY	FSW	FSWS	PM
NO NEED FOR PROGRAM			
Adequate Knowledge	"Are set in their ways." Older parents who have multiple children fit this reason (late 20s). It was indicated that the moms could be younger as well with several children already.	"Feel they know enough (already a parent)." They think they know enough but this reason might be more relevant to assessment and FAWs. If this is a reason, they are not even able to get in the door to explain the program.	
	"Parents feel they know everything about children – not open to new ideas/change."		
	"Parent may not desire someone telling her how to raise children." GM does not always want their daughter to participate but sometimes the younger mothers don't listen to the GM and enroll.		
PROGRAM PROCEDURES			
Timeframe			"Too much time in between assessment and enrollment." Biggest issue. Also commented that projects don't really know all of the reasons for not enrolling.
STAFF			
Staff Demeanor/ Personality	"They are not comfortable with the person presenting the program." Personality can be a factor with this but also the wording they use—everything.		

SUBCATEGORY	FSW	FSWS	PM
VIEW OF PROGRAM			
Lack of Knowledge about Program			"Unfamiliar with what all services we provide." Presentation counts and inexperience will make presenting what the program has to offer more difficult. Newer FSWs have a problem with this.
Invasion of Privacy		"Invasion of privacy (not comfortable with home visits)." Not a common occurrence unless other family members were uncomfortable.	"Living with others (relates to intrusive nature)." This is a factor but it depends on the circumstances for that family—illegals and domestic violence.

A total of 27 HFF project staff discussed top enrollment reasons and tips during the **third round of data collection (Delphi Round 3)**. Staff reached consensus on three final top reasons families do not agree to enroll in the program. Reasons refer to families being discouraged from participating by people they live with or being uncomfortable with home visits. Staff also agreed that too much time between assessment and enrollment could prevent engagement.

Table 54: Delphi Round 3: Top Three Reasons People Who Are Eligible for Healthy Families do not Enroll

FACTORS IN INDIVIDUAL'S LIFE	
Discouraged by Family/ Friends	"Unstable living situations (living with others who are not receptive to home visits)."
PROGRAM PROCEDURES	
Timeframe	"Too much time in between assessment and enrollment."
VIEW OF PROGRAM	
Invasion of Privacy	"Invasion of privacy (not comfortable with home visits)."

Initial Engagement: Enrollment Tips

For enrollment, a total of fifteen top tips for encouraging potential participants to enroll in the program were provided by FSWs, FSW supervisors and program managers during the

second round of data collection (Delphi Round 2). These top tips fall within seven subcategories. The "staff" major category contained six tips the most of all four major categories. Four top tips related to the way the program is described to participants were provided, as well as four top tips suggesting changes to program procedures. Only one top tip related to offering potential participants an incentive as a means of encouraging engagement was suggested. The "program procedures" and "staff" major categories both contained top tips provided by staff in all three positions.

Table 55: Delphi Round 2: Top Enrollment Tips by Staff Position

Category	FSW	FSW Supervisor	Program Manager	TOTAL
DESCRIPTION OF PROGRAM				4
Be Honest	1			
General Information about Program	2	1		
OFFER INCENTIVE	1			
Resources/Referrals/Information		1		
PROGRAM PROCEDURES				4
Timeframe	1	1	1	
Training		1		
STAFF				6
Interaction with Family/Demeanor	1	2	1	
Staffing			2	
ALL CATEGORIES				15

Four top tips suggest that FSWs convey needed information about the program to potential participants. Staff felt it important that FSWs ensure that families understand what program services are available and that FSWs be honest about the frequency and duration of home visits so that participants know what to expect.

One top tip suggests providing referrals and helpful information during the first visit with a family.

Four top tips relate to program procedures. Three of these tips stress the importance of a quick progression from assessment to enrollment. Staff recommended trying to enroll families

within one week of their assessment. Staff also recommended that FSWs receive training on ways to successfully engage families in the program.

The remaining six top tips relate to staff interaction with families and to staffing issues. Staff emphasized the importance of involving all family members while always maintaining and demonstrating respect for the family and their home. It was suggested that staff must be positive, caring, upbeat, engaging and genuine when interacting with the family. Staff also stressed the importance of the supervisor being involved with the family in addition to the FSW.

There were two subcategories containing top tips suggested by staff in all three positions: "Timeframe" and "interaction with family/demeanor." All staff groups agreed that it is important to contact families quickly after an assessment is completed, with FSWs and FSW supervisors suggesting that no more than one week should pass between assessment and enrollment. Regarding interaction with families, staff suggests that it is important to be friendly, respectful, positive, upbeat, caring and genuine when trying to engage families. FSWs and FSW supervisors both selected top tips related to providing potential participants with general information about the program. FSWs suggest emphasizing the voluntary and flexible nature of the program, while FSW supervisors mentioned the importance of families understanding what HFF services entail. The four remaining subcategories contain top tips agreed upon by only one staff group.

Table 56: Delphi Round 2: Tips for Engaging Families at Enrollment

(Delphi Round 1 statements appear in quotes, followed by any additional comments made during Delphi Round 2)

SUBCATEGORY	FSW	FSW Supervisor	PM
DESCRIPTION OF PROGRAM			
Be Honest	"Be honest about how often FSW will be in home."		
General Information about Program	"Emphasize that we are voluntary and can be flexible." Good to set time for the HVs (be available nights and weekends).	"Provide information of the program, making sure they understand what services are about."	
	"Explain what home visits will be like."		
OFFER INCENTIVE			
Resources/ Referrals/ Information		"Offer referrals and helpful info at first home visit."	

SUBCATEGORY	FSW	FSW Supervisor	PM
PROGRAM PROCEDURES			
Timeframe	"Contact within an appropriate timeframe after assessment." Recommended time frame after assessment is one week.	"Quick follow-up after initial assessment by FSW to enroll MOB (< 1 week)."	"Less time between assessment and enrollment."
Training		"Offer FSWs training on how to engage MOBs initially."	
STAFF			
Interaction with Family/ Demeanor	"Respect MOB and her home." Adhere to their requirements (ex: take off shoes before entering house), listen more, be non-judgmental.	"Respect and involve all family members, especially parents/guardians of teen moms."	"Positive, upbeat, caring, genuine staff." Two other tips tie into this: "Strong/engaging FAWs/FSWs (well trained)" and "Motivated staff/supervisors."
		"Be friendly, sincere and honest."	
Staffing			"FAW schedule first home visit and go with FSW." Transition from FAW to FSW and there needs to be a stronger connection between these. Participation by the supervisors can help—going on the home visit with the FSW is helpful to cover FSW's absence during vacations or when they are out due to sickness.
			"Follow-up from supervisors." Supervisor should accompany FSW on first home visit.

The 27 HFF staff who discussed enrollment during the **third and final round of data collection (Delphi Round 3)** identified two final top tips. Final consensus suggests that allowing no more than one week from the time a family is assessed to the time an FSW attempts

to enroll the family will lead to more families opting to enroll in the program. The second final top tip suggests that staff respect and involve all members of the family in the program.

Table 57: Delphi Round 3: Top Two Tips for Engaging Families at Enrollment

PROGRAM PROCEDURES	
Timeframe	"Quick follow-up after initial assessment by FSW to enroll MOB (< 1 week)."
STAFF	
Interaction with Family/ Demeanor	"Respect and involve all family members, especially parents/guardians of teen moms."

All final top reasons why families do not enroll in the program had corresponding top tips selected by staff. Staff suggested that FSWs "respect and involve all family members," which would likely help families and other members of the household feel more comfortable with the idea of home visits. Staff agreed that too much time passing between assessment and enrollment is a top reason why some families do not enroll in the program. They suggested a shorter time frame between assessment and enrollment; specifically, no more than one week.

Ongoing Engagement: Retention Reasons

During the **second round of data collection (Delphi Round 2)**, project staff identified a total of 15 top reasons why families do not remain enrolled in Healthy Families Florida. Reasons from four of the five major categories were identified as top reasons, with "view of the program" being the only category that did not contain a top reason. Major categories containing the top reasons are "staff" and "factors in the individual's life." None of the subcategories contained a top reason submitted by staff in each of the three groups.

Table 58: Delphi Round 2: Top Retention Reasons by Staff Position

Category	FSW	FSW Supervisor	Program Manager	TOTAL
FACTORS IN INDIVIDUAL'S LIFE				5
Domestic Violence	1			
Legal Issues	1			
Home Life/Living Situation	1			
Too Busy	1		1	
NO NEED FOR PROGRAM				2
Bored		1	1	

Category	FSW	FSW Supervisor	Program Manager	TOTAL
PROGRAM PROCEDURES				1
Program Structure	1			
STAFF				7
Change in FSW	1		1	
Staff Demeanor/Personality		2		
Staff Flexibility			1	
Staff Reliability		1	1	
ALL CATEGORIES				15

FSWs identified four top reasons participants are not retained that relate to things going on in the participant's life, such as domestic violence, illegal activities and moving out of the service area. The fourth reason, being too busy, was also identified as a top reason by program managers.

FSW supervisors and program managers felt that participants may become "bored" with the program and no longer see a need for continued participation. They indicated that this can occur when visits are not "fun" or if visits are not tailored to meet a family's needs.

Only one top reason related to program procedures was identified as a top reason. Regarding program structure, FSWs mentioned that a family not being promoted to the next level quickly enough is a top reason why families are not retained in the program.

Finally, FSWs, FSW supervisors and program managers identified seven top reasons related to staff characteristics. FSWs and program managers felt that having a change in FSW is a top reason why families are not retained in the program. Personality differences between an FSW and participant or aspects of the FSW's approach were identified as top reasons for difficulty retaining participants. FSW supervisors and program managers both felt that staff unreliability, such as offering inconsistent visit times and not keeping scheduled visit times, is an important reason as well. Related to this top reason, program managers mentioned that limited flexibility on the part of the FSW can hinder ongoing engagement of families in the program.

As with enrollment, there was no subcategory that contained a top reason identified by staff in each of the three positions. FSWs and program managers identified top reasons in three major categories containing top reasons why families are not retained, while FSW supervisors identified top reasons in two of the four categories. Top reasons identified by FSWs focus on factors in a participant or family's life, leveling criteria and experiencing a change in FSW. FSW supervisors primarily identified top reasons related to staff characteristics.

Table 59: Delphi Round 2: Reasons Participants Are Not Retained in HFF

(Delphi Round 1 statements appear in quotes, followed by any additional comments made during Delphi Round 2)

SUBCATEGORY	FSW	FSWS	PM
FACTORS IN INDIVIDUAL'S LIFE			
Domestic Violence	"Domestic violence/abuse in the home."		
Legal Issues	"Illegal activities."		
Home Life/Living Situation	"Moved out of service area."		
Too Busy	"Too busy with full-time work/school, etc."		"Chaotic nature of lives of family." Moved to Level X.
NO NEED FOR PROGRAM			
Bored		"Bored with curriculum/activities or FSW." Need to make the visits fun.	"Boredom." FSW might be burned out and sometimes can get involved too early prenatally. Program can "get stale." This is a reason when the FSW plans visits without regard to the family's needs.
PROGRAM PROCEDURES			
Program Structure	"Not moved up in level quick enough."		
STAFF			
Change in FSW	"Do not want another FSW." Related to staff turnover—might have switched several times without smooth transition in FSWs.		"Staff turnover." Not common, but is a problem when it happens. Supervisor can help by going on home visits and helping with the transition from one FSW to another.
Staff Demeanor/ Personality		"Personality differences." FSW/mom might have personality differences but can change an FSW for a better relationship between the mom and FSW.	

SUBCATEGORY	FSW	FSWS	PM
STAFF continued			
Staff Demeanor/ Personality (continued)		"FSWs approach (coming on too strong; trying to teach/counsel and getting too involved in "mommy drama" and other family issues)." FSWs get too involved.	
Staff Flexibility			"Lack of flexibility on part of FSW/project in scheduling home visits."
Staff Reliability		"Scheduling: FSWs do not keep appointments." This is a problem because the modeling for the family encourages them to not keep appointments – very undesirable. This includes not calling the family to let them know.	"Inconsistent visits (times vary, FSW cancellations)." Sometimes the FSW has to delay their visit to the following week.

During the **third and final round of data collection (Delphi Round 3)**, a total of 32 HFF project staff discussed top reasons families do not remain in the program. After discussing the top reasons identified during round two, staff reached consensus on three final top reasons why families are not retained in the program. These top reasons relate to families moving away, participants losing interest in the program and participants refusing to receive services from a new home visitor.

Table 60: Delphi Round 3: Top Three Reasons Participants Are Not Retained in HFF

FACTORS IN INDIVIDUAL'S LIFE	
Home Life/Living Situation	"Moved out of service area."
NO NEED FOR PROGRAM	
Bored	"Bored with curriculum/activities or FSW."
STAFF	
Change in FSW	"Do not want another FSW."

Ongoing Engagement: Retention Tips

During the **second round of data collection (Delphi Round 2)**, project staff (FSWs, FSW supervisors and program managers) suggested a total of 19 top tips for engaging current

program participants. Of the three stages of engagement (assessment, enrollment and retention), retention has the highest number of top tips identified. Each major category contained at least one top tip, with a total of nine subcategories containing top tips. The majority of top retention tips are classified in the "staff' category (12 top tips). Five tips related to program procedures were identified as top tips. Both of these major categories (staff and program procedures) each contained top tips from all three staff positions. The two remaining major categories, "description of program" and "offer incentives" each contained one top tip.

Table 61: Delphi Round 2: Top Retention Tips by Staff Position

Category	FSW	FSW Supervisor	Program Manager	TOTAL
DESCRIPTION OF PROGRAM				1
General Information about Program	1			
OFFER INCENTIVE				1
Resources/Referrals/Information	1			
PROGRAM PROCEDURES				5
Activities/Services		1	1	
Correspondence		1	1	
Program Structure	1			
STAFF				12
Interaction with Family/Demeanor	4	1	1	
Staffing			3	
Staff Flexibility	1	1		
Staff Reliability	1			
ALL CATEGORIES				19

FSWs agreed upon one top tip related to the way the program is initially presented to participants. They explained the importance of informing participants upfront about home visit requirements. Another top tip, also suggested by FSWs, calls for the provision of needed referrals in order to help meet families' needs. Five top tips relate to program procedures, such as activities or policies. Staff suggests incorporating variety into the program, through the use of resource materials as a supplement to the *Growing Great Kids* curriculum, as well as having more group activities. Staff also suggested several top tips suggesting increased correspondence with families between home visits. The remaining 12 top tips related to staff interaction with families, staffing issues and staff reliability and flexibility.

The only subcategory containing a top tip from staff in all three positions is "interaction with family/demeanor." Staff suggested praising participants often and tailoring program services (visits) to the individual family in order to make services personally meaningful. In addition, program managers suggested that tips related to making the program fun tie into this top tip. The most similarity between staff positions was noted with top tips provided by FSW supervisors and program managers. They identified top tips within three of the same subcategories, falling within two major categories. Regarding program activities and services, FSW supervisors suggest using a variety of materials in addition to GGK curriculum while program managers suggest more group activities for parents. Both groups also suggest more correspondence between staff and participants, through notes or calls between visits. Finally, FSWs and FSW supervisors both suggest that FSW flexibility is a top tip for successful ongoing engagement of families.

Table 62: Delphi Round 2: Tips for Retaining Families in HFF

(Delphi Round 1 statements appear in quotes, followed by any additional comments made during Delphi Round 2)

SUBCATEGORY	FSW	FSW Supervisor	PM
DESCRIPTION OF PROGRAM			
General Information about Program	"Honesty of program requirements as to home visits at assessment."		
OFFER INCENTIVE			
Resources/ Referrals/ Information	"Make appropriate referrals."		
PROGRAM PROCEDURES			
Activities/ Services		"Variety of curriculum." Use GGK but also have resource materials that are used to make the visit interesting, such as articles in parenting magazines.	"More parent group activities." Activities to connect with the program and other parents—expand the circle of support, even including contact with other FSWs and supervisors.

SUBCATEGORY	FSW	FSW Supervisor	PM
PROGRAM PROCEDURES continued			
Correspondence		"Meet family ASAP. Write letters, make phone calls to assist FSWs ASAP." This is referred to as simple outreach and a way to re-engage or conduct ongoing engagement (birthday cards and notes sent to the mother to let them know the FSW is thinking about them and cares).	"Creative outreach as needed." Important to keep in touch between visits by sending notes and calling the mother (birthdays, getting through a difficult time). Including the whole family, not just the mother, was also suggested.
Program Structure	"Not stay on levels so long."		
STAFF			
Interaction with Family/ Demeanor	"Praise Mom often."	"Tailor program to meet MOB's needs/wants." This must be within the bounds of the program and it was suggested that "wants" be removed from this tip – just needs.	"Make visits personally meaningful." Home visits must be fun and individualized for each family. Accomplished by doing the following (additional tips): "Meeting the family 'where they are.'" "Engaging FSWs." "Making the paperwork process fun (create FSPS and other forms that are fun and interesting to fill out)." "Keep visits interesting." "Use variety of curriculum, do fun craft projects, have group activities." "Offer new and interesting activities."

SUBCATEGORY	FSW	FSW Supervisor	PM
STAFF continued			
Interaction with Family/Demeanor (continued)	"Be sensitive to issues in home."		
	"Realize when it is appropriate to push and to step back, allowing parent time to breathe."		
	"Engage the whole family."		
Staffing			"High risk specialist to assist families in difficulty and act as 'floating FSW.'" Considered part of creative outreach.
			"Stay focused on our job … PCI, development, etc." Staff should broaden support in order to avoid burn out. Need support for staff.
			"Follow-up from supervisors." Supervisor is involved in communication with the family when the FSW is not available—attending home visits as much as possible. The mother should feel like they can call the supervisor anytime, not just the FSW. Supervisor should talk with FSW and find out what is going on in his/her life (to avoid FSW burnout).
Staff Flexibility	"Make sure FSW tries to meet family's schedule (weekend, morning, evenings)."	"Be creative and flexible."	
Staff Reliability	"Listen to questions/concerns/needs and address them appropriately."		

Each of the three groups that discussed retention during the **third round of data collection (Delphi Round 3)** identified different top tips, resulting in a total of ten final top tips. Nine of these tips were first suggested and agreed upon during the first and second Delphi rounds and one was a new tip that the group identified and agreed upon during the final round. Top tips for retention related to the way the program is presented initially, providing needed referrals, correspondence with families, staff interaction style, reliability and family support workers receiving support from supervisors.

Table 63: Delphi Round 3: Top Ten Tips for Retaining Families in HFF

DESCRIPTION OF PROGRAM	
General Information about Program	"Honesty of program requirements as to home visits at assessment."
OFFER INCENTIVE	
Resources/ Referrals/ Information	"Make appropriate referrals."
PROGRAM PROCEDURES	
Correspondence	"Meet family ASAP. Write letters, make phone calls to assist FSWs ASAP."
STAFF	
Interaction with Family/ Demeanor	"Make visits personally meaningful."
	"Tailor program to meet MOB's needs/wants."
	"Engage the whole family."
Staff Reliability	"Listen to questions/concerns/needs and address them appropriately."
Staffing	"Stay focused on our job … PCI, development, etc."
	"Follow-up from supervisors."
NEW TIP IDENTIFIED DURING DELPHI ROUND 3	
"Additional funding for support services and better collaboration with housing providers."	

Two of the three top reasons why families do not remain enrolled in the program have corresponding top tips. Four of the ten top tips selected address the problem of families becoming bored with the program. Staff suggested that visits be personally meaningful for families, that the program be tailored in order to meet each individual family's needs, that the entire family be involved in home visits and that staff really listen to any concerns or needs expressed by the family and address them accordingly. Two top tips address the issue of families refusing a new FSW when they are no longer able to continue receiving services from the same FSW. Staff suggests that supervisors provide follow-up and that they meet the families as soon as possible and engage in correspondence with the family.

Summary

Three rounds of data collection using the Delphi technique allowed Healthy Families Florida project staff to reach consensus on a set of top reasons families do not engage, both initially and after enrolling in the program, and tips to encourage engagement at assessment, enrollment and retention. Also of interest in this project was comparing results between staff in different positions. This was possible with the first two rounds of data collection. In the third and final round of data collection, a broader representation of a final set of top reasons and tips as agreed upon by staff from all positions was obtained. As a final comparison of interest, the level of correspondence between top reasons and tips was examined. Only some top reasons were addressed with corresponding tips. A summary of all final top reasons and top tips is presented in Table 64.

Table 64: Final Top Reasons and Top Tips

Top Reasons	Top Tips
ASSESSMENT	
People feel they have enough knowledge and support and thus do not agree to complete an assessment.	No Corresponding Top Tips Selected
People do not feel comfortable having strangers enter their home.	FAWs should be engaging when interacting with families. FAWs should be excited, warm, friendly and ask questions about the mothers. Make the program fun, interesting and personally meaningful.
	Offer tangible incentives, such as free gifts, samples, coupons or information.
	Help connect families to other resources and services in the community.
ENROLLMENT	
Families may face unstable living situations, such as living with other people who are not receptive to home visits.	Make sure that you show respect for all family members and involve everyone, especially when attempting to enroll teen moms.
Too much time passing from the time a family is assessed and the time the program tries to encourage them to enroll.	Ensure a quick follow-up after the family is assessed (preferably less than one week).
Families may not be comfortable with home visits and may see them as an invasion of their privacy.	No Corresponding Top Tips Selected

Top Reasons	Top Tips
RETENTION	
Families become bored with the curriculum, activities or their FSW.	Make sure that visits are tailored to the family's needs and wants and that visits are personally meaningful. Listen to any questions, concerns and needs expressed by the family and make sure they are addressed appropriately. Engage all family members.
When faced with a change in FSW, families prefer to leave the program rather than continue with a new FSW.	Supervisors should be more involved with the families. Meet them when they begin working with their FSW and engage in correspondence (letters and phone calls) to assist FSWs. Supervisors should also provide more follow-up for FSWs.
Families move out of the service area.	No Corresponding Top Tips Selected
	Staff must stay focused on their job and should receive support to avoid burnout.
	Staff should be honest and upfront about program requirements when first presenting the program to families.
	Make sure that staff provides appropriate referrals to meet families' needs.
	Additional funding for support services and more collaboration with housing providers.

Chapter VII
Engagement and Retention Report Summary and Recommendations

During 2005-06 state fiscal year, the Research, Evaluation and Systems Unit in the Ounce of Prevention Fund of Florida conducted several research projects for the purpose of understanding and improving the engagement and retention of families in Healthy Families Florida (HFF). It is widely acknowledged that an effective voluntary long-term intervention that provides home visits and other services to prevent child abuse and neglect must be able to engage and retain families. Additional justification for this research was based on the amount of attention directed toward engagement and retention at the national level through Healthy Families America, the need to review previous research findings in published research and the emphasis in the HFF Five-year Evaluation Report to continue efforts to improve engagement and retention of families in the program.

In this report, a comprehensive review of research on engagement and retention in home visiting programs designed to prevent child abuse and neglect was presented. The report began by reviewing important components in theoretical models that explain engagement and retention in home visiting programs that have the prevention of child abuse and neglect as a major goal. Second, findings in previous relevant research on engagement and retention in these programs were reviewed. Third, retention rates for Healthy Families Florida families were calculated and relationships between explanatory factors and retention among families enrolled during 2003-2004 were analyzed. Fourth, there was a close look at HFF families who closed from December 2005 through March 2006. Fifth, results from a mail survey of participants who closed due to "Not Interested" or "Other" reasons were presented. Sixth, research that tapped expertise at the HF project level on reasons families do not engage or remain in the program and tips for engaging families and keeping them in the program was covered. In this final chapter of the report, a summary of each chapter in the report is included, major observations based on the findings in previous and current research are listed and recommendations for program improvement in engaging and retaining families based on these findings are put forth.

> ***The objective in the final chapter is to share the most useful information contained in this report for the HF projects in an effort to improve the engagement of families and the retention of families in Healthy Families Florida.***

Beginning with Chapter II, a short summary of the content in each chapter in the report is presented below. In these summaries, the questions posed and results generated from the research documented in each chapter are described briefly. Next, major findings and observations based on this comprehensive treatment of the relevant topics and the research conducted during the 2005-06 fiscal year with HFF participants are highlighted. Recommendations for HF project staff and HFF central staff to consider in their efforts to improve the engagement and retention of families are presented after each set of major findings. The recommendations are linked to the major findings and observations.

Chapter II: Review of National Research on Engagement and Retention of Families

Summarizing all of the results in the Daro, McCurdy, Falconnier, and Stojanovic (2003) and Daro, McCurdy, and Nelson (2005) studies and other relevant studies, the factors that have

been proposed as having effects on the engagement and retention of participants are in several different categories or levels as part of an integrated theory. Decisions to engage and stay in a program are influenced by participant, provider, program and neighborhood or community level factors. While these factors have appeared in theoretical models, their significance in predicting engagement and enrollment has not always been confirmed in the results of statistical analyses. Recognizing this, many of them still merit our attention.

Participant factors in theoretical models include age, race/ethnicity, infant health risk, perception of benefits, the subjective norms among the participant's reference group (whether participation is supported among friends and family members) and previous experience in similar programs.

Provider factors in theoretical models of home visiting programs typically refer to characteristics of home visitors and personal interaction with the family. Characteristics of the home visitors refer to age, race, gender, educational attainment, prior experience on the job, hours of individual supervision and interpersonal skills with emphasis on the ability to adopt other viewpoints and show empathy with others. Provider factors that are considered important in predicting the intent to enroll focus on the interaction of the home visitor and the participant. Two other factors that have been identified as important in previous research are the cultural competence of the home visitor and service delivery style.

Several program factors that have been identified in theoretical models have also been identified as predictive of participant intent to enroll, actual enrollment and retention. Intent to enroll has been affected by the association of the program with child welfare public agencies or other public social services and is believed to have a negative impact on enrollment. Prenatal enrollment or initiation of service during pregnancy is another program attribute that has been identified as a factor that influences decisions to enroll. In predicting actual enrollment, an additional factor that is identified and labeled intervening is the time between enrollment and the receipt of services. The longer the length of time between the family's intent to enroll and actual enrollment, the more likely the participant will acquire other information that will negatively affect actual enrollment. Another program factor considered important in affecting retention is the match between the participant and the home visitor on race or parenting status. Program factors that are considered predictive of higher retention refer to low supervisory caseloads, stable funding, low staff turnover and tangible incentives.

Among the neighborhood or community level factors in theoretical models, resources available in the neighborhood or community and whether the individual or family has the knowledge or ability to access these will impact decisions to enroll in a program. Other neighborhood or community factors are broadly referred to as "social disorganization" with the presence of crime and poverty posited to have a negative impact on enrollment in a social program.

Factors that influence initial engagement are not the same as those related to ongoing engagement or retention. More general explanations of what is important in predicting engagement and retention are also important to consider. Enrollment of a mother is determined by her "readiness to change" and her needs as they relate to the health of her infant. After enrollment, decisions to remain in the program are shaped continuously. Retention is influenced by having her concerns addressed, her subjective experiences or comfort with the program and provider characteristics, such as having an experienced home visitor. Researchers also state that

"many new parents are initially drawn to these programs out of concern for their infant's well-being. However, they remain in a program only if they perceive that their needs are being addressed or if they are receiving information they find useful" (Daro, McCurdy, & Nelson, 2005, p. 21). This is identified as a dual mission which makes it essential for the program to improve parenting while addressing the basic needs and personal concerns of the parent. Also, the researchers contend that the importance of subjective experiences of the participant appears to be greater than objective experiences. Community context is important but contrary to what was proposed in the theoretical model, participants living in distressed communities are more likely to remain enrolled. Matching home visitor and participant ethnicity, age and parenting status varies in importance across ethnic groups. As a final factor mentioned here, project sites that have been operating longer have better participant retention.

When comparing the findings for all of the previous studies covered in this section, the picture of what is predictive or explanatory is mixed. There are variations in whether a factor is significant in its relationship with a measure of retention as well as the direction of that relationship. These inconsistencies make the platform for future analysis less stable and make confirmation of findings in future analyses more important but also more difficult. Based on the previous studies reviewed in this chapter of the report, there are very few factors that have a consistent significant relationship with engagement and retention across more than one study or analysis. Those that do are listed below:

- Participant Factors
- Age: Older participants have higher retention
- Race: Black and Hispanic participants have higher retention
- Infant Risk: The higher the infant risk at birth, the higher the retention
- Provider Factors (these factors did not meet the criteria with only one study for each significant factor or findings were not consistent across studies)
- Program Factors
- Matching FSW and Participant on Race/Ethnicity: Black participants matched with Black FSWs have higher retention
- Neighborhood or Community Factors (these factors did not meet the criteria with only one study for each significant factor or findings were not consistent across studies)

Chapter III: Engagement and Retention of Healthy Families Florida Participants Enrolled in 2003-2004FY

Before presenting retention rates for HFF and the analyses of factors related to retention in this chapter of the report, frequency distributions for closure reasons were examined. For all participants enrolling in the 2003-2004 fiscal year, the closure reasons with the highest percentages were "Moved out of Service Area" (MOOSA) (16.5 percent), "Not Interested" (14.6 percent), "Vanished (Lost Contact)" (9.9 percent) and "Parent School/Work Full-time" (8.3 percent). Looking at the frequency distributions for closure reasons across time in the program, two patterns emerged. The percentage closed due to "Not Interested" dropped from 37.2 percent for those who close sometime within the first 3 months of their participation in the program to 29.1 percent for those who close within the first 12 months of their participation in the program.

The percentage who closed due to "Vanished (Lost Contact)" increased from 3.1 percent for those who closed in the first 3 months to 15.8 percent for those who closed during the first 12 months. Frequency distributions for closure reasons for subgroups of the entire enrollment sample based on when they closed were also reviewed. The retention subgroups with the highest percentages closing due to "MOOSA," were the subgroups closing before 3 months in the program and those closing between 6 and 9 months in the program. These percentages were 35.5 percent and 32.1 percent, respectively. The subgroup with the highest percentage closing for the reason "Vanished (Lost Contact)" closed from 9 to 12 months. This percentage was 24.15 percent. The subgroup with the highest percentage closing due to "Not Interested" was those closing up to 3 months with the percentage being 37.2 percent. "MOOSA" and "Not Interested" are the predominant reasons for closing before 3 months after enrollment.

How successful is Healthy Families Florida at retaining families?

Based on retention rates calculated in the HFF Five-year Evaluation Report (Williams, Stern & Associates, 2005), the analysis conducted by Healthy Families America (2004) and retention rates calculated in this study, retention in Healthy Families Florida compares favorably. The retention in Healthy Families Florida for this study for all participants enrolling during fiscal year 2003-2004 was 91.5 percent at 3 months, 79 percent at 6 months, 66.2 percent at 9 months and 56.4 percent at 12 months. These retention percentages are all higher than those recorded in the HFA analysis and the retention percentages in the HFF Five-year Evaluation Report. However, when considering that retention drops to just over half of the participants who enrolled 12 months earlier, there is still justification for continuing efforts to improve retention. Looking at variation in retention at 3, 6, 9 and 12 months across types of communities served did not indicate any statistically significant differences. Despite this absence of significant results, at 9 and 12 months the percentages for participants retained in the rural areas were much lower than in the major cities suggesting that retention in rural areas might be more challenging after participants have been participating in the program longer than 6 months. The analysis also did not indicate statistically significant differences in retention rates across enrollment cohorts based on the quarter of enrollment during the 2003-2004 fiscal year. In other words, participant retention success remained relatively stable across enrollment cohorts.

What participant characteristics and programmatic experiences in Healthy Families Florida are related to whether or not families are retained at 3 months, 6 months or 12 months?

Among the participant characteristics and program experiences included in this analysis, several were statistically significant in their relationships with 3 month retention, 6 month retention and 12 month retention. Number of children at intake was significantly associated with 3 month retention and 6 month retention. The higher the number of children at intake, the lower the retention. Single parents were less likely to be retained at 12 months. Black participants had higher retention at 3, 6 and 12 months while White participants had lower retention at all three time periods. Hispanics were more likely to be retained at 12 months. Older participants had higher retention at 12 months. Education (less than high school) was not significantly related to retention at 3, 6 or 12 months.

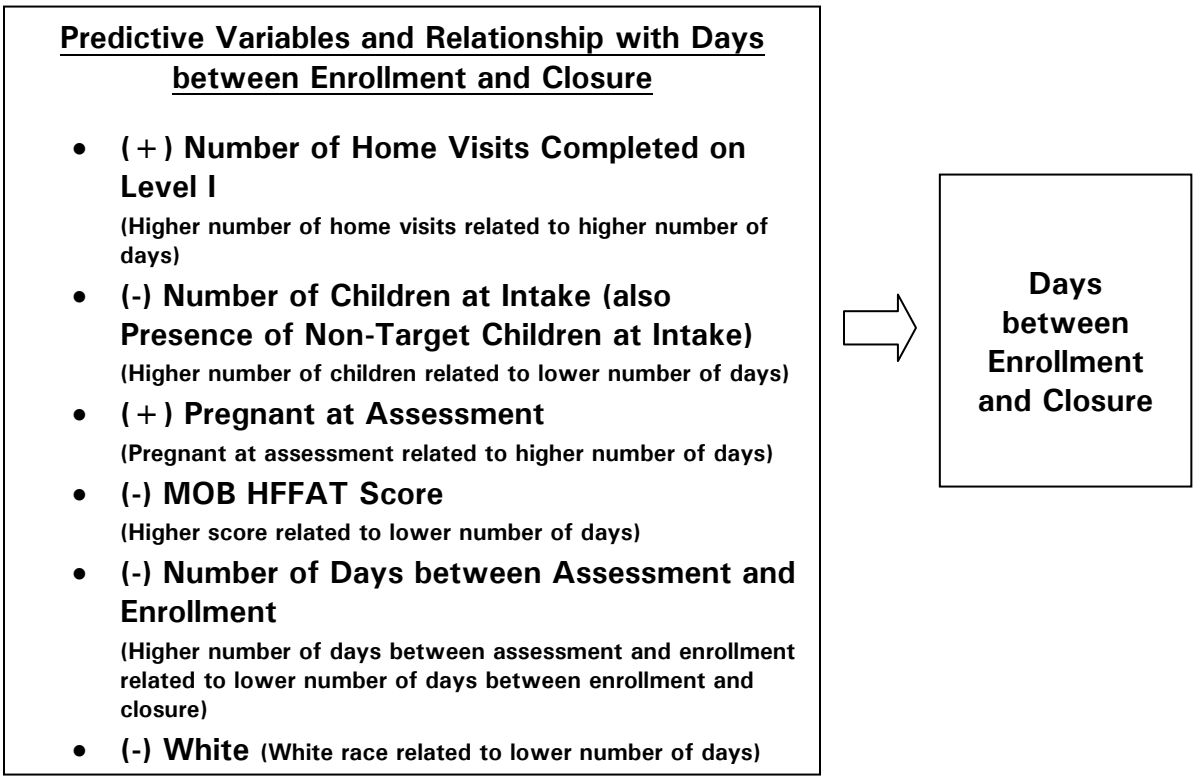
There were significant results in the analysis of the mother's *Healthy Families Florida Assessment Tool (HFFAT)* total score. HFFAT total scores varied significantly across categories for those retained and those not retained at 6 and 12 months. Those retained had lower HFFAT

scores. Individual items on the HFFAT had statistically significant relationships with retention at 3, 6 and 12 months. When looking at individual items on the HFFAT, there were several that had a significant association with one of the three retention rates (3, 6, or 12 months) and three concerns that were significantly associated with all three retention rates. These concerns were little or no prenatal care (< 5 visits) or poor compliance with treatment/medication, continued smoking/tobacco use and limited awareness of discipline options. Participants with any of these concerns were less likely to be retained. The final set of relationships in this analysis included pregnant at assessment, number of home visits completed during Level 1 and retention at 3, 6 and 12 months. Participants who were pregnant at assessment had higher retention at 3, 6 and 12 months. Those with a higher number of home visits on Level 1 had higher retention at 3, 6 and 12 months.

What participant characteristics and programmatic experiences in Healthy Families Florida are related to the number of days in the program?

The answer to this question was based on the development and testing of a conceptual model that included several predictor factors and one dependent variable, the number of days between the enrollment date and the closure date or end of the study period. While tests of bivariate relationships were conducted for each predictor factor and number of days in the program, the primary emphasis was a multivariate analysis in which the variation in the predictor variables was controlled in the determination of the significance of each. Relying on stepwise regression to identify the "best fit" model, the statistically significant or "best" predictors are specified in Figure 10.

Figure 10:"Best Fit" Model for Predicting Days between Enrollment and Closure



The significant statistical relationships in the above figure indicate the following:

- The higher the number of home visits on Level 1 the higher the number of days in the program
- The higher the number of children at intake the lower the number of days in the program
- If a participant is pregnant at assessment, the number of days in the program will be higher
- The higher the HFFAT score of a participant the lower the number of days in the program
- The higher the number of days between assessment and enrollment the lower the number of days in the program
- If a participant is White, the number of days in the program will be lower

This analysis of retention of participants and families in Healthy Families Florida was valuable for a variety of reasons. While there were still several findings that were inconsistent across studies, there were a few findings in this analysis (bivariate or multivariate) that were consistent with earlier findings in the analysis of HFF participant data or in one other analysis of participant data from home visiting programs preventing child abuse and neglect. Using these criteria, the predictors identified as significant and an explanation of the specific bivariate relationships are listed below:

- *Black participants have higher retention*
- *Hispanic participants have higher retention*
- *White participants have lower retention and lower number of days in the program**
- *Prenatal enrollment is related to higher retention and higher number of days in the program (based on pregnant at assessment in the HFF analysis)**
- *A higher number of children at intake is related to lower retention and lower number of days in the program**
- *Older participants have higher retention (12 month retention in HFF analysis)*
- *Single parent status related to lower retention (12 months) and lower number of days in the program*
- *A higher number of completed home visits is related to higher number of days in the program (completed home visits on Level 1 in the HFF analysis)**
- *A higher number of days between assessment and enrollment is related to lower number of days in the program**
- *A higher HFFAT total score for the mother is related to lower retention and lower number of days in the program**
- *Individual HFFAT concerns related to lower retention were active substance abuse in the home (6 months), history of alcohol/substance abuse (12 months), MOB/SO committed one or more victimless crimes (12 months), little or no prenatal care or poor compliance with treatment/medication (3, 6 and 12 months), continued smoking/tobacco use (3, 6*

and 12 months), verbalized unrealistic expectations about child development (3 months) and limited awareness of discipline options (3, 6 and 12 months)

- *Individual HFFAT concerns related to high retention were inadequate income/housing (12 months) and suicidal ideation/attempted suicide (3 months)*

The asterisk (*) next to the predictors listed above indicates that the significant relationship was identified in a multivariate as well as a bivariate analysis and should be considered a stronger predictor. New predictors identified in this analysis were number of children at intake and several individual HFFAT concerns. It is also important to note that several factors were not statistically significant. Examples of these include education level of the mother and several HFFAT individual concerns that refer to experience with domestic violence in the home, maternal depression, or experience with abuse or neglect as a child. If analysis of HFF participant data is conducted on retention and related factors in the future, consistency across findings should continue to be considered. Any replication of findings will add confidence to corresponding changes and improvements to the program. Future analyses should also consider new factors not included in previous tests of statistical significance.

Chapter IV: Review and Analysis of Information on Healthy Families Florida Participants Who Left the Program

The purpose of the research on engagement and retention in the fourth chapter was to learn more about people who are leaving the program due to completion or for reasons other than program completion. The families studied in this chapter included those who closed between December of 2005 and March of 2006. The three main research questions answered in this chapter follow, along with a brief explanation of the approach implemented to answer each question.

Who is leaving the program?

For this analysis, a number of demographic variables, such as age, race, education level, marital status, timing of assessment, the number of children and the type of community in which closed participants reside were included. Risk for child abuse and neglect, as suggested by closed participants' responses to specific items on the HFFAT as well as by the total score on the HFFAT, were also examined. Finally, a number of variables related to closed participants' experiences with Healthy Families Florida, such as the length of time from assessment to enrollment, the number of home visits completed on Level 1, the length of time on program levels and the overall length of time in the program were reviewed.

Why are people leaving the program?

The frequency of families closed due to each closure reason was presented. Then seven "closure reasons groups" were formed in order to conduct analyses that would allow us to answer the third research question.

What distinguishes people closing for different reasons?

Statistical relationships between demographic, abuse and neglect risk and service experience variables mentioned above for each of closure reason group were tested and then the research determined if there were differences between the closure reason groups.

Descriptions of the closed participants were helpful to contribute to an understanding of the families that close. The sample of HFF closed participants consisted of 748 primary participants from all HFF projects who left the program between December 1, 2005 and March 23, 2006. Summarizing the description provided in the earlier chapter of this report, it was learned that almost half (49 percent) of closed participants in this sample received services from Healthy Families projects located within small city or town communities. Over a fourth (26 percent) of closed participants received services from Healthy Families projects serving major cities. The average age at time of closure was 24 years. Forty three percent of these participants identified their race as Black (non-Hispanic), 29 percent as White (non-Hispanic) and 26 percent as Hispanic. At the time of intake, the highest level of education completed was less than 12th grade for 48 percent of closed participants in the sample. Sixty one percent of the sample was pregnant at the time of assessment and 78 percent was single. Almost half (47 percent) of closed participants had more than one child.

Referring to HFFAT total scores and scores on individual items for those participants with detailed information entered in the HFF Data System, it was learned that the average HFFAT score for the closed participants was 25. Of the 553 participants who had HFFAT item information available in the data system, 447 (86 percent) endorsed at least one of the following HFFAT abuse and neglect risk factor indicators as positive:

- 43 percent experienced abuse and/or neglect as a child
- 37 percent experienced or had a fear of violence in relationships
- 33 percent reported substance abuse not resulting in treatment or substance abuse present by someone in the household other than the mother of the baby
- 32 percent had a childhood caregiver who abused substances or was mentally unstable
- 28 percent were experiencing maternal depression
- 23 percent witnessed domestic violence as a child or adolescent
- 23 percent were treated or hospitalized for substance abuse or mental illness as an adult
- 20 percent committed violent or criminal behavior as an adult

Program service experience was also included in descriptions of this sample of closed participants. An average of 40 days passed from the time of assessment to enrollment in the program. Level 1 home visit data was available for 459 closed participants, who completed an average of 23 visits while on Level 1. The average length of time in the program was approximately one and a half years (555 days). Almost two-fifths of closed participants (38 percent) were on Level X at the time of closure and almost a third (32 percent) was on Level 1 or a special status of Level 1. Data for all demographic, abuse and neglect risk and program service experience variables mentioned previously are presented separately for each closure reason group on pages 60 through 74 in Chapter IV of this report.

In this group of HFF closed families, the most common closure reason was “Moved out of Service Area” (MOOSA) (24 percent), followed by “Vanished (Lost Contact)” (20 percent), “Not Interested” (18 percent), “Completed HFF” (15 percent), “Parent School/Work Full-time (11 percent), “Other” reasons (7 percent) and the remaining closure reasons (6 percent). When

testing the statistical relationships between several different factors and closure reasons, the following was learned:

- **Differences Across Size of Community Served**
  1. The highest percentages of participants closed due to "Not Interested" were served by HFF projects in major cities and mid-sized cities, while the lowest percentage of participants closed due to "Not Interested" were served by projects in rural communities.
  2. The highest percentage of participants who closed due to "Vanished (Lost Contact)" were served by HFF projects in mid-sized cities, while the lowest percentage of participants closed due to "Vanished (Lost Contact)" were served by projects in small cities or towns.
  3. The highest percentage of participants closed due to "Parent School/Work Full-Time" were served by HFF projects in rural communities, while the lowest percentage of participants closed due to "Parent School/Work Full-Time" were served by HFF projects in major cities.
  4. The lowest percentage of participants closed due to completion of the program received services from HFF projects in mid-sized cities.
  5. The highest percentage of participants closed due to "Other" reasons was served by HFF projects in small cities or towns.
- **Differences in Demographic Characteristics Across Closure Reason Groups**
  1. A higher percentage of those closed due to "MOOSA" were White while a lower percentage were Black.
  2. A higher percentage of those closed due to "Vanished (Lost Contact)" were Black while a lower percentage were White.
  3. A lower percentage of those closed due to "Other" reasons were Hispanic.
  4. A lower percentage of participants who completed the program were single at intake, while a higher percentage of those closed due to "Vanished (Lost Contact)" were single.
  5. A lower percentage of participants closed due to "Parent School/Work Full-Time" had less than a high school education at the time of closure.
  6. Program completers had a significantly higher average age at the time of closure than all other closed participants.
- **Differences in Abuse and Neglect Risk Factors Across Closure Reason Groups**
  1. Participants closed due to "Other" or "All Remaining Closure Reasons" had the highest mean HFFAT scores, while those who "Completed HFF" had the lowest.
  2. Participants closed due to "Not Interested" had lower odds of having committed violence against another person than those closed for all other reasons.

3. Those closed due to "Vanished (Lost Contact)" had lower odds of experiencing current or prior mental illness or substance abuse requiring treatment or hospitalization and lower odds of reporting abuse or neglect during their childhood.
4. Those closed due to "Other" reasons had higher odds of witnessing domestic violence during childhood or adolescence; higher odds of having committed violence against another person; higher odds of abusive relationships and higher odds of reporting a physical response to anger. They had lower odds, however, of fearing violence in their home.
5. Those closed due to "Moved out of Service Area" (MOOSA) had higher odds of receiving treatment or being hospitalized for mental illness or substance abuse and higher odds of reporting current or recent substance abuse by another member of their household.

- **Differences in Program Experience Across Closure Reason Groups**
  1. Number of home visits completed on Level 1 was significantly related to closure reason, with those closed due to "MOOSA" and "Not Interested" receiving the fewest home visits and those in the "All Remaining Closure Reasons" group receiving the highest number of home visits.
  2. Number of days in the program was significantly related to closure reason group, with those closed due to "Not Interested" with the shortest length of stay and those completing the program spending the longest period of time in the program.

Chapter V: Healthy Families Florida Closed Participant Survey

In order to update and add to findings from previous analyses conducted by Williams, Stern & Associates, as well as to find out more information about families closed due to "Not Interested" and "Other" closure reasons, a survey of closed HFF participants was conducted. For this survey, the sample included 183 participants closed as "Not Interested" or "Other" between December 1, 2005 and March 23, 2006. These 183 closed participants were included in the survey in order to gain a better understanding of their subjective experience with the program.

While the response rate was lower than expected (20 percent) and the results should not be generalized to all participants who close for those two reasons, the survey of HFF closed participants yielded useful information and set the stage for future efforts to collect information from HFF closed participants. Based on the responses received, the closed participants appeared to be satisfied overall with Healthy Families Florida. Regarding their experience with the program, the majority of respondents were satisfied with each aspect of program experience addressed with each survey item. The same pattern was seen with all items related to experience with their home visitor. Respondents indicated that they believe it is important to have a home visitor who has experience as a parent. Regarding personal reasons for closure, participants offered useful insight by way of their open-ended responses. Respondents indicated overall satisfaction with the program and agreed that they would recommend the program to a friend.

Chapter VI: "Ask the Experts": Engagement and Retention from the Perspective of Healthy Families Local Project Staff

Research presented in the sixth chapter involved the use of a modified Delphi technique in order to learn more about engagement and retention in Healthy Families from front line project staff. The overall objective was to gain valuable insight from those who are interacting with Healthy Families Florida participants and potential participants on a daily basis. The purpose of this research project was twofold as indicated in the following:

- To determine the most common reasons families do not engage, or remain engaged, in Healthy Families Florida at all stages of program involvement (assessment, enrollment and retention) from the perspective of HFF project staff (family assessment workers, family assessment worker supervisors, family support workers, family support worker supervisors and program managers)
- To determine top suggestions, or "tips," that staff feel are most useful in encouraging engagement at each stage of program involvement (assessment, enrollment and retention)

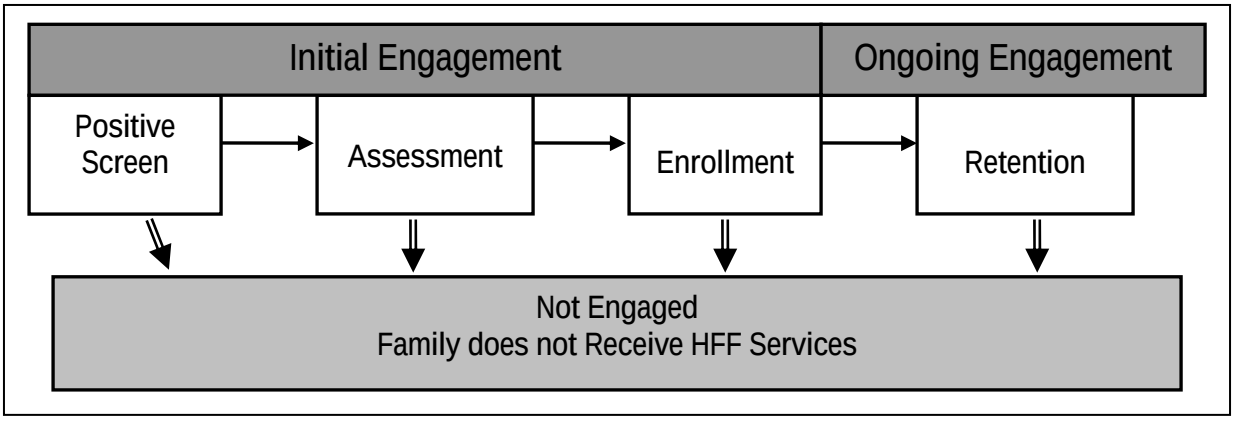
As mentioned above, engagement involves three distinct stages: assessment, enrollment and retention. Assessment and enrollment, the first two stages, represent the *initial* engagement with the program and are explained below:

1. **Assessment** involves the time from screening to assessment to determine program eligibility and refers to families being interested in completing an assessment. The initial interaction with the family between screening and assessment is the primary focus.
2. **Enrollment** involves the time from assessment to enrollment in the program and refers to families agreeing to participate in Healthy Families and enrolling in the program.

The third and final stage of engagement, retention, refers to the *ongoing* engagement of a family in the program:

3. **Retention** begins with enrollment and refers to a family's continuation in the program through the levels. Interaction with the family after they have enrolled, during home visits and when providing other services are included.

Figure 11: Initial and Ongoing Engagement



Three rounds of data collection using the Delphi technique allowed Healthy Families Florida project staff to reach consensus on a set of top three reasons families do not engage, both initially and after enrolling in the program, and tips to encourage engagement at assessment, enrollment and retention. It was of interest to identify differences in opinion between staff in different positions and it was possible to do this with the first two rounds of data collection. A broader representation of a final set of top reasons and tips as agreed upon by staff from all positions was identified during the third and final round of data collection. Also of interest was the level of correspondence between top reasons for not engaging or being retained in the program and tips. Only some of the top reasons were addressed with corresponding tips. A summary of all final top reasons and top tips is presented in Table 65.

Table 65: Final Top Reasons and Top Tips

Top Reasons	Top Tips
ASSESSMENT	
People feel they have enough knowledge and support and thus do not agree to complete an assessment.	No Corresponding Top Tips Selected
People do not feel comfortable having strangers enter their home.	FAWs should be engaging when interacting with families. FAWs should be excited, warm, friendly and ask questions about the mothers. Make the program fun, interesting and personally meaningful.
	Offer tangible incentives, such as free gifts, samples, coupons or information.
	Help connect families to other resources and services in the community.
ENROLLMENT	
Families may face unstable living situations, such as living with other people who are not receptive to home visits.	Make sure that you show respect for all family members and involve everyone, especially when attempting to enroll teen moms.
Too much time passing from the time a family is assessed and the time the program tries to encourage them to enroll.	Ensure a quick follow-up after the family is assessed (preferably less than one week).
Families may not be comfortable with home visits and may see them as an invasion of their privacy.	No Corresponding Top Tips Selected
RETENTION	
Families become bored with the curriculum, activities or their FSW.	Make sure that visits are tailored to the family's needs and wants and that visits are personally meaningful. Listen to any questions, concerns and needs expressed by the family and make sure they are addressed appropriately. Engage all family members.
When faced with a change in FSW, families prefer to leave the program rather than continue with a new FSW.	Supervisors should be more involved with the families. Meet them when they begin working with their FSW and engage in correspondence (letters and phone calls) to assist FSWs. Supervisors should also provide more follow-up for FSWs.

Top Reasons	Top Tips
RETENTION continued	
Families move out of the service area.	No Corresponding Top Tips Selected
	Staff must stay focused on their job and should receive support to avoid burnout.
	Staff should be honest and upfront about program requirements when first presenting the program to families.
	Make sure that staff provides appropriate referrals to meet families' needs.
	Additional funding for support services and more collaboration with housing providers.

Major Findings and Recommendations Addressing Engagement and Retention

This summary section of the final chapter of the Technical Report lists the major findings based on the content in each chapter and recommendations offered by the research staff that corresponds with these findings. However, before presenting major findings and recommendations from the current study of engagement and retention, suggestions and recommendations to improve engagement and retention in HFF that were proposed prior to this project are presented. Quality Improvement Groups have been convened in HFF to address challenges and develop suggested best practices to overcome challenges and improve performance. Project staff is invited to participate in these groups and often represent different regions of the state. Among several groups convened in the past to address issues to improve performance, one focused on engagement and retention in 2002. The objective of this group was to develop "suggested best practices for increasing retention/engagement." Following is a summary of the best practices identified by this group:

- Enrolling families as early as possible in pregnancy
- Adopting culturally appropriate curricula to meet the special needs of a family and child, allowing a delivery that is compatible with the preferred "learning style" of the family
- Decreasing the time interval between the assessment and the first home visit through a tracking system that allows the FAW, the supervisors and the FSW to which the family is assigned to work in an efficient and coordinated fashion
- Involving FAWs in the initial engagement of families that are hesitant to participate in the program
- Reducing FSW attrition by reducing compassion fatigue, by providing incentives for increasing performance in outcomes, such as home completion rates and having opportunities to advance to a higher paying position within the program
- Increasing contact between the family and project staff other than the FSW completing the home visits in order to allow undisrupted coverage of a family when an FSW is unavailable and to improve the family's connection to the project

- Creating an evening shift for FSWs to visit families in the evening with different evenings assigned to different FSWs
- Developing ways to make the home visits more interesting, such as introducing toys in the administration of the Ages and Stages Questionnaire, videos and projects that are fun and free

Another Quality Improvement Group was convened in 2004. This group addressed assessments and strategies for increasing the number of assessments completed each month. Assessments are conducted as a service for the families and they determine eligibility for enrollment in HFF. This group developed strategies that referred to expanding service areas, better management of time and more coordination with other programs that use similar referral sources for families. One suggested strategy was to develop a protocol for managing screens that would specify the number of attempted contacts and the duration of the contact attempts before discontinuing action on that family.

A more recent effort to address engagement and retention was undertaken during the Program Managers' Meeting held in July 2005, shortly after the release of the HFF Five-year Evaluation Report in 2005 (Williams, Stern and Associates, 2005). Program managers and other project staff discussed several different categories of program features and staff procedures that needed attention including participant engagement and retention. Some suggestions for improving participant engagement and retention presented during this meeting included the use of incentives and other ways to recognize families for participating in home visits and completing each level of the program. Some examples of incentives and recognitions offered at the meeting were taking photographs of the families and giving them copies of these photographs or videotaping the families and making the tapes available to the family at the completion of the program. Other suggestions for improving engagement and retention that were proposed during this meeting included:

- Increasing contact between families and supervisors when families express a lack of interest
- Encouraging FSWs to work together to cover families when one FSW is not available
- Developing incentives for staff when their performance is exceptional as an incentive to retain FSWs which is helpful in retaining families
- Allowing Level 1 to be completed within a shorter time frame
- Asking program graduates to be mentors for new families
- Offering a group component for parents
- Developing "special teams" or hiring high-risk specialists to assist in service delivery for very "high-risk" families that have mental health, substance abuse and domestic violence issues

Some of the recommendations developed through the earlier efforts overlapped and several led to the implementation of new approaches or tools for serving families in HFF. The adoption of *Growing Great Kids* in 2004 as the home visiting curriculum was one example of an improvement. The Level Completion Quality Improvement Group in 2006, in which several changes to the leveling criteria were made, was another example. Training modules were

developed to improve the capacity and expertise of project staff in engaging families and retaining them in the program. Examples of the training modules added were Strategies for Effectively Re-Engaging Families, An Overview of Domestic Violence: Strategies to Assist Healthy Families Staff and The Impact of Child Abuse and Neglect: What Can Be Done? Requests for additional funding have also been submitted and tied to several of the needs identified for improving family engagement and retention. This section of the report continues efforts to improve engagement and retention of families by offering suggestions or recommendations that correspond with the major findings documented in the report.

The major findings based on the information documented in this report are identified in this section. Findings in the 2005-2006 analysis of HFF participants that confirm previous research or earlier efforts to improve engagement and retention are identified. Recommendations are also presented that correspond with each of the major findings and observations. The recommendations presented here are intended to benefit both the HF project staff and HFF central office staff. There were two objectives that guided the development of the following recommendations and they were:

1. *To recommend ways to continue to improve our understanding of why families do not engage initially and why they do not continue as participants.*
2. *To recommend ways or approaches to address some of the reasons families do not engage or continue with the program after determination of whether they are consistent with HFF policies and procedures.*

National Research on Engagement and Retention of Families

Major Findings

1. Factors that are related to engagement and retention include participant characteristics, provider characteristics and interaction between home visiting staff and participants, program attributes and neighborhood or community resources, levels of distress or social disorganization.
2. Not all findings were consistently significant across multiple studies or analyses.
3. Participant characteristics that were significant in their relationships with engagement or retention across more than one study or analysis were age of the participant with the older participants retained longer, race/ethnicity of the participant with African American and Hispanic participants retained longer and infant health risk with higher risk related to higher retention.
4. Among the program factors, the matching of African American participants with African American home visiting staff was related to higher retention across more than one study or analysis.
5. There was no provider, neighborhood or community factor that was significant in its relationship with engagement and retention across more than one study or analysis.

Recommendations

1. Ongoing review of relevant research on participants in home visiting programs will continue to be important in our understanding of engagement and retention and

identification of predictive factors. To the extent possible, an ongoing review of published research should be conducted. Findings that are relevant to current policies, procedures and trainings should be identified.

2. Ongoing monitoring and research of engagement and retention in HFF will continue to be important in our understanding of engagement and retention and the identification of predictive factors. To the extent possible, ongoing monitoring and research of engagement and retention in HFF should be conducted. Findings that are relevant to current policies, procedures and trainings should be identified.

Engagement and Retention of HFF Participants Enrolled in 2003-2004 FY

Major Findings

1. Among the HFF participants who enrolled in 2003-2004 and closed during the study period, the closure reasons with the highest percentages were "Moved out of Service Area" (MOOSA) (16.5 percent), "Not Interested" (14.6 percent), "Vanished (Lost Contact)" (9.9 percent) and "Parent School/Work Full-time" (8.3 percent).
2. MOOSA and Not Interested were the predominant reasons for closing within 3 months of enrollment in HFF.
3. Retention rates in HFF for the entire 2003-2004 enrollment cohort were 91.5 percent at 3 months, 79 percent at 6 months, 66.2 percent at 9 months and 56.3 percent at 12 months.
4. Compared to retention in other home visiting programs, retention in HFF at 3 months, 6 months, 9 months and 12 months is above the average.
5. Retention rates across enrollment cohorts based on quarter of enrollment during 2003-2004 remained relatively stable.
6. Retention rates did not vary significantly across the type of community served based on population size.
7. The participant characteristics that were significantly related to retention were number of children at intake with higher number of children related to lower retention; participant race with Black and Hispanic participants having higher retention and White participants having lower retention; age with participants who were older having at enrollment had higher retention; and marital status with single parents having lower retention.
8. Participants with higher *Healthy Families Florida Assessment Tool (HFFAT)* total scores had lower retention.
9. The specific HFFAT concerns or items related to lower retention were little or no prenatal care (< 5 visits) or poor compliance with treatment/medication, continued smoking/tobacco use, limited awareness of discipline options, a history of alcohol/substance abuse, mother or significant other has committed 3 or more victimless crimes and active substance abuse in the home (by someone other than the mother of the baby).
10. Participants who were pregnant at assessment had higher retention at 3, 6 and 12 months.

11. Participants with a higher number of completed home visits on Level 1 had higher retention at 3, 6 and 12 months.
12. In one multivariate model identified as the "best fit," significant predictors of number of days in the program based on enrollment and closure dates were the following:
    - The higher the number of completed home visits on Level 1 the higher the number of days in the program
    - The higher the number of children at intake the lower the number of days in the program
    - If a participant was pregnant at assessment, the number of days in the program was higher
    - The higher the HFFAT score of a participant the lower the number of days in the program
    - The higher the number of days between assessment and enrollment the lower the number of days in the program
    - If a participant was White, the lower the number of days in the program

Recommendations

1. Develop and use new retention rates that are more meaningful in measuring project success in retaining families at your project. Web-based reports have been created by RES staff that will allow retention rates to be calculated using a cohort methodology. There will be two major types of rates generated with this report: 1) based on DEIP and closure date and 2) first and last home visit dates. The report will allow flexibility in the selection of a cohort and the retention interval (1, 3, 6, 9, 12, 18, 24 or 36 months). The cohorts will be set by date parameters that will indicate the time period for the DEIP or the first home visit. It is recommended that special attention be focused on retention during the first 12 months of participation when using these Web-based reports.
2. HF project staff should be familiar with the reasons their participants close. The HFF Web-based Report, *Aggregate Report for Closure Reasons* and Table 12 in the *HFF Quarterly Performance Report* indicate the number of closed participants by closure reason. A high number of participants closing due to completion of the program is desirable.
3. HF project staff should continue to consult tables in the current *HFF Quarterly Performance Report* to understand more about the length of time closed participants were in the program. Table 13 indicates the percentage of those who closed were participating in the program for <3 months, 3-6 months, 6-12 months, 12-24 months, 24-36 months and 36+ months. Unless participants in a project complete the program prior to 36 months, higher percentages for the 36+ months are desirable. Table 14 indicates the percentage of closed participants who were on each level of the program. Lower percentages closing on Level 1, 1P and Level X are desirable. Consulting Tables 15 through 23 might also be helpful. These tables display percentages for lengths of stay for each level in the program.

4. HF project staff should review the participant characteristics and HFFAT concerns that are related to retention or the number of days in the program based on the statewide analysis presented in this report (see pages 44-50).
5. HF project staff should review their experience serving mothers who have higher HFFAT scores (higher than 25 or the average for the participants in their project) and consider innovative ways to retain these families in the program that are consistent with HFF program policies and procedures.
6. HF project staff should be aware of the importance of assessing potential participants while they are pregnant.
7. HF project staff should attempt to enroll participants as soon as possible after an assessment is completed.
8. HF project staff should attempt to complete the expected number of home visits on Level 1.
9. HF project staff should review their experience serving mothers with non-target children at intake and consider innovative ways to retain these families in the program that are consistent with HFF program policies and procedures.

Healthy Families Florida Participants Who Left the Program

Major Findings

1. For the 748 participants who left the program between December 1, 2005 and March 23, 2006 and were included in this sample, it was learned that:
   a. Almost half (49 percent) of closed participants in this sample received services from Healthy Families projects located within small city communities. Over a fourth (26 percent) of closed participants received services from Healthy Families projects serving major cities.
   b. The average age at time of closure was 24 years.
   c. 43 percent of these participants identified their race as Black (non-Hispanic), 29 percent as White (non-Hispanic) and 26 percent as Hispanic.
   d. At the time of intake, the highest level of education completed was less than 12^{th} grade for 48 percent of closed participants in the sample.
   e. 61 percent of the sample was pregnant at the time of assessment and 78 percent was single.
   f. Almost half (47 percent) of closed participants had more than one child.
2. Referring to information on the HFFAT, it was learned that:
   a. The average HFFAT score for the closed participants was 25.
   b. 43 percent experienced abuse and/or neglect as a child and 23 percent witnessed domestic violence as a child or adolescent.
   c. 33 percent reported substance abuse not resulting in treatment or substance abuse present by someone in the household other than the mother of the baby.

d. 32 percent had a childhood caregiver who abused substances or was mentally unstable.

e. 28 percent were experiencing maternal depression.

3. Referring to information on their program services, it was learned that:

   a. An average of 40 days passed from the time of assessment to enrollment in the program.

   b. The average length in the time in the program was approximately one and a half years (555 days).

   c. Almost two-fifths of the participants (38 percent) were on Level X at the time of closure and almost a third (32 percent) was on Level 1 or a special status of Level 1.

4. The most common closure reason was moving out of the service area (24 percent), followed by "Vanished (Lost Contact)" (20 percent), "Not Interested" (18 percent), "Completed HFF" (15 percent), "Parent School/Work Full-time" (11 percent), "Other" reasons (7 percent) and the remaining closure reasons (6 percent).

5. Statistical analysis of participants who closed indicated that there were several significant differences across closure reasons when considering community size, participant demographic characteristics, HFFAT concerns and program experiences. Refer to these findings on pages 74 through 78.

6. As final findings in the analysis conducted with the closed participants, it was learned that:

   a. Number of home visits completed on Level 1 was significantly related to closure reason, with those closed due to "MOOSA" and "Not Interested" receiving the fewest home visits and those in the "All Remaining Closure Reasons" group receiving the highest number of home visits.

   b. Number of days in the program was significantly related to closure reason group, with those closed due to "Not Interested" spending the lowest number of days in the program and those completing the program spending the highest number of days in the program.

Recommendations

1. HF staff should be familiar with the descriptions of each closure reason, as specified in the *Healthy Families Florida Data Collection Forms and Guidelines*. These descriptions are presented on page 59 in Chapter IV of this report. HF projects should review the closure reasons and ensure that staff understand each reason and apply them consistently.

2. HF projects should be familiar with the reasons that families close and identify those reasons that occur with the greatest frequency. Refer to Table 12, "Reasons Families Left HFF," in the *Healthy Families Florida Quarterly Performance Report (QPR)* or to the HFF Web-based Report, *Aggregate Report for Closure Reasons*, for the number of families closed for each closure reason.

3. HF staff should review the results of the statistical relationships tested in which community size levels, demographic characteristics, HFFAT concerns and program experiences were related to closure reasons. These results appear on pages 74 through 78

of the report. Each project should determine if their understanding of their participants is consistent or inconsistent with the statewide results. If there are inconsistencies, the project should attempt to determine why. Some of the differences might be related to the characteristics of the participants served by that project, the HFFAT concerns identified for their participants, or special circumstances experienced in their project compared to other projects.

4. Participant closure reasons should be reviewed in a Quality Improvement Group. In particular, the "Not Interested" and "Other" reasons should be reviewed carefully. This group should identify and clarify the conditions for specification of the reasons or develop new closure reasons in order to avoid the designation of "Other" for a closure reason.
5. HF projects should utilize the *Aggregate Assessment Concerns* HFF Web-based Report in order to better understand abuse and neglect risk for those closing from their project, as suggested by HFFAT item frequencies. When running this report, closure reason can be specified in order to determine frequencies for each HFFAT item for those closing due to the closure reason of interest. HF project staff should identify innovative ways to address particular HFFAT concerns that are common among former participants served by their project.

Healthy Families Florida Closed Participant Survey

Major Findings

1. For this survey, the sample included 183 closed participants whose closure date was between December 1, 2005 and March 23, 2006 and whose closure reason was "Not Interested" or "Other." These 183 closed participants were included in the survey in order to gain a better understanding of their subjective experience with the program.
2. While the response rate was lower than expected (20 percent) and the results should not be generalized to all participants who close for those two reasons, the survey yielded useful information and set the stage for future efforts to collect information from HFF closed participants.
3. Based on the responses received, the closed participants appeared to be satisfied overall and with each specified aspect of program experience in Healthy Families Florida. It was also learned that:
   a. Respondents indicated that they believe it is important to have a home visitor who has experience as a parent.
   b. Respondents agreed that they would recommend the program to a friend.

Recommendations

1. In order to obtain useful feedback from previous participants, HF projects should use the closed participant survey tool to survey the families who close. If projects want additional information that is not addressed in current questionnaire items, they may add questions to the end of the questionnaire. It is suggested that all existing items remain

intact. Projects are advised not to add more than a few questions, as closed participants may be less likely to respond as the length of the survey questionnaire increases.

2. If HF projects use the closed participant survey tool, they should share their survey method and their opinion of whether the survey was useful with RES and HFF central office staff. If projects want assistance in implementing use of the survey, they may contact RES staff for assistance.

"Ask the Experts": Engagement and Retention from the Perspective of Healthy Families Local Project Staff

Major Findings

1. Using a modified Delphi Technique with three rounds of data collection from HF project staff, consensus was reached on top reasons for families not agreeing to be assessed, enrolling in the program and staying in the program (2 reasons for assessment, 3 reasons for enrollment and 3 reasons for retention). Refer to pages 125 and 126.
2. Using a modified Delphi Technique with three rounds of data collection from HF project staff, consensus was reached on top tips for encouraging families to agree to be assessed, to enroll in the program and to stay in the program (3 tips for assessment, 2 tips for enrollment and 10 tips for retention). Refer to pages 125 and 126.
3. Some but not all of the top reasons for not assessing, not enrolling and not staying in the program had corresponding top tips (1 of 2 top reasons for not agreeing to be assessed had a corresponding top tip, 2 of 3 reasons for not enrolling had a corresponding top tip and 2 of 3 top reasons for not staying with the program had a corresponding top tip)

Recommendations

1. Review the lists of all reasons and tips submitted by the HF project staff in Appendix VI to identify similarities with the experience of your project staff and identify new ideas for addressing the problems with engagement and retention that are consistent with HFF policies and procedures.
2. Consider the application of the modified Delphi technique with your project staff to identify reasons for not assessing, enrolling and retaining families and for developing ways to address these reasons. If projects want assistance in applying the technique, they may contact RES staff for assistance.

References

Daro, D. A., & Harding, K. A. (1999). Healthy Families America: Using research to enhance practice. *The Future of Children, 9*(1), 152 – 176.

Daro, D., McCurdy, K., Falconnier, L., & Stojanovic, D. (2003). Sustaining new parents in home visitation services: Key participant and program factors. *Child Abuse and Neglect, 27*(10), 1101 – 1125.

Daro, D., McCurdy, K., & Nelson, C. (2005). *Engagement and retention in voluntary new parent support programs: Final report.* Chicago: University of Chicago, Chaplin Hall Center for Children.

Duggan, A., Windham, A., McFarlane, E., Fuddy, L., Rohde, C., Buchbinder, S., & Sia, C. (2000). Hawaii's Healthy Start program of home visiting for at-risk families: Evaluation of family identification, family engagement, and service delivery. *Pediatrics, 105*(1), 250 – 259.

Gomby, D. S., Culross, P. L., & Behrman, R. E. (1999). Home visiting: Recent program evaluations – analysis and recommendations. *The Future of Children, 9*(1), 4 – 26.

Green, B., Jones, M., Hughes, D., & Williams, A. (1999). Applying the Delphi technique in a study of GPs' information requirements. *Health and Social Care in the Community, 7*(3), 198-205.

Harding, K., Reid, R., Oshana, D., & Holton, J. (2004). *Initial results of the HFA implementation study*. Chicago: Prevent Child Abuse America, National Center on Child Abuse Prevention Research.

McCurdy, K., & Daro, D. (2001). Parent involvement in family support programs: An integrated theory. *Family Relations, 50*(2), 113 – 121.

McCurdy, K., Gannon, A., & Daro, D. (2003). Participation patterns in home-based family support programs: Ethnic variations. *Family Relations, 52*(1), 3-11.

McGuigan, W. M., Katzev, A. R., & Pratt, C. C. (2003). Multi-level determinants of retention in a home-visiting child abuse prevention program. *Child Abuse & Neglect, 27,* 363-380.

Powell, C. (2003). The Delphi technique: Myths and realities. *Journal of Advanced Nursing, 41*(4), 376-382.

Sharp, E. A., Ispa, J. M., Thornburg, K. R., & Lane, V. (2003). Relations among mother and home visitor personality, relationship quality, and amount of time spent in home visits. *Journal of Community Psychology, 31*(6), 591-606.

Wasik, B. H. (1993). Staffing issues for home visiting programs. *The Future of Children, 3*(3), 140-157.

Williams, Stern & Associates. (2003, February). *Healthy Families Florida early leavers study*. Miami: Author.

Williams, Stern & Associates. (2005, February). *Healthy Families Florida evaluation report: January 1, 1999 – December 31, 2003*. Miami: Author.

Appendices

*Please note that appendices are numbered in correspondence with report chapters.
There is no Appendix I.

Appendix II
Review of National Research on Engagement and Retention of Families

Figure 1: Daro, McCurdy, Falconnier, & Stojanovic (2003) Model for Analyzing Factors Related to Healthy Families Participant Retention

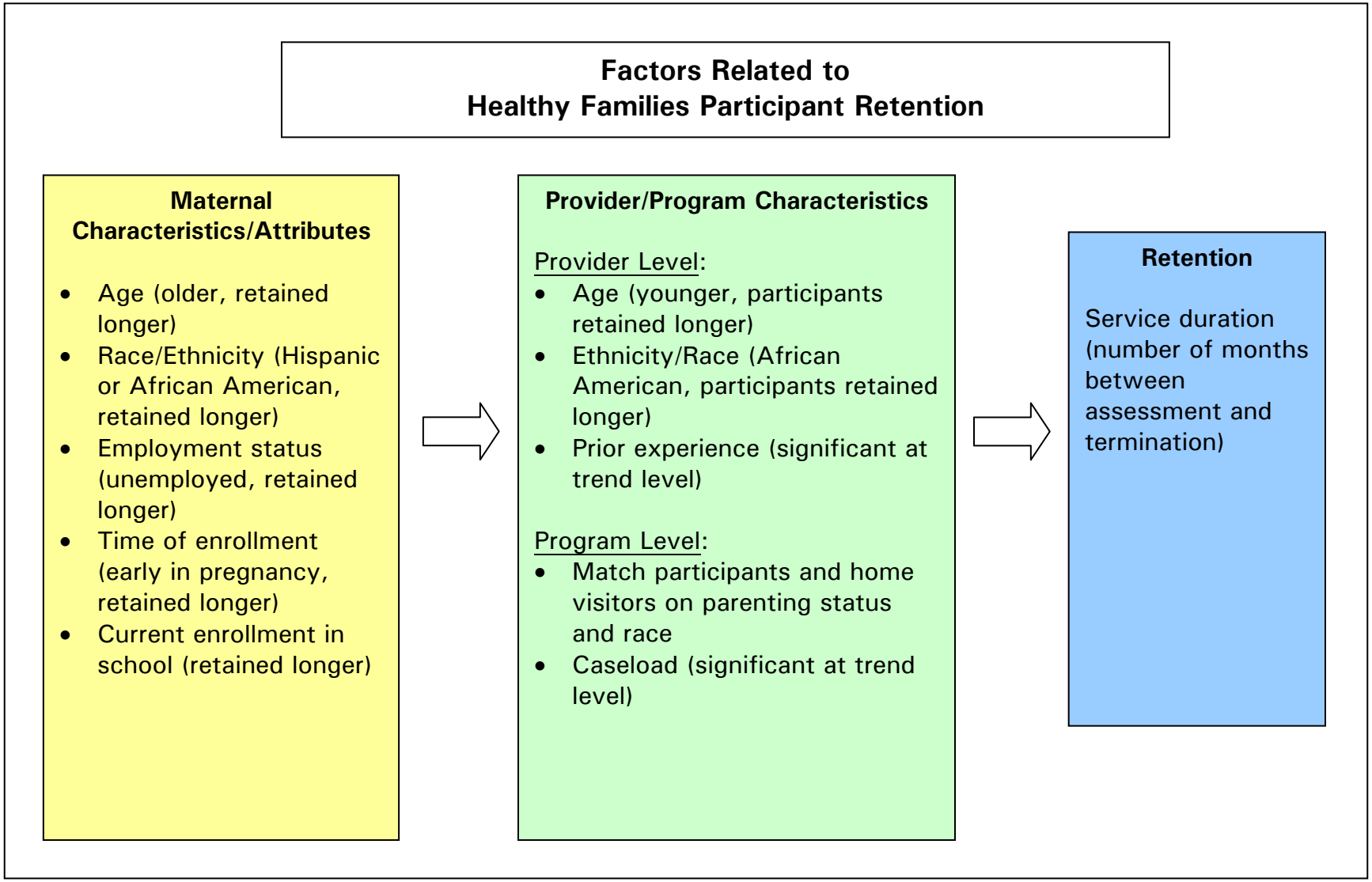


Figure 2: Daro, McCurdy, Falconnier, & Stojanovic (2003) Model for Analyzing Factors Related to Healthy Families Participant Dosage (Number of Home Visits)

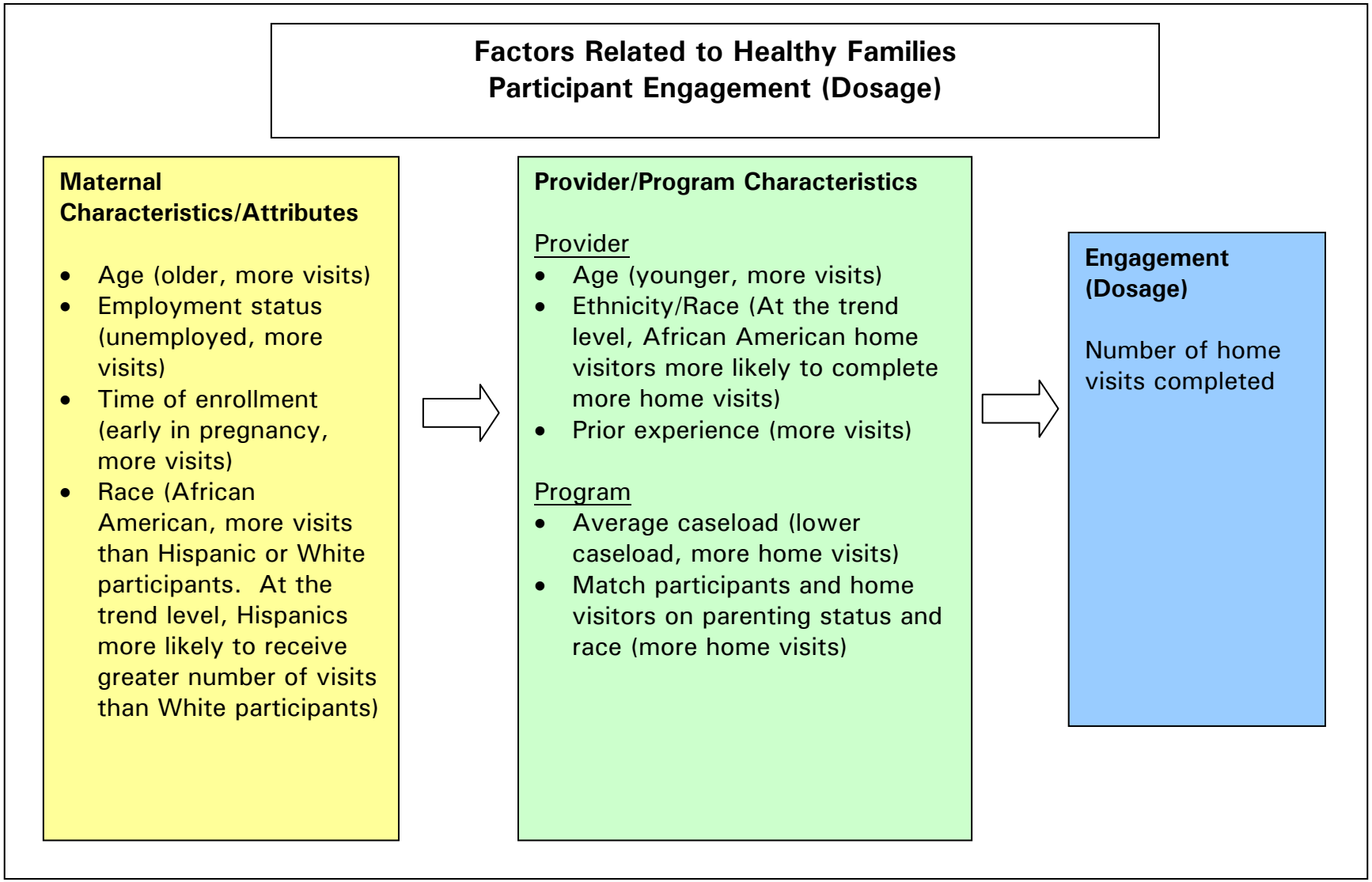


Table 1: Daro, McCurdy, Falconnier, & Stojanovic (2003) Factors not Predictive of Retention or Dosage

Retention	Dosage
PARTICIPANT: • Education level • Family Stress Checklist (FSC) score PROVIDER: • Parenting status of home visitor • Home visitor's education level PROGRAM: • Percentage of cases visited within 2 weeks of assessment	PARTICIPANT: • Education level • Family Stress Checklist (FSC) score • Enrollment in school PROVIDER: • Parenting status of home visitor • Home visitor's education level • Race of home visitor PROGRAM: • Percentage of cases visited within 2 weeks of assessment • Length of time between initial assessment and first home visit

Figure 3: Daro, McCurdy, & Nelson (2005) Model for Analyzing Factors Related to Healthy Families Participant Retention

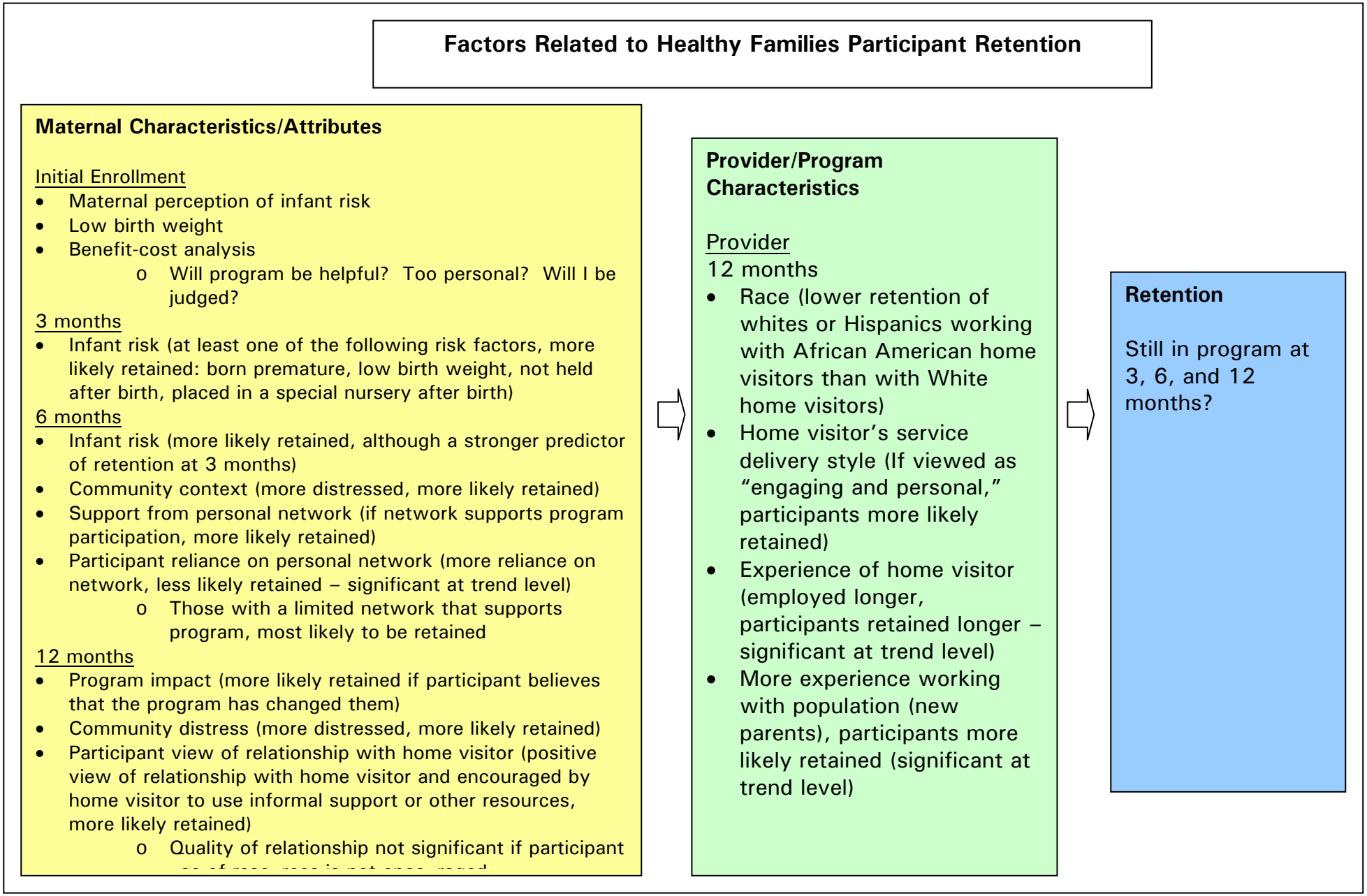


Figure 4: Daro, McCurdy, & Nelson (2005) Model for Analyzing Factors Related to Healthy Families Participant Dosage (Number of Home Visits)

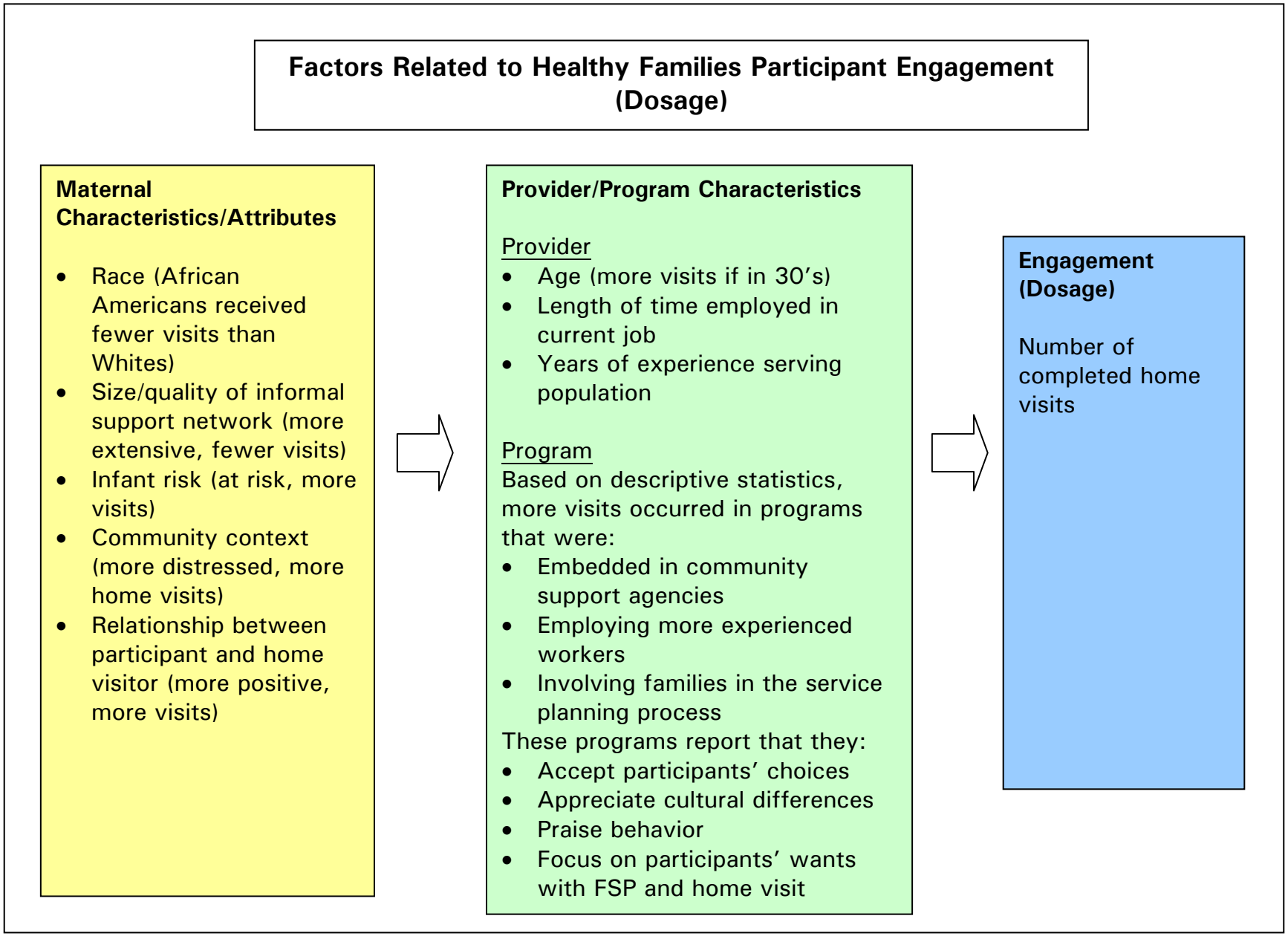


Table 2: Daro, McCurdy, & Nelson (2005) Factors not Predictive of Retention or Dosage

Retention	Dosage
PARTICIPANT: • Socioeconomic status • Timing of enrollment • Early Head Start Risk Index (factors: not married, not employed or in school, 20 or younger, no high school diploma or GED) • Total number of concerns • Race • Readiness to change • Received material goods from program • Home visitor encouraged use of informal supports (considered alone, not significant, but interaction effect noted with assessment of relationship with home visitor) • Assessment of relationship with home visitor (considered alone, not significant, but interaction effect noted with home visitor encouragement of use of supports) • Use of other social service programs • Dependency ratio (number in need of care and those able to provide care within participant's census block group) PROVIDER: • Home visitor's education level • Home visitor's age • Home visitor's parenting status PROGRAM • Level of supervision and personal support provided to home visitors • External activities • Caseload • Change in home visitor	PARTICIPANT: • Socioeconomic status • Timing of enrollment • Early Head Start Risk Index (factors: not married, not employed or in school, 20 or younger, no high school diploma or GED) • Total number of concerns • Personal network supports program • Received material goods from program • Home visitor encouraged use of informal supports • Participant's readiness to change • Program impact (belief that program changed participant) • Assessment of relationship with home visitor and home visitor's encouragement of use of informal supports • Use of other social service programs • Dependency ratio (number in need of care and those able to provide care within participant's census block group) PROVIDER: • Home visitor's education level • Home visitor's race • Home visitor's parenting status • Home visitor's service delivery style PROGRAM • Level of supervision and personal support provided to home visitors • External activities • Caseload • Change in home visitor

Appendix III
Engagement and Retention of Healthy Families Florida Participants Enrolled in 2003-2004 FY

Table 1: Retention of All Participants Who Enrolled in 2003-04 by Healthy Families Project

HF Project/County	Total Enrolled in 2003-04	Number and Percentage Retained			
		Retained at 3 months	Retained at 6 months	Retained at 9 months	Retained at 12 months
ALACHUA	61	59	56	48	42
	100.00	96.72	91.80	78.69	68.85
BAKER	23	21	56	11	9
	100.00	91.30	69.57	47.83	39.13
BAY/GULF	41	39	35	32	24
	100.00	95.12	85.37	78.05	58.54
BREVARD	154	138	124	104	94
	100.00	89.61	80.52	67.53	61.04
BROWARD	193	163	144	127	117
	100.00	84.46	74.61	65.80	60.62
CHARLOTTE	89	75	64	54	43
	100.00	84.27	71.91	60.67	48.31
CLAY	52	46	37	23	18
	100.00	88.46	71.15	44.23	34.62
COLLIER	41	37	31	25	21
	100.00	90.24	75.61	60.98	51.22
DADE	249	239	221	192	169
	100.00	95.98	88.76	77.11	67.87
DESOTO	36	33	23	19	16
	100.00	91.67	63.89	52.78	44.44
DUVAL	305	275	234	186	159
	100.00	90.16	76.72	60.98	52.13
ESCAMBIA	27	25	21	21	21
	100.00	92.59	77.78	77.78	77.78
FRANKLIN	16	16	13	13	12
	100.00	100.00	81.25	81.25	75.00
DIXIE/GILCHRIST/LEVY	45	44	39	32	25
	100.00	97.78	86.67	71.11	55.56
GADSDEN	34	34	28	22	20
	100.00	100.00	82.35	64.71	58.82
NORTH FLORIDA	59	52	48	35	28
	100.00	88.14	81.36	59.32	47.46
HENDRY/GLADES	79	72	63	56	45
	100.00	91.14	79.75	70.89	56.96
HILLSBOROUGH	286	258	203	163	126
	100.00	90.21	70.98	56.99	44.06
INDIAN RIVER	79	77	62	51	45
	100.00	97.47	78.48	64.56	56.96
LAKE/SUMTER	75	73	70	53	39
	100.00	97.33	93.33	70.67	52.00
LEE	34	32	26	22	21
	100.00	94.12	76.47	64.71	61.76
LEON	25	21	19	15	14
	100.00	84.00	76.00	60	56.00

HF Project/County	Total Enrolled in 2003-04	Number and Percentage Retained			
		Retained at 3 months	Retained at 6 months	Retained at 9 months	Retained at 12 months
MANATEE	95	84	65	52	45
	100.00	88.42	68.42	54.74	47.37
MARION	71	66	62	57	51
	100.00	92.96	87.32	80.28	71.83
MARTIN	134	125	110	94	83
	100.00	93.28	82.09	70.15	61.94
MONROE	35	33	29	23	17
	100.00	94.29	82.86	65.71	48.57
NASSAU	53	49	43	32	26
	100.00	92.45	81.13	60.38	49.06
OKALOOSA	58	54	40	36	30
	100.00	93.10	68.97	62.07	51.72
ORANGE	290	260	217	187	169
	100.00	89.66	74.83	64.48	58.28
OSCEOLA	173	144	117	96	77
	100.00	83.24	67.63	55.49	44.51
PALM BEACH	161	161	156	138	121
	100.00	100.00	96.89	85.71	75.16
PASCO	120	114	99	84	72
	100.00	95.00	82.50	70.00	60.00
PINELLAS	87	79	70	62	52
	100.00	90.80	80.46	71.26	59.77
POLK	277	256	225	189	164
	100.00	92.42	81.23	68.23	59.21
PUTNAM	45	40	39	35	30
	100.00	88.89	86.67	77.78	66.67
SANTA ROSA	44	42	38	33	29
	100.00	95.45	86.36	75.00	65.91
SARASOTA	160	148	118	96	81
	100.00	92.50	73.75	60.00	50.63
SEMINOLE	94	82	71	60	51
	100.00	87.23	75.53	63.83	54.26
ST JOHNS	30	27	21	17	13
	100.00	90.00	70.00	56.67	43.33
ST. LUCIE	101	96	87	75	63
	100.00	95.05	86.14	74.26	62.38
VOLUSIA/FLAGER	156	143	122	101	80
	100.00	91.67	78.21	64.74	51.28
WAKULLA	16	15	14	13	12
	100.00	93.75	87.50	81.25	75.00
WALTON	24	22	19	16	12
	100.00	91.67	79.17	66.67	50.00
All Projects	4227	3869	3339	2800	2386
	100.00	91.53	78.99	66.24	56.45

Table 2: Retention of Participants Who Enrolled in 2003-04, Closed for Reasons that Are Not Encouraged or Remained in the Program during the Study Period by Healthy Families Project

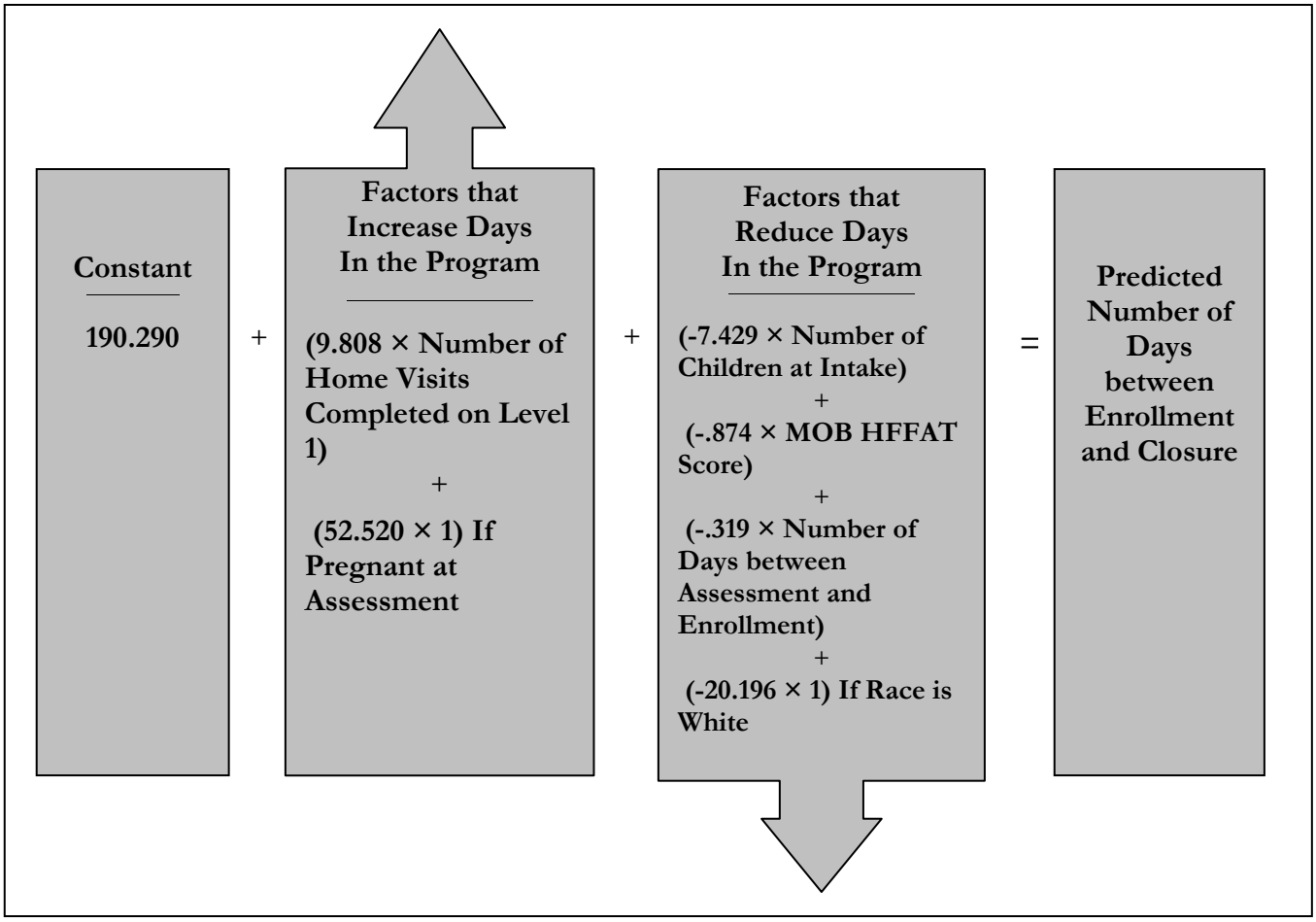
HF Project/County	Total Enrolled in 2003-04	Number and Percentage Retained			
		Retained at 3 months	Retained at 6 months	Retained at 9 months	Retained at 12 months
ALACHUA	52	50	48	43	40
	100.00	96.15	92.31	82.69	76.92
BAKER	22	20	15	11	9
	100.00	90.91	68.18	50.00	40.91
BAY/GULF	40	38	35	32	24
	100.00	95.00	87.50	80.00	60.00
BREVARD	144	129	116	97	88
	100.00	89.58	80.56	67.36	61.11
BROWARD	175	155	139	125	115
	100.00	88.57	79.43	71.43	65.71
CHARLOTTE	66	59	52	47	38
	100.00	89.39	78.79	71.21	57.58
CLAY	45	40	34	21	16
	100.00	88.89	75.56	46.67	35.56
COLLIER	35	32	29	23	21
	100.00	91.43	82.86	65.71	60.00
DADE	237	229	215	189	169
	100.00	96.62	90.72	79.75	71.31
DESOTO	30	29	22	19	16
	100.00	96.67	73.33	63.33	53.33
DUVAL	258	240	211	174	152
	100.00	93.02	81.78	67.44	58.91
ESCAMBIA	25	23	19	19	19
	100.00	92.00	76.00	76.00	76.00
FRANKLIN	15	15	13	13	12
	100.00	100.00	86.67	86.67	80.00
DIXIE/GILCHRIST/LEVY	41	40	35	29	23
	100.00	97.56	85.37	70.73	56.10
GADSDEN	33	33	28	22	20
	100.00	100.00	84.85	66.67	60.61
NORTH FLORIDA	51	46	42	30	28
	100.00	90.20	82.35	58.82	54.90
HENDRY/GLADES	71	64	57	52	42
	100.00	90.14	80.28	73.24	59.15
HILLSBOROUGH	254	228	186	151	120
	100.00	89.76	73.23	59.45	47.24
INDIAN RIVER	71	69	55	47	43
	100.00	97.18	77.46	66.20	60.56
LAKE/SUMTER	69	67	65	52	38
	100.00	97.10	94.20	75.36	55.07
LEE	34	32	26	22	21
	100.00	94.12	76.47	64.71	61.76
LEON	22	20	19	15	14
	100.00	90.91	86.36	68.18182	63.64

HF Project/County	Total Enrolled in 2003-04	Number and Percentage Retained			
		Retained at 3 months	Retained at 6 months	Retained at 9 months	Retained at 12 months
MANATEE	79	73	56	47	42
	100.00	92.41	70.89	59.49	53.16
MARION	70	66	62	57	51
	100.00	94.29	88.57	81.43	72.86
MARTIN	106	98	87	78	72
	100.00	92.45	82.08	73.58	67.92
MONROE	29	27	24	21	16
	100.00	93.10	82.76	72.41	55.17
NASSAU	51	48	42	31	26
	100.00	94.12	82.35	60.78	50.98
OKALOOSA	50	47	38	35	30
	100.00	94.00	76.00	70.00	60.00
ORANGE	272	243	212	184	168
	100.00	89.34	77.94	67.65	61.76
OSCEOLA	152	126	105	89	74
	100.00	82.89	69.08	58.55	48.68
PALM BEACH	150	150	146	130	116
	100.00	100.00	97.33	86.67	77.33
PASCO	110	106	92	83	71
	100.00	96.36	83.64	75.45	64.55
PINELLAS	81	74	65	57	49
	100.00	91.36	80.25	70.37	60.49
POLK	252	237	211	183	160
	100.00	94.05	83.73	72.62	63.49
PUTNAM	42	38	37	33	30
	100.00	90.48	88.10	78.57	71.43
SANTA ROSA	42	40	36	31	29
	100.00	95.24	85.71	73.81	69.05
SARASOTA	148	137	111	89	77
	100.00	92.57	75.00	60.14	52.03
SEMINOLE	90	80	70	59	51
	100.00	88.89	77.78	65.56	56.67
ST JOHNS	22	20	17	14	13
	100.00	90.91	77.27	63.64	59.09
ST. LUCIE	95	91	83	72	63
	100.00	95.79	87.37	75.79	66.32
VOLUSIA/FLAGER	142	132	113	96	77
	100.00	92.96	79.58	67.61	54.23
WAKULLA	16	15	14	13	12
	100.00	93.75	87.50	81.25	75.00
WALTON	20	19	17	16	12
	100.00	95.00	85.00	80.00	60.00
All HF Projects	3809	3525	3099	2651	2307
	100.00	92.54	81.36	69.60	60.57

Predicting the Number of Days a Participant Will Be Enrolled in the Program

As presented on page 48 in the text of the report, the equation used to predict the number of days between enrollment and closure includes several factors. Each of these factors has a statistic or coefficient. Figure 1 shows each factor with its coefficient based on data for all participants enrolled during 2003-2004. Refer to the next page for an example of how the formula can be used to predict the number of days that a participant will remain enrolled in the program.

Figure 1: Equation for Calculating the Predicted Number of Days in HFF for Participants Enrolled during 2003-2004



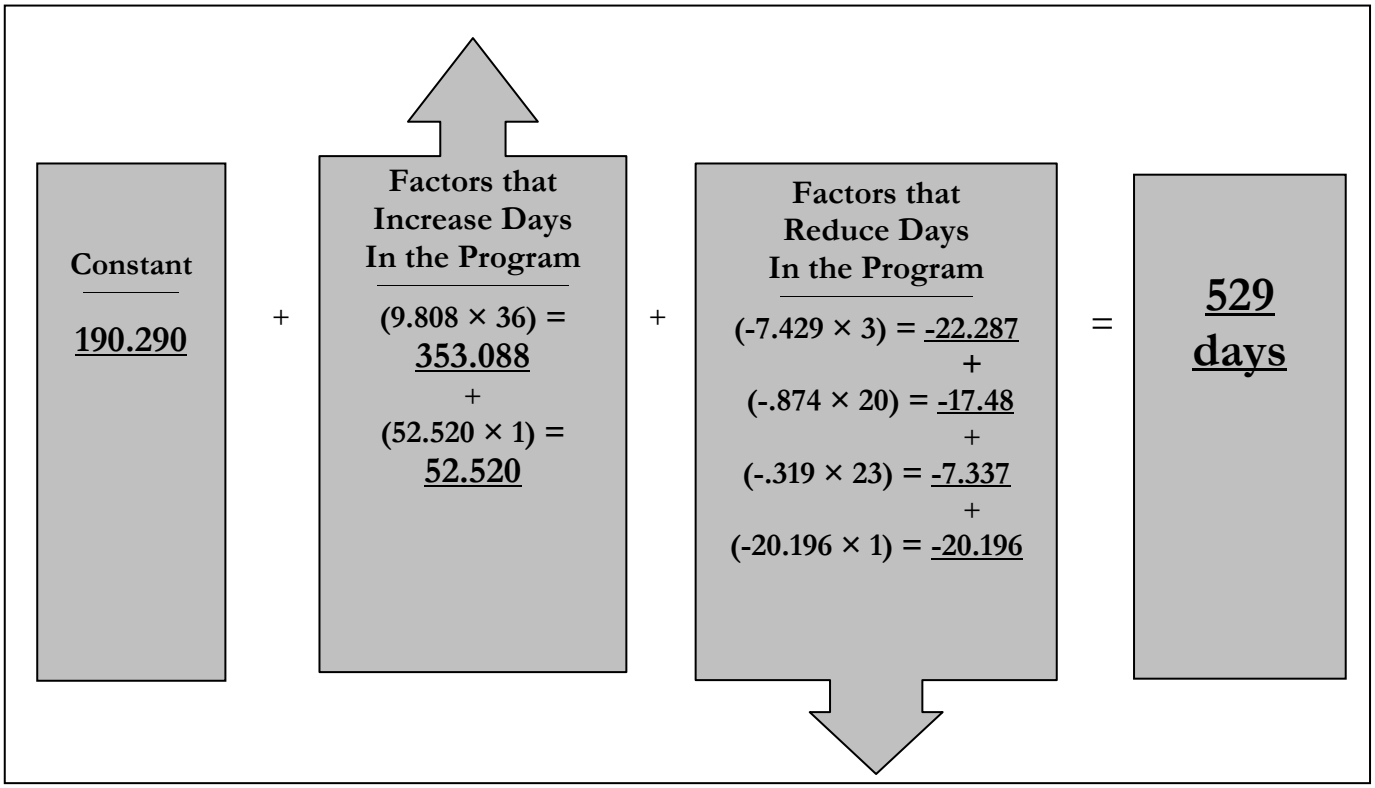
An example of the calculation is on the next page.

Data for an example participant have been inserted into the formula and appear in the figure below. Based on this formula, it is predicted that there would be 529 days between the date that this participant enrolled in the program and the date that she closed from the program.

Example participant data:

- Participant completed **36** Home Visits while on Level 1
- Participant was pregnant at the time of assessment (Pregnant = **1**, Not Pregnant = 0)
- Participant had **3** children at intake
- Participant had an HFFAT score of **20**
- There were **23** days between assessment and enrollment
- Participant's race is White (White = **1**, Not White = 0)

Figure 2: Example Calculation of Predicted Number of Days in HFF



Appendix IV
Review and Analysis of Healthy Families Florida Participants Who Left the Program

Figure 1: HFF Aggregate Assessment Concerns Web-Based Report: Initial Screen

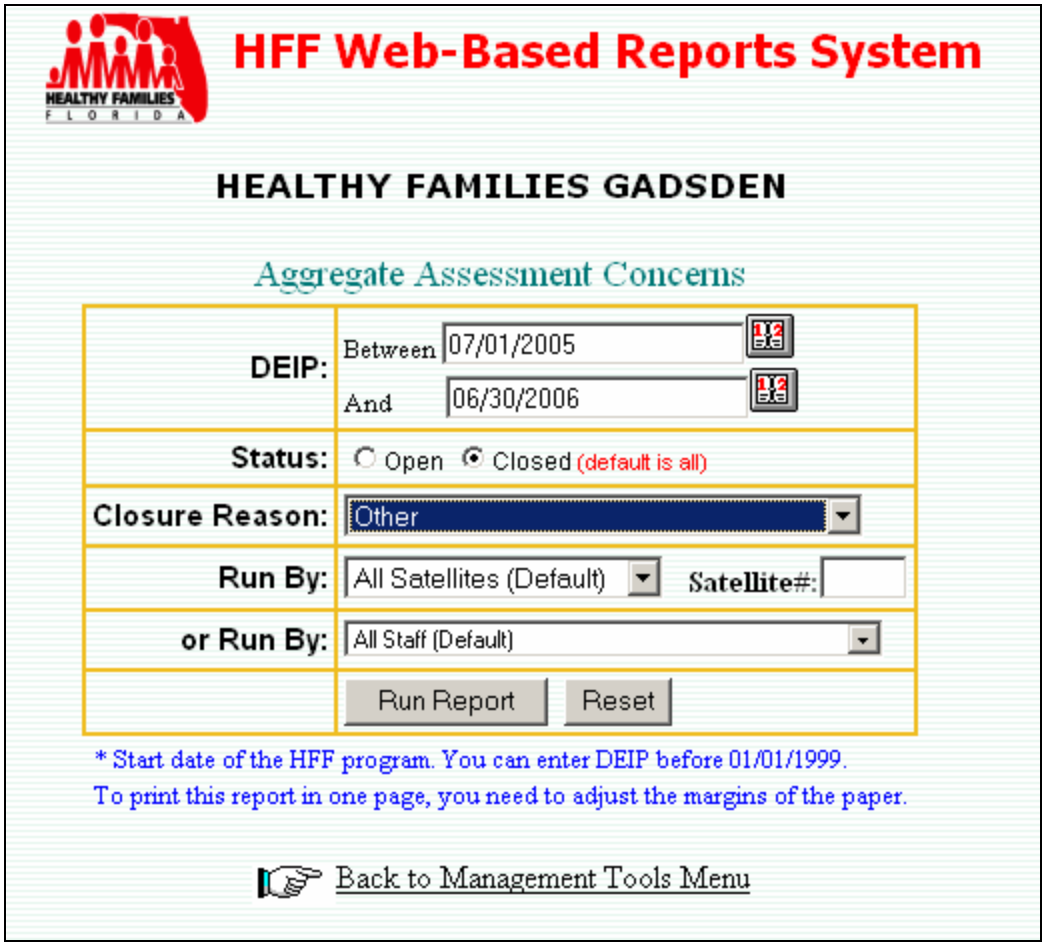


Figure 2: HFF Aggregate Assessment Concerns Web-Based Report: Sample Output

HEALTHY FAMILIES GADSDEN

Aggregate Assessment Concerns Report For (1) Closed Primary Participants

(DEIP Between 7/1/2005 And 6/30/2006)

(Closure Reason: Other)

Basic Needs	MOB	SO	Infant and Maternal Health (continued)	MOB	SO
1) Inability to meet basic needs (no access to food, clothing, no access to any form of transportation)	0%	0%	21) No medical home for child or children	0%	0%
2) Inadequate income and/or housing	0%	0%	22) Child or other family members or caregivers in home with special needs (developmental/physical/ medical disabilities or behavioral/learning disorder)	0%	0%
3) Social Isolation: (no one to call in an emergency and/or no plan in place, no involvement with social service agencies, no access to a phone, inability to communicate within the community)	0%	0%	23) Self-reported the use of drugs and/or alcohol during pregnancy prior to knowledge of pregnancy	0%	0%
History of Parent(s) (Childhood)			Relationships and Support (Current)		
4) Witness to domestic violence during childhood/adolescence	0%	0%	24) Currently (within last 12 months) victim of domestic violence or other abuse	0%	0%
5) Instability of care during childhood	0%	0%	25) Past abusive relationships (not related to childhood)	0%	100%
6) Raised by alcoholic, drug-addicted or mentally unstable caregiver	0%	0%	26) Limited contact with close friends and/or family	0%	0%
7) Verbalized experiencing abuse or neglect during childhood/adolescence	0%	0%	27) Expressed fear of violence in home	0%	0%
8) MOB and/or SO placed in protective care (i.e. with relative or state)	0%	0%	28) Current physical response to anger (throw things, hit, punch, slap, etc.)	0%	0%
History of Parent(s) (Adulthood)			29) Inappropriate coping mechanisms	0%	100%
9) Current mental illness requiring treatment or hospitalization	0%	0%	Parent/Child Interaction		
10) Active substance abuse in home environment by anyone other than MOB (within last 12 months or since becoming a parent)	0%	0%	30) Negative verbalization about the baby (expressed disapproval, anger, hostility)	0%	0%
11) Verbalized suicide ideation and/or attempted suicide (Within the last two years or since becoming a parent)	100%	0%	31) Verbalized unrealistic expectations about child developmental milestones, toilet training (before 18 mos or older than five yrs) and/or walking (before nine mos or older than 16 mos)	100%	0%
12) History of mental illness or substance abuse, requiring treatment or hospitalization	0%	0%	32) Limited awareness of discipline options or leaves a crying child unchecked for longer than ten minutes	100%	0%
13) History of alcohol/substance abuse that didn't result in treatment or hospitalization	0%	100%	33) Parent(s) verbalizes need to physically punish a child one year of age or younger	0%	0%
14) MOB and/or SO has committed violence against another person	0%	100%	34) Verbalized feelings of inadequacy about parenting or no positive statements	0%	0%
15) MOB and/or SO Repeated (three or more) victimless crimes (arrested &/or convicted for theft, possession, vandalism, etc.) OR any one of the following: DUI, drug dealing or prostitution charge or currently involved in the criminal justice system	0%	0%	35) CPS report on parent(s) made(prior or present)	0%	0%
Infant and Maternal Health			36) Parent's other children placed in protective care or termination of parental rights	0%	0%
16) Late prenatal care (12 weeks or later)	0%	NA	Maternal/Parental Life Course		
17) Little or no prenatal care (less than 5 visits) or poor compliance with treatment or medication	0%	NA	37) Less than high school and/or no GED	0%	0%
18) Upon knowledge of pregnancy, continued use of alcohol (drinking) or drugs and/or baby/mother has positive drug screen	0%	NA	38) Parent is less than 18 yrs old	0%	0%
19) Upon knowledge of pregnancy, continued smoking/use of tobacco	0%	NA	39) Not legally married or separated	100%	100%
20) Current maternal depression	0%	NA	40) Observed or parent verbalized a sense of hopelessness, victimization, being overwhelmed, etc.	0%	0%

Appendix V
Survey of HFF Closed Participants

Figure 1: HFF Closed Participant Survey Introductory Letter

Figure 2: HFF Closed Participant Survey Questionnaire

Figure 1: HFF Closed Participant Survey Introductory Letter

ENTER TO WIN A $100 GIFT CERTIFICATE!!!!!!

Entries must be received by February 5th.

Hello!

Recently, you were a participant in a program called Healthy Families. We are doing a study of that program and would like for you to share your opinions about that program. Your responses on this questionnaire are very important since they can help us make the program better for families.

Completion of this questionnaire is voluntary. Any other services you might be receiving from another program will not be affected if you decide not to participate in this survey. Your responses will be kept private and will be used only for our study of Healthy Families.

To be entered in the drawing to win a $100 gift certificate for a store near you, simply:

- Complete either the English or Spanish version of the enclosed questionnaire.
- Print your name and a telephone number where you can be reached on the enclosed card.
- Mail both the questionnaire and the card using the enclosed envelope by February 5th. You do not need to worry about a stamp, just put it in the mail!

HURRY! Entries must be received, *along with your questionnaire,* by February 5th to be entered in the drawing!!!

We will contact you if you are a winner in the drawing. Good luck and thank you for participating!

Figure 2: HFF Closed Participant Survey Questionnaire

The Ounce of Prevention Fund of Florida

Please indicate how you feel about each statement:

	Responses (Fill in only one circle for each statement)				
Please respond based on your experiences in Healthy Families.	**Strongly Agree 5**	**Agree 4**	**Neutral 3**	**Disagree 2**	**Strongly Disagree 1**
First, what did you think about the Healthy Families Program?					
Healthy Families services were what I was told at the beginning.	○	○	○	○	○
Healthy Families improved my relationship with my child.	○	○	○	○	○
Healthy Families helped me become a better parent.	○	○	○	○	○
Healthy Families made my life better.	○	○	○	○	○
The activities during home visits were helpful.	○	○	○	○	○

Healthy Families should (write your suggestions here)

_____

_____

	Strongly Agree 5	**Agree 4**	**Neutral 3**	**Disagree 2**	**Strongly Disagree 1**
Second, what did you think about your home visitor?					
I trusted my home visitor.	○	○	○	○	○
My home visitor cared about my child and me.	○	○	○	○	○
My home visitor was easy to talk to.	○	○	○	○	○
My home visitor respected my opinions.	○	○	○	○	○
It was easy to contact my home visitor.	○	○	○	○	○
My home visitor listened to me.	○	○	○	○	○
My home visitor visited me at times that were good for my child and me.	○	○	○	○	○
It is best to have the same home visitor for all home visits.	○	○	○	○	○

Please continue on the other side

I think it is important to have a home visitor who is similar to me in the following ways (circle all that apply):

Age **Race** **Experience as a parent** **Where we live** **Grade level completed in school** **Other** _____

Do you want to share any comments about your home visitor? If yes, please write them here.

_____

_____

	Strongly Agree 5	Agree 4	Neutral 3	Disagree 2	Strongly Disagree 1
Third, why did you stop participating in Healthy Families?					
I was too busy to participate.	○	○	○	○	○
My child and I did not need the services.	○	○	○	○	○
I, and/or members of my household, did not want the home visitor in our home.	○	○	○	○	○
I did not want to share personal matters with my home visitor.	○	○	○	○	○
My family told me that I shouldn't participate.	○	○	○	○	○
My friends told me that I shouldn't participate.	○	○	○	○	○
I had enough support from family members.	○	○	○	○	○
I had enough support from friends.	○	○	○	○	○

Some other reasons I stopped participating in Healthy Families are (write any other reasons here):

_____

_____

I would recommend Healthy Families to my friends.	○	○	○	○	○
Healthy Families is a good program.	○	○	○	○	○

Thank you for completing this questionnaire!

Ounce of Prevention Fund of Florida
111 N Gadsden St., Suite 200
Tallahassee, FL 32301-986

Appendix VI
"Ask the Experts": Engagement and Retention from the Perspective of Healthy Families Local Project Staff

Table 1: Results from Delphi One: Reasons People Do Not Agree to Be Assessed for HFF

Assessment Reasons Provided by Family Assessment Workers (FAW)
It takes up time that some people don't have.
They think they know how to care for/raise a baby.
They confuse us with Children's and Families and Healthy Start.
They don't like strangers coming to their home.
They work fulltime.
They initially think we are DCF.
They don't want to commit to a long term program.
They initially think we will be "in their business."
They are already receiving other services from other agencies and this would be a duplication.
Don't have the time.
They feel it's too intrusive and can't commit to a long-term program.
MOB too busy or working.
May be having someone share a HUD apt. who is there illegally and don't want authorities involved.
Affiliation with DCF – scared because of negative connotation.
Don't have time for the program.
Because of hearsay, maybe heard from other participants that had a bad experience.
Because we are an intense program.
They think we are related to DCF.
They may be leery about HF because they don't know what we do.
Like the idea of home visits, but do not think weekly home visits are necessary – too often.
Working fulltime and going to school fulltime, not time to accommodate intense weekly home visits.
Not first time parents, feel know enough about parenting.
Know what resources are already available.
Lack of education/poor – association of being more needy.
Child abuse prevention on the website – too much convenient information.
They feel home visits are an invasion of privacy.
They do not want to commit to regular home visits – time consuming.
They want to hide some aspect of their home life.
They fear CPS involvement.
They don't feel they need the service.
Engaged in another program; i.e., Healthy Start.
Have a good support system and everything they need.
Do not want a visitor to come to their home.
Knowledgeable about resources.
Too busy to meet – not home during the day.
Legal issues.

Assessment Reasons Provided by Family Assessment Workers (FAW) continued
Confidentiality – privacy.
"Dirty," unorganized facilities.
Time – work
No permanent housing.
Want other services.
Program is too intrusive.
They're saying we're too noisy.
We're intrusive.
They're too busy.
Don't like weekly home visits.
Think we are DCF.
Badge scares them.
Heard negative things from other MOBs.
Lack of knowledge about the Healthy Families program.
FOB not involved.
Embarrassed about their home.
They don't feel comfortable having someone come into their home.
They have plenty of support from family and friends, and don't see the need.
They consider most programs and services are for the needy, and they don't feel they are needy.
Assessment Reasons Provided by Family Assessment Worker Supervisors (FAWS)
Their SO does not want someone in the house after work.
FOB or SO not wanting MOB to participate.
Label of lower income and lack of education.
Have a strong support system already in place.
If working, not convenient for them having someone meet them after work at home.
Their SO does not want someone in the house after work.
Too intrusive.
Long commitment.
Substance abuse.
Domestic violence.
FOB or SO not wanting MOB to participate.
Feel they know everything.
Looks at it as a program for poor people.
Illegal, undocumented – trust issues.
Have enough support.
That is rare.
Busy (working).
Unable to locate them.

Assessment Reasons Provided by Family Assessment Worker Supervisors (FAWS) continued
They think they know enough.
Assessment Reasons Provided by Program Managers (PM)
They might think they know enough about parenting.
They might feel they don't need help.
They might assume services are for "other people" (lower socioeconomic class, "abusers," "bad parents," etc.)
They feel it will take too much time, especially if they work.
For illegals, fear of being reported to INS.
Too intrusive.
View program as another "social service."
Have several children already.
Don't understand what is being offered.
Involved currently in abusive relationship.
Service being offered by a total stranger by telephone.
Living with others.
Don't understand/see the value in what is being offered.
Enough family support.
Not interested in someone coming into the home.
Too busy with work/school.
Don't believe they need it.
People think they know everything they need to know about raising a child.
Confuse us with other "Healthy" programs.
People can't understand that we can help them "long term."
They don't know enough about what we do.
Don't like strangers in the home.
Too much information about home visiting instead of the assessment as a service.
Fear of intrusion into personal lives, homes.
Busy schedules.

Table 2: Results from Delphi One: Tips to Encourage People to Be Assessed for HFF

Assessment Tips Provided by Family Assessment Workers (FAW)
Change the identification name on Caller ID to Healthy Families.
More training in cold calling.
Change letterhead to "Healthy Families" and make it eye-catching to pregnant women.
Offer an incentive.
Having a broader timeframe (more than 14 days) to assess would welcome the opportunity for a parent to recognize there are programs available.
Offer the parent tangible items "i.e. gift pack" to get their attention (ex: antibacterial hand cleaner, a pair of booties or a onesie, pertinent info regarding other groups in the area for new parents).
By telling them up front that it is an in-home program.
By telling MOB that we are here to assist in a non-threatening manner.
By letting them (MOB) know that they can get supportive services to help reduce stress.
Tell them it's a free service. "If it's free – it's for me."
Let more people know who we are and what we do, maybe promote, advertise, get our program out there.
Reassure families that even though we are intense, we are voluntary.
Reassure families we are not involved with DCF.
Central location for assessment, non-threatening/convenient environment.
More emphasis on parent education and support, less on abuse/neglect.
Written correspondence beyond initial pamphlet/letter of invitation to initial assessment.
Free gift, bag of free samples, packet of community resources.
Make sure the family understands that the program is voluntary.
Let them know that HFF does not have an income requirement – we are not only for low-income families.
Be sure they understand that, though we are mandated reporters, we are not CPS.
Provide flexible hours to meet with the families.
Encourage participation with both MOB and FOB.
Inquire the information they would like to know more about regarding resources.
Be courteous, nonjudgmental and receptive on the phone.
More and better referrals.
Public presentations.
Legal issues training for staff.
DCF services trainings for staff.
Flexible time with staff.
Gift packet.
Baby books.
Resources.
Basic needs exp: assist with electric/shelter, etc.
Emergency account for MOBs.

Assessment Tips Provided by Family Assessment Workers (FAW) continued
Always do follow-up with families who were assessed quickly.
Follow-up with a thank you latter for them spending a few moments with MOB.
Emphasizing that HFF is a resource-referral organization is a helpful, non-threatening introduction.
Being non-threatening.
Give name of agency (or individual) making referral.
Willing to (do visit) work around a family's schedule is often appreciated.
If prenatal, ask how mom is feeling. If postnatal, ask how both mom and baby are doing.
Assessment Tips Provided by Family Assessment Worker Supervisors (FAWS)
Central/convenient location to talk privately, not in homes 100% of the time.
Free gift/samples/coupons/information.
Written correspondence with pamphlet/letter of invitation.
More referrals/screens/record/prenatal collaboration.
Welcome gift for new baby.
Incentives for the families.
Change to screening tool where just being single is not automatic positive – must be single and something else (under 18 years old or over 18 and no diploma or GED).
Educate referral sources better on what HFF can assist with.
Our number one form of outreach is usually a letter, then a phone call. After that it's drop bys but I think the biggest challenge by far is locating the family.
Free baby items.
Assessment Tips Provided by Program Managers (PM)
Being assured that there is flexibility in scheduling visits.
Making the program fun, interesting, personally meaningful.
Helping them get connected with other community services.
Diaper bags as "gift bags."
Increase P.R. campaign statewide.
Contacting women face to face at WIC and other settings (provider offices).
Well thought out, clear/concise presentation of what exactly is being offered.
Discussion of HF strengths.
Provide referral info at assessment.
Provide packet of educational info.
Engaging FAW.
Incentives.
Either show or tell them something of great interest to them.
We have to "sell" our services, so we need a strong selling pitch.
Most people want material things.
Offer something that is so important that no one could turn it down.
Focus on assessment as a service.
Flexibility in scheduling assessments.

Assessment Tips Provided by Program Managers (PM) continued
Skill development for workers to overcome

Table 3: Results from Delphi One: Reasons People Do Not Enroll in HFF

Enrollment Reasons Provided by Family Support Workers (FSW)
Most who do not enroll are afraid it is connected to DCF.
Some think it's like Healthy Start and they were not helpful before.
Not willing or able to commit to the weekly visits for first 6 months.
A teenager whose guardian does not understand the program and fears DCF.
They do not want an intensive home visiting program (don't want weekly home visits).
They have employment commitments.
Too much time elapsed between initial assessment and potential enrollment.
It may not be clear to the family what our services are.
Fear of DCF.
Current abusive relationship.
Life too busy.
FSW does not "sell" the program well.
Past or present abusive relationships.
Do not have the time.
Think we are DCF.
Do not know what program is about.
Are set in their ways.
Do not want anyone in their home.
Lack of knowledge.
They are scared to trust.
Too many demands.
Bad response from friends.
Realize they don't have time.
They think we will take their kids away.
Different styles/new employees are not as friendly.
Time.
Think we are CPS.
Some associate HF with DCF/HRS.
Family member don't want you in home.
Expect more services that HFF does not provide.
They don't have the time for the program.
They don't understand how much they can benefit from the program.
They move in with other family member and they don't want people to come to their home.
No time – program may require too much commitment.
Parent may not desire someone telling her how to raise children.
Program may seem too invasive.

Enrollment Reasons Provided by Family Support Workers (FSW) continued
For younger parents, their parents may object to someone else teaching parenting.
Program may not be able to offer parent desired incentives.
Do not know about the program.
Do not want to take the time to enroll.
Too busy to commit to home visits.
Parents feel they know everything about children – not open to new ideas/change.
SO won't allow it or family members they live with.
Afraid of state agencies reporting them.
The pressure of a commitment.
More of mothers are working.
Parents feel that they already know the material.
Unwanted "weekly" visits.
Invasion of privacy.
Feel they don't know how to parent.
Don't want to be bothered.
Weekly home visits seem to be the #1 reason and if families have multiple children, a home visit program doesn't seem to rank on families' to-do lists.
Also, if SO is in home and have control issues, weekly home visits are not going to happen.
Don't want to "commit."
Too busy lives already (work, family, etc.)
Skeptical of "agencies" in the home.
Don't see the benefits of the program (i.e. can't clearly picture the structure of visits).
Think they know enough/don't want to be told what to do/think they're admitting "helplessness" by enrolling.
Lack of knowledge of what it is an FSW brings to the family.
Significant other and family members.
Culture.
Busy working and/or going to school.
They think we are connected with CPS.
Feel the program will be too intrusive.
They are not comfortable with the person presenting the program.
They do not want someone in the home every week.
They have employment and feel they are too busy.
They think they know all there is to know about their children.
They have issues such as DV or substance abuse and feel we will call DCF on them.
Enrollment Reasons Provided by Family Support Worker Supervisors (FSWS)
Feel they know enough (already a parent).
Already raised/parented children.
Too busy for weekly home visits.

Enrollment Reasons Provided by Family Support Worker Supervisors (FSWS) continued
Invasion of privacy (not comfortable with home visits).
Unstable living situations (living with others who are not receptive to home visits).
Stigma attached to home visiting (DCF involvement).
When we do not approach families involving teenagers correctly/respectfully, we risk losing these MOBs.
Weekly home visits can be overwhelming.
Sometimes we make promises we can't keep regarding "bag of goodies." I've overheard FAWs trying to sell the program over the phone by stating we have a "bag of goodies" to give you.
FAW may have a strong personality or any personality that could turn family off.
FSW could also conflict with families regarding teaching style, personality, etc.
They are afraid we work with immigration (many are illegal).
The presentation of our program is not clear to the families.
They may be well versed in child development.
They're afraid we're like DCF.
They work fulltime.
They think we are just there to provide things they want.
Work fulltime/school fulltime.
Not interested.
Enrollment Reasons Provided by Program Managers (PM)
Too busy.
Think they know enough about parenting.
Intrusive nature.
Big commitment.
Domestic violence.
Threatened.
Living with others.
Enough family support.
Not interested in someone coming into the home.
Too busy with work/school.
Don't believe they need it.
They are pressured by relatives not to accept our services.
People confuse us with Healthy Start and Department of Children and Families.
They feel we can't teach them anything.
Unfamiliar with what all services we provide.
They are not "sold" enough to recognize the potential value of Healthy Families. This reason encompasses all other reasons people give including:
Too busy
Too intrusive
Don't need it

Enrollment Reasons Provided by Program Managers (PM) continued
Too much time in between assessment and enrollment.

Table 4: Tips to Encourage People to Enroll in HFF

Enrollment Tips Provided by Family Support Workers (FSW)
Explain exactly what the program is about.
It is not for everyone and a commitment need to be made.
Take some activities to show the family.
Learning and brain games (colored and very visual).
Info on topics that the family might need (relief for nausea, etc.).
Listen – meet the family's needs.
Be excited about our program and convey that enthusiasm.
Explain simply what our program entails.
Emphasize that we are voluntary and can be flexible,
Smile.
Be friendly.
Do a GGK activity.
Bring a small baby gift.
Bring information for both parents on child rearing if applicable.
Make visit fun.
Fill out as much of the paperwork for them.
Explain what home visits will be like.
Do not make mandated reporter sound ominous.
Be honest and on time.
Respect MOB and her home.
Have more gift giveaways.
Have doctors introduce FSW.
Advertise more to get info out.
More time for new employees to shadow seasoned employees.
More training before they get cases.
Better explanation of program by FAWs.
Ask families if they have any questions or comments.
Ensure that I will be there to guide them in their child rearing not telling them how to raise their child.
FAWs spend less than three hours assessing families.
Offer more services.
Be honest about program and benefits.
FAW enroll at the assessment.
Go to the school and tell high school students about our program.
Place flyer in the target neighborhoods.
Community outreach program.
Find out what the parent desires and tell her you plan to gear program in that direction (if possible).

Enrollment Tips Provided by Family Support Workers (FSW) continued
Create a light and relaxed atmosphere around client.
Be very respectful.
Let parent know that HF truly cares.
I feel that HFF is doing a great job in engaging families.
Make them feel that they are important, that we are in the program together, that the program is there to help them.
Be honest about how often FSW will be in home.
Focus more on education not on gifts and freebies at assessment.
Give example of info given by FSWs.
Be very friendly and excited about MOB and BA.
Show lots of respect.
Mothers need someone to talk to.
Mothers need organization.
Mothers feel confused even though they know answers – need reassurance.
Be honest and upfront about the program/service.
Positive attitude about home visit program, contact within an appropriate timeframe after assessment.
Nonjudgmental.
Not being fake to families, being consistent with families.
Letting them know one really cares and is concerned.
Be positive, natural and fun while introducing the program.
Bring ideas/examples of projects and/or topics of home visits.
Clearly state the purpose/benefits of the program; make it all about the family.
“Connect with the family.”
Emphasize that it is a partnership not a teacher-student relationship.
Stress that the program is free and voluntary.
Make more awareness of our program in local health departments, schools, adult learning centers, doctors offices, TV commercials, newspapers, etc.
Phone calls.
Letters.
Creative outreach.
Not pressuring or “stalking” families.
Presenting the program in a new and exciting manner.
Explain the program thoroughly.
Help with needed referrals.
Engage families prenatally.
HF being flexible with family’s schedule and tell them we are flexible.
Normalize with the family.

Enrollment Tips Provided by Family Support Worker Supervisors (FSWS)
Quick follow-up after initial assessment by FSW to enroll MOB (< 1 week).
Offer FSWs training on how to engage MOBs initially.
Offer a token (small gift) on a regular basis and at initial enrollment.
Present program as tailored to MOB's needs.
Offer referrals and helpful info at first home visit.
Make it clear what the program can offer.
Establish a rapport and make it clear: all home visit expectations.
Respect and involve all family members, especially parents/guardians of teen moms.
Let them know I am not there to tell them what to do.
See family weekly for 3 or 4 weeks to build rapport.
Provide information of the program, making sure they understand what services are about.
Do not pressure families to sign up.
Make sure they understand the importance of the first five years of a child's life.
Encourage them that these skills will benefit their children.
Be friendly, sincere and honest.
Talk about program with excitement and clarity.
Enrollment Tips Provided by Program Managers (PM)
Flexible home visit hours.
Well-planned visits.
Personally meaningful visits.
Positive, upbeat, caring, genuine staff.
Clear explanation of the program.
Consistent/persistent creative outreach.
Transition visits from 1 FSW to another.
Use of digital cameras to have photos to deliver to families.
High-risk specialist on each team to work with families fitting profile of those most difficult to enroll.
Creative outreach.
Incentives.
Strong/engaging FAWs/FSWs (well trained).
Follow-up from supervisors.
Motivated staff/supervisors.
Offer something that they absolutely cannot refuse.
Skill development in staff, particularly those who are first contacts with the families (FAWs).
Less time between assessment and enrollment.

Table 5: Results from Delphi One: Reasons Participants Are Not Retained in HFF

Retention Reasons Provided by Family Support Workers (FSW)
Get busy with work/school, etc.
Removed from custody by DCF.
Not enough resources given to them – baby items, etc.
Some families think HF is a way to get things for themselves and their baby.
Employment conflicts.
School conflicts.
Illegal activities.
Domestic violence issues.
Moved out of service area.
Moved out of area.
Do not want another FSW.
Staff turnover.
Busy life.
Not moved up in level quick enough.
They move.
Domestic violence/abuse in the home.
Rapport between FSW and parent.
No longer interested.
Working fulltime or going to school.
Get bored with the program.
Too busy for program.
Family or friends.
Moved with family member.
Want free items.
Move away.
Don't have time.
Get jobs, too busy.
Lose interest.
Went back to work.
Bored with worker.
Only wanted program to get "stuff."
Time conflicts.
Worker not being flexible to see client.
They move.
Number of home visits – too many.
Not enough services offered.

Retention Reasons Provided by Family Support Workers (FSW) continued
Get too busy.
Some families move around too much.
They think HF is part of HRS.
Parent cannot keep up with commitment level (i.e. cannot keep weekly visits) due to changes in their lives.
Parent does not desire to change her method of parenting and as a result is not stimulated by lessons/activities.
Parent may have pressure from family to quit.
Parent may feel more confident in her ability to handle parenting on her own.
Do not want to commit.
Do not want to be responsible.
Do not want to be accountable.
Family members convinced them to get out.
Friends tell them that we are not a good program.
Life style changes (fulltime work, school)
Not interested in learning.
Move away.
Program not what they thought it was.
Forced by someone to join program.
They did realize how committed they needed to be. Even though FSW explain how flexible the visits could be they just feel too busy.
Time consuming.
Other things more important.
Work schedule or school.
Become bored with the program. Home visits are not exciting anymore.
Move out of service area.
Reach their diaper limit (things not available anymore).
Staff turnover.
Feels program called DCF/CPS.
Feels knows enough and have gotten all they can from program.
SO controlling situation and MOB trying to survive.
Do not enjoy visits.
Get too busy with “life”/no time to spare.
Can’t “connect” with FSW (on a “personal” level).
FSW doesn’t meet family’s needs.
Families think they’ve learned enough.
Change of FSWs.
Move out of service area.
FSW does not follow through in information that MOB requested.

Retention Reasons Provided by Family Support Workers (FSW) continued
FSW is boring.
FSW lack of experience in the area of child development.
Lack of consistency from FSW.
Inflexible levels to accommodate a family that has to return to work.
Uncomfortable with weekly visits.
They get through the first year and life is easier.
They become employed or return to school.
They move out of service area.
They have overcome obstacles through our support and are now independent enough not to need someone there.
Retention Reasons Provided by Family Support Worker Supervisors (FSWS)
Too busy for weekly home visits (this is a BIG ONE!)
Bored with curriculum/activities or FSW.
No longer in need of support – stabilized in their life.
Feels they have learned what they need to know.
Unstable relationships (DV issues).
FSW's approach.
Personality differences.
FSWs trying to be counselors and getting too involved in "mommy drama" and other family issues.
FSWs not respecting families.
Home visits not interesting.
Weekly home visits too big of a commitment.
Scheduling: FSWs do not keep appointments.
Families get bored, FSWs are not providing exciting activities.
Families move out of area (many are migrant).
Families thought this was a give me only program.
Clash of personality between FSW and family.
Retention Reasons Provided by Program Managers (PM)
Inconsistent visits (times vary, FSW cancellations).
Not being offered flexible home visit times.
They feel they are too busy (work long hours, etc.).
Boredom – uninteresting visits (focus on paperwork).
Visits are personalized to meet each family's individual needs.
FSWs/project fails to really use creative outreach.
Staff turnover.
Chaotic nature of lives of family.
CPS reports by HF staff.
Intuit FSWs value judgments.
Lack of flexibility on part of FSW/project in scheduling home visits.

Retention Reasons Provided by Program Managers (PM) continued
Too focused on case management.
Bored with program/uninterested.
Not useful to them.
Too busy (work/school).
Move out of area.
Children removed or put in care of others.
Parent incarcerated.
Drug involvement.
Domestic violence (criminal involvement).
They think they have been taught everything they need to know about being a parent.
They get bored.
They do not place enough value on the service to make it a priority.
Substance abuse/mental health issues.
Boredom.
Busy schedules.

Table 6: Results from Delphi One: Tips to Encourage Participants to Be Retained in HFF

Retention Tips Provided by Family Support Workers (FSW)
Make sure FSW tries to meet family's schedule (weekend, morning, evenings).
Explain from the beginning about timeframe/how visits last (weekly first 6 months).
Have home visits other places besides always in the home (make it more interesting).
Offer activities and resources and change how home visit is sometimes.
Lots of praise for family.
Listen to the family's needs.
Respect the culture.
Involve other family members.
Make PCI fun.
Be flexible.
Be persistent/committed.
Be professional but not an "expert."
More group activities.
Outings/special events.
Parent awards.
Keep your word/promise – do what you say.
Smile and make things fun – don't be afraid to be silly sometimes.
Listen to what people have to say.
Not stay on levels so long.
Be honest and on time.
Engage the whole family.
Try as much as possible to work around their schedule. Help make parents a schedule.
Refer to another site.
Make visits fun/interactive.
Flexible time.
Be on time.
Be sensitive to issues in home.
Make sure I have the info they asked for.
Always ask family what they want to do/talk about next week.
Offer more services.
Cut number of home visits.
Spend more time in the homes (give MOB more time).
More community outreach.
Do more HF family gatherings for our families.
Listen to questions/concerns and address them appropriately.
Be flexible.

Retention Tips Provided by Family Support Workers (FSW) continued
Make visits more exciting and interactive.
Point out parent's successes and progression toward personal goals.
Realize when it is appropriate to push and to step back, allowing parent time to breathe.
Honesty of program requirements as to home visits at assessment.
Home visits boring.
Home visits too often (6 months after baby's birth).
Ask MOB her needs and wants for home visits.
Stop bugging clients for home visits when they can't see you.
Try to get material more fun yet educational.
Make more visits with joint team workers.
Decrease number of home visits to an amount participants feel they need, unless there is evidence (concrete) that more are needed.
Continue making home visits exciting and fun while giving information.
More training (update and refresher course so FSW won't get burned out).
Plan visits to meet families' needs and interests.
Keep families actively involved during visits.
Be consistent and reliable; do what you say you will.
Be flexible in scheduling visits (various times and locations if necessary).
Be positive and encouraging as opposed to critical and judgmental.
Continuous training for FSW.
Activities for participants and their babies.
Incentives (small gifts for moms and babies).
Keep communicating, send letters.
Make the visits fun and include other children.
Make appropriate referrals.
Praise Mom often.
Being reassured that she's doing great.
Remember what you say and do it.
Retention Tips Provided by Family Support Worker Supervisors (FSWS)
Reduce amount of home visits for level ones based on need (weekly visits for higher need MOBs and biweekly visits or monthly visits for others).
Not require ASQ's, FSP's, PSI's to be done on our schedule – not theirs (not making mandatory).
Train staff on how to build rapport.
Reevaluate the need for weekly home visits. Let it be as needed.
Do more boundaries training.
Hire more trained staff to deal with high risk families.
Teach more cultural diversity.
Be creative and flexible.
Variety of curriculum.

Retention Tips Provided by Family Support Worker Supervisors (FSWS) continued
Work on relationship between FSW and family.
Make sure families understand what we are there for.
Trust and respect culture.
Retention Tips Provided by Program Managers (PM)
Making the paperwork process fun (create FSPS and other forms that are fun and interesting to fill out).
Make visits personally meaningful.
Use variety of curriculum, do fun craft projects, have group activities.
Ongoing true creative outreach.
Improve human resource processes (staff recruitment, selection, and retention processes).
More parent group activities.
High risk specialist to assist families in difficulty and act as "floating FSW."
Engaging FSWs.
Follow-up from supervisors.
Consistency of home visits (time and materials).
Creative outreach as needed.
Meeting the family "where they are."
Offer new activities.
Keep a variety of things open to them.
Continuous training for FSWs so they can avoid burnout.
Keep visits interesting.
Be flexible with scheduling.
Make appropriate referrals.
Stay focused on our job … PCI, development, etc.

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