

Active engagement: Strategies to increase service participation by vulnerable families

Discussion paper



NSW Department of
Community Services



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Executive summary

Active engagement strategies are those which raise the rate of participation in, and completion of, effective programs by families identified as likely to benefit.

These strategies aim to address three key issues:

1. high rates of refusal by some vulnerable families to participate in services
2. high rates of attrition by some vulnerable families
3. barriers facing families in gaining access to services.

The focus of this paper is to identify effective strategies that promote engagement by families in services and to examine the strength of the evidence base underpinning these strategies. It is based upon a review of literature from peer-reviewed scientific journals. However, given the paucity of research literature on active engagement with abusive families, three additional search strategies were adopted, namely: (1) practice guides for dealing with abusive families were examined; (2) a more general search examined the literature with other hard-to-reach populations including people with mental health problems, homeless families and substance abusing populations; and (3) literature on engaging families in successive waves of research data collection was considered.

The paper outlines why active engagement strategies are needed and how participation rates in services may be increased.

High refusal rates have been recorded. Estimates of drop-out rates for therapeutic services range from 35 per cent to 70 per cent, with higher rates among families receiving involuntary or court ordered services. Even where attendance was voluntary and early home visiting support services were offered, around 10 per cent to 25 per cent of families chose not to participate.

High attrition rates were also recorded. Some families enrol in but do not complete programs. In one review of attrition rates in home visiting programs, 20 per cent to 67 per cent of all families left before the two-year completion of the programs (Gomby, 1999). Varying attrition rates have been recorded within the same program in different locations (eg 38 per cent compared to 64 per cent in the Hawaii Healthy Start program). Substantial drop-out rates were recorded in other programs, even when children were targeted more directly and free early childhood education was included (47 per cent by Walker (1995) and 31 per cent by Weikart & Schweinhart (1992)). Service providers and program factors are stronger predictors of retention or attrition rates in programs than the characteristics of the families they serve.

Active engagement strategies are grouped into two areas, namely: (1) those aimed at increasing recruitment or initial uptake of services (the paper lists 12 strategies in this area, eg 'frequent maintenance of contact') and (2) those aimed at retention of the families within the service system (the paper lists 35 strategies in this area, eg 'provide transport for centre based treatment'). Each of these areas is subdivided into two levels, namely, 'caseworker' and 'agency' levels.

In conclusion, most studies in this area were found to concentrate on only one or two strategies to recruit and retain families. The result is a collection of small scale studies offering single factor, often contradictory explanations for participant decisions.

Some strategies have been found to be useful in some cases and it is recommended these are utilised by caseworkers and in the Early Intervention Program design to improve outcomes.

It is important to make the service attractive to families. If they feel threatened or, if by attendance, they are labelled as failures, they will feel uncomfortable attending. Other agencies will also not refer to a program unless they see merit in it, so relationships need to be built within the service provider community.

1. Introduction

It is now well established that it is important to intervene early if more serious problems are to be avoided later in life (Shonkoff & Phillips, 2001). The risk factors that increase a family's vulnerability are well known and effective services are available to support these families. One of the major barriers to service delivery is that vulnerability increases the likelihood of refusing the offer of services. The more vulnerable families who do enrol are more likely drop out before completing the program (Sanders & Cann, 2002).

Active engagement strategies are those designed to increase the rate of enrolment and retention in intervention programs. Many of these strategies are based on clinical experience, are expressed as broad concepts open to subjective interpretation in their implementation, and have not been rigorously evaluated. The evidence that does exist in relation to their effectiveness relies mainly on research that has been undertaken in the United States and the United Kingdom.

The focus of this paper is to identify effective strategies that promote engagement by families in services and to examine the strength of the evidence base underpinning these strategies.

1.1 Overview of the literature

This paper is based on a review of literature from peer-reviewed scientific journals accessed through a number of databases including *SocINDEX*, *Psychology and Behavioural Sciences*, *PsycArticles*, *PsycBooks*, *PsycExtra*, *Academic Search Premier*, *Social Service Abstracts*, *Sociological Collection*, *Sociological Abstracts*, *Health Business Full Text Elite*, *Health Source Consumer Edition*, *Health Source Nursing/Academic Edition* and *MEDLINE*.

Where enrolment or engagement were the primary focus, often only one or two strategies were examined resulting in a collection of small scale studies offering single factor, often contradictory explanations for participant decisions (Daro, McCurdy, Falconnier & Stojanovic, 2003).

Given the paucity of research literature on active engagement with abusive families, three additional search strategies were adopted:

1. Practice guides for dealing with abusive families were examined to gain an understanding of commonly accepted practice wisdom. This literature tends to promote general ideas rather than giving concrete guidelines, for example referring to 'working in partnership with families', 'respecting families', 'being strength-based' without breaking this down into the 'how' of the process (eg see the Parent Adviser Model in Davis, Day & Bidmead, 2002). In addition, such broad concepts are difficult to quantify by researchers. This does not mean that the models based on clinical experience are not effective, but they lack a strong evidence base.
2. A more general search examined the literature with other hard-to-reach populations including people with mental health problems, homeless families and substance abusing populations. This provided some 'harder' evidence, but it is not known whether the findings can be generalised to maltreating families.
3. The literature on engaging families in successive waves of research data collection may provide some ideas as to how to retain families in intervention programs (Giard et al., 2005; Howard & Beckwith, 1996).

2. Why are active engagement strategies needed?

Active engagement strategies are those which raise the rate of participation in, and completion of, effective programs by families identified as likely to benefit. These strategies aim to address three key issues:

- high rates of refusal by some vulnerable families to participate in services
- high rates of attrition by some vulnerable families
- barriers facing families in gaining access to services.

2.1 High refusal rate

Families at highest risk for child maltreatment as well as other parenting difficulties are those least likely to take up primary health services (Sanders & Cann, 2002). In the United Kingdom, Naughton and Heath (2001) compared the records of 'cause for concern' and 'well functioning' families. Non-attendance at services was the strongest predictor of presence on the child protection register. In the United States, less skilled parents were less likely to attend services (Katz et al., 2001; Daro et al., 2003).

It has been suggested that this under-representation may initially be a result of existing policies and programs failing to identify all children and families who might benefit from services (Shonkoff & Phillips, 2001; Kovacs, 2003) or that families are not aware that services are available (Kovacs, 2003).

Nevertheless, even where vulnerable families are identified and made aware of services, a higher proportion refuse the offer of services, or fail to complete the programs offered. Estimates of drop-out rates for therapeutic services range from 35 per cent to 70 per cent (Kazdin, 2000; Mueller & Pekarik, 2000) with higher rates among families receiving involuntary or court-ordered services (Rooney, 1992, cited in Dawson & Berry, 2002). Attrition becomes a significant issue for many child protective service agencies who often serve mainly court-ordered clients and refer voluntary clients with less complex problems to other agencies.

However, even when attendance was voluntary and early home visiting support services were being offered to disadvantaged families, it has been reported that around 10 per cent to 25 per cent of families chose not to participate (Gomby et al., 1999; Olds et al., 2002).

2.2 High attrition rate

Some families enrol but do not complete the program. In examining attrition rates in her review of home visiting programs, Gomby (1999) cites figures that range between 20 per cent and 67 per cent of all families leaving before the two-year completion of home visiting programs. Even the same program can have different attrition rates in different areas, for instance, 38 per cent compared with 64 per cent in the same year for different areas in the Hawaii Healthy Start program. The Comprehensive Child Development Program which relies on home visiting and a brokerage model of services shows that only 56 per cent were engaged in the program after three years (St. Pierre et al., 1994).

Even when children were targeted more directly and free early childhood education was included, there were still substantial drop-out rates. Although research has shown clear gains for parents and children if they attend Child-Parent Centres (Reynolds, Ou & Suh-Ru, 2004), in Walker's (1995) study of these centres, 47 per cent dropped out in the first year of the program. The centre-based component of the High/Scope Perry Pre-school program reflected a lower, but still substantial, drop-out rate of 31 per cent (Weikart & Schweinhart, 1992).

In order to increase enrolment and engagement rates, the barriers to participation need to be identified and addressed. While situations in the lives of many families and communities make it difficult to sustain a routine that allows for continued enrolment in any intervention (McCurdy & Jones, 2000; McGuigan, Katzev & Pratt, 2003), service provider and program factors are stronger predictors of retention or attrition in programs than the characteristics of the families they serve (Daro et al., 2003: 1115).

2.3 Barriers to accessing services

Barriers to accessing services may exist at a broader level than individual caseworker technique or effort. Families may not have heard of a service nor programs that are available. Although the sample was only small ($n = 32$ services), half the services surveyed in Kovacs' (2004) study mentioned lack of community awareness as an issue affecting accessibility of services. High demand services (one fifth of the sample) purposely did not advertise for fear that they would be swamped with requests.

Diminished access is also related to:

- practical factors such as cost, transport, child care, eligibility rules or program scheduling
- cultural factors such as language, citizenship and status
- personal factors related to mental and cognitive functioning of individual parents
- the stigma associated with labelling (Shonkoff & Phillips, 2001).

Those most likely to drop out were older mothers with larger numbers of children (Katz et al., 2001), although Daro et al. (2003) found that older, unemployed mothers were more likely to continue with parenting programs.

2.3.1 Practical factors

Cost: Most support services in Australia do not involve a direct cost to families, but when parents on a tight budget have to pay for public transport to attend, a babysitter to look after children or gap fees for general practitioners, the indirect costs can be prohibitive (Sawyer et al., 2000).

Transport: The lack of public or service owned transport was reported as negatively affecting accessibility to 85 per cent of the parent education groups (Kovacs, 2003) and drug treatment (Lewis, Haller, Branch & Ingersoll, 1996). Given that vulnerability correlates highly with large numbers of small children, it is not surprising that these parents find it difficult to attend programs delivered outside the home.

Operational hours: Narrow hours of operation, especially if services were only available during working hours, were also seen as hindering the uptake of services, in particular they were seen to discourage the attendance of fathers.

Child care: Over half of the group-based parent education services were negatively affected by lack of child care (Kovacs, 2003; Lewis, Haller, Branch & Ingersoll, 1996).

Eligibility rules: One third of services in the study by Kovacs (2003: 50) believed that they did not support the families most in need. This may be a function of eligibility rules such as when services are only available to mothers with a child under four years.

2.3.2 Other factors

Lack of confidence: Service providers suggest that most needy families 'lacked the confidence' to attend. This lack of confidence is likely to be related to vulnerability, poverty, cultural minority status, language difficulties and personal feelings of failure.

Stigma: Parents are likely to refuse a service where there is a clear stigma attached. If a service clearly targets 'disadvantage' it heightens the sense of failure that families on the periphery of mainstream society are likely to experience.

Threat: Mothers who were victims of domestic violence and had young children reported that they were too afraid to seek services for fear of child removal. They also felt there were few appropriate services, if any, for young children exposed to domestic violence. These concerns may be justified. In many jurisdictions, mothers are regarded as neglectful if they fail to protect their children from witnessing domestic violence (DeVoe & Smith, 2003). Also the adult services provided to assist victims of domestic violence often do not incorporate a service to meet the needs of the children (Child Welfare League of America, 2001; VanDeMark et al., 2005; Waugh & Irvine, 2003).

Lack of trust in usefulness of service: When a small group of refusers (n = 19) were followed up, they did not really have the confidence that the service would meet their needs. Some thought they already had plenty of support and it would be more useful to talk to friends and family and the program would be of less use. Others recognised that they were overburdened, but felt the service would take up precious time (every week for a year) that was needed to 'get things done'. Many were clear that practical help to get these things done would be more useful than someone wasting their time asking how they felt (Barlow, Kirkpatrick, Stewart-Brown & Davis, 2005).

3. How do we increase participation rates in services?

Program success is best predicted by early cooperation and engagement by the family (Berry, 1992; Dawson & Berry, 2002). Successful completion of an intervention program has also become a key criterion when court proceedings are considering termination of parental rights resulting in increased importance of engagement in services¹. It is therefore important that the barriers to engagement are broken down and participation encouraged.

3.1 Active engagement strategies

Active engagement strategies can be at an agency or an individual caseworker level, with some overlap between the policy of the agency and the parameters within which the caseworker is able to operate. The evidence is however, piecemeal and few of these strategies have been evaluated, most only being of secondary importance to the aim of the study in question. Because the evidence is limited and each study adopts a single strategy, pulling it together results in a 'shopping list' of possibly successful strategies characterised by vague and elusive concepts.

The strategies are differentiated between those aimed at increasing **recruitment** or **initial uptake** of services and those aimed at **retention** of families within the service system. Within each of these areas there are two levels of strategy – caseworker and agency. Each of these is subdivided into either concrete strategies for which there is some research evidence or strategies that are based on practice beliefs but where solid research evidence is lacking. The number of asterisks reflects the strength of the evidence as follows:

- * reflects claims made by clinicians or service providers but without any detail as to the difference an intervention made
- ** reflects claims made by researchers, clinicians or service providers with some limited data as evidence (for example, based on pre- and post comparisons in terms of percentages)
- *** reflects that there has been some statistical analysis of two groups. If Random Control Trials are used this has been identified in the text.

3.2 What strategies increase initial uptake of services?

3.2.1 Caseworker level

Only a few caseworker level strategies offer concrete guidelines; most are framed in terms of broad statements supported by clinical opinion (Elliott, Bjelajac, Fallor, Markoff & Reed, 2005). For instance, caseworkers are advised to 'be strengths-based', 'start where the family is at', 'respect the family', 'be responsive' and 'empower' the family. These general ideas of what is useful need to be translated into the practice of how to do it.

Prompt initial response*: Long delays mean families miss out on services (Staudt*, 2003). Program providers suggest that parents should be contacted within 48 hours of being referred (Berry & Dawson*, 2003) as it is believed that families are more likely to attend services if they are in crisis. Once the crisis is past, the incentive to attend is diminished.

Follow up quickly***: Low income mothers were less likely to drop out early in a post-partum parent intervention program if they were followed up after a week rather than after month (Katz et al.***, 2001 – Random Control Trial, n = 286).

Frequent maintenance of contact***: Where contact was weekly rather than monthly higher participation rates were maintained during the first four months (Katz et al., 2001). The difference in attrition rates did not extend over a period longer than four months. Both control and intervention groups had an attrition rate from this parenting education program of 41 per cent at 12 months (Katz et al., 2001).

¹ In the United States there has also been a shift to shorter time frames in which families must show an improvement. If agencies cannot show family improvement by the 12th month of services, courts begin termination of parental rights. This is intended to encourage children's healthy development by giving them some sense of permanency in a safe family-like environment (Dawson & Berry, 2002).

Follow up if no response:** If families do not return a call, fail to keep an appointment or are not at home at the pre-arranged time, caseworkers should persist attempting at least three (Tomison*, 2002; personal communication) or four times (Senturai et al.**, 1998) to re-establish contact. Giard et al.*** (2005) found that visiting the last known address in a group of families who were highly mobile significantly improved retention rates (non-equivalent comparison group, n = 2,729).

Assertive community outreach (ACT)*: Active community outreach is when support is provided to assist families in the local community usually through home visiting services (Baronet & Gerber, 1998; Clark et al., 1998; Tomison, 1998).

Within the mental health setting, ACT involves individualised service. One worker is responsible for a client at all times, can be reached 24 hours a day and there are low (10:1) caseloads (Baronet & Gerber, 1998). With mental health care, ACT has been shown to be effective in decreasing psychiatric hospitalisation and decreasing the use of emergency services and adhering to treatment schedules. This was considered to be most likely due to continuous support and close monitoring provided by the home visiting components. However the ACT model did not have any overall impact on psychological wellbeing or community adjustment (Baronet & Gerber, 1998 – meta analysis).

With a small sample of parents of young children (n = 34) who were abusive or neglectful, providing services through home visiting did increase take-up rate and reduce attrition (Balgopal, Patchner & Henderson*, 1988) and this group of involuntary clients reported being favourably disposed to learning the knowledge and skills that were taught. With larger groups of mothers in random control trials, the Olds (Olds & Kitzman, 1993) home visiting studies showed there was no difference in attrition rates whether families were home visited or not.

If the program is a clinic-based intervention, families are more likely to engage if they are offered an initial home visit before being offered clinic-based intervention (Naughton & Heath**, 2003).

Outreach worker accompany a known agency worker*: In Tomison's (1995) tracking of the Brimbank outreach program, when visiting the family for the first time, the outreach worker accompanied a worker from another agency already known to the family (for instance, the infant health nurse). This strategy was perceived to increase take-up and retention. This strategy of pairing public health nurses with maternity social workers, was also adopted successfully with an intervention program with pregnant women who were abusing substances (La Fazia et al., 1996).

Visit seen as supporting mother*:** When mothers were visited before the birth of their child, they were more likely to continue with the service than if their first visit was after the baby was born (Gomby, 1999). This may be part of forming a trusting relationship as the alliance is primarily formed with the mother to support her in looking after the baby rather than interpreted as 'protecting the baby' from an unskilled mother.

3.2.2 Agency level

Allow recruitment time: Case managers recruiting pregnant, substance-abusing women found that the largest single source of women (25 per cent) was self-referral. However, they were most likely to have received initial information from an established agency (La Fazia et al., 1996). Case managers spent 'considerable' time and energy identifying and 'courting' personnel from traditional agencies for potential referrals. This involved providing staff training, making presentations and maintaining personal contact with key personnel on a systematic basis. On average, 50 per cent of case management time was spent in direct recruitment, and the other 50 per cent in ongoing case management (eg identifying needs, organising prenatal and postnatal medical care, safe housing, food, transportation and child care).

Non-stigmatising*: Caseworkers, especially where the aim is to prevent child maltreatment, are likely to be more accepted when they adopt the role of 'friendly visitor' (Tomison*, 1998). Stigma can be reduced by ensuring that the name given to the worker implies 'support' rather than 'intervention'. This

is likely to be especially important if they are coming from a statutory child protection agency and there is an implication of wrongdoing or failure. To overcome this, a section within the agency can be 'rebadged' with a positive title such as 'early childhood support' (Aldgate & Statham**, 2001) or funds can be channelled through another agency such as currently occurs with Department of Community Services' community partners.

Recruit families through an agency that is not seen as representing authority*: Hard-to-reach families are more likely to be recruited through the community than through 'authorities', such as schools (Hamner & Turner**, 2000) or welfare authorities. The authority these agencies carry is seen as threatening and many families do not access traditional social services and health care systems. La Fazia et al.* (1996) found it useful to add non-traditional agencies, such as missions, needle exchange locations and food charities. This proved to be a more efficient recruiting strategy than either traditional agencies or direct recruiting by 'working the streets'. Direct recruiting, while successful, was very costly in terms of numbers actually recruited (La Fazia et al., 1996).

Other agencies can also act as 'ambassadors*: An agency or service can act as an ambassador to help overcome any stigma and threat of authority implied by the provider. In the United Kingdom, first time mothers receive a visit from a health nurse. If it was thought they may benefit, health workers promoted programs offered by the more stigmatised social services. They reassured parents that social services had a new 'supportive' function and were no longer confined to a role investigating abuse. This strategy was seen as one of the reasons for take-up of these previously stigmatised services. The success of strategies adopted here was the subsequent preference by the majority of families visited for social service workers over workers from other agencies (Aldgate & Statham, 2001).

Offer services during a time of transition such as the antenatal period*:** Families are responsive to take up services during periods of transition such as a first pregnancy (Katz et al.***, 2001; Daro et al.***, 2003). Naughton and Heath** (2001) noted that there is nearly 100 per cent take-up for ante-natal care, although the first attendance late in pregnancy is a traditional indicator of potential maltreatment.

Early post-natal care also has high attendance rates and provides a 'window of opportunity' when parents may be more receptive to services (Naughton & Heath, 2001). In the United Kingdom, even at six weeks, 85 per cent of babies are brought in for the six week check and 80 per cent to 94 per cent immunised at two, three and four months. The immunisation rates for children in Australia are even higher with 90 per cent of children estimated to have received the standard immunisations by 24 months (Australian Bureau of Statistics, 2004).

The method of service delivery may not affect take-up rates at transition times such as these. Whether families were offered home visiting or free transport made no difference to take-up rates of antenatal care, which were high even amongst a New York population with high levels of disadvantage (Olds, 1996).

3.3 What strategies increase retention rates?

3.3.1 Caseworker-family relationship is critical

Building a trusting relationship between the caseworker and the family is of critical importance to engagement and retention in a program, but how this can be achieved does not lend itself easily to research. In following up vulnerable families retrospectively it was found that the strength of the relationship correlates with improved parent-child relationships (Lee & Ayón**, 2004; Spratt & Callan, 2004).

Although arguably of greatest importance to the success of any program, the caseworker-parent relationship is also the most difficult to define, quantify and empirically test. Terminology can be different but there is a common underlying theme of trust, partnership, support and friendliness underpinning ideas about what is critical to an effective caseworker-parent relationship. Adopting the role of 'friendly visitor' has been promoted as being especially effective for families not yet in the statutory child protection system (Tomison, 1995).

Vulnerable parents often have difficulty in establishing trusting relationships. How to build a trusting relationship cannot be reduced to a formula of behaviours. However a number of key themes emerge from the research literature. These include:

- the importance of communication style
- provision of practical, material support
- facilitating ease of access to services
- developing strategies to maintain contact.

3.3.1.1 Importance of communication style

Respect the family: This includes telephoning families the day before to confirm appointments (Senturai et al.^{***}, 1998; Daro et al.^{***}, 2003). It is also suggested that caseworkers should be punctual and reliable, not cancel appointments or cut appointments short (Gomby^{***}, 1999).

Be supportive and non-punitive^{}:** Mothers successfully engaged with their caseworker where they felt the caseworker listened and understood them (Dawson & Berry^{**}, 2003). These caseworkers made them feel that they were doing a good job at parenting given the very difficult circumstances in which they found themselves. This meant the mothers did not feel judged negatively and were more likely to admit to having trouble and to ask for help if they needed it (Aldgate & Statham^{**}, 2001; Dawson & Berry^{**}, 2002).

This strategy includes framing questions in a non-judgemental way. If parents are asked directly if their children miss out on meals it is likely they will feel they are being blamed and become defensive. Stowman and Donohue (2005) suggest that researchers 'normalise' the experience of parents by adding a softening preceding statement such as: "No matter how hard they try, many families find it hard to provide an evening meal every day for their family. How often has this happened to you this week?" This strategy elicits greater responsiveness when the issues involved are sensitive.

Start where the family is at^{*}: When first meeting the parents, it is suggested the caseworker begin by asking the parents what is happening, listening to their point of view and letting them talk and give their version of events (Tolley, 2003). Even if the caseworker disagrees with their actions, parents need to feel that they have stated their case and the caseworker has listened and is sympathetic to the plight they are in. If they are worried about the next meal, caseworkers should not start on alternative ways of disciplining their children just because it is the next module of the program. Similarly, Prochaska and DiClemente (1992) advise validating parents' perceptions. If parents do not feel change is necessary, it is important to recognise this and work on encouraging a re-evaluation of their current behaviour and personalising the risk.

Use verbal encouragement^{*}: For instance, if families agree to an appointment caseworkers should sound positive in the same way as if they were arranging to call in on a friend. Official and officious sounding language implies distance and may be perceived as threatening, so should be avoided. Having a friendly and welcoming receptionist was regarded by parents as important in the decision to take up a program. If the receptionist was cold and officious, families did not feel like taking up the service (Aldgate & Statham^{*}, 2001).

Including the family in decisions^{*}: This might be as simple as offering a couple of strategies and letting parents choose the one they think might work for them. This might range from choosing from a few behaviour management skills that they would like to try, to deciding to place a child in care. Families are more likely to comply with service agency decisions if they have been included in the decision making process (Aldgate & Statham^{*}, 2001; Huntsman, 2005). Encouraging client input into service decisions is becoming more widely used as an informal strategy. Sundell and Vinnerljung (2004), however, urge caution in adopting a more formal version of this approach, such as Family Group Conferencing. In their prospective random control trial study of children being investigated by child protection services in Sweden, they found that the impact of Family Group Conferencing was not only 'scant' but tended to be negative rather than positive^{***}.

Empower the parents*: This word has, to some extent, lost its meaning through overuse and lack of empirical definition. Nevertheless, when parents are encouraged to take responsibility for seeking solutions, and build incrementally on small successes, there is an increase in parental confidence and they feel better about themselves as parents (Johnson & Malloy**, 2002).

3.3.1.2 Provision of practical, material support early on

It has been shown that families who receive simple, practical and effective service at the beginning of their treatment are more likely to build and maintain a relationship with their caseworkers (Dawson & Berry, 2003). The support itself needs to be useful. Material support, skills building and the provision of emotional support are all rated highly by parents.

Offer material and concrete support:** The importance of meeting the *immediate needs* of families in the treatment process by providing concrete services cannot be underestimated. Families often face many barriers to engagement, including inadequate housing, poverty, unemployment, lack of childcare and lack of transport. Families with children must have sufficient funds to be able to provide for their basic needs before other strategies can be tried out. In some cases this may be as simple as buying some food, repairing a washing machine or providing disposable nappies.

Littell and Tajima** (2000) found that programs that provided a wide range of concrete services had higher levels of client collaboration, as reported by their caseworkers. In the evaluation of the Strengthening Families Initiative in Victoria (Spice**, 2002) and the United States Homebuilders model (Berry & Dawson**, 2003) parents rated the brokerage funds as one of the most important and useful aspects of the assistance. The average cost per family per year in Australia was AUD\$350 (Spice, 2002).

Practical support can also be provided in other ways that build rapport such as by being part of the everyday life of the family, helping them shop, helping unpeg or fold up the washing or negotiating a car or roof repair (Dawson & Berry*, 2001). It provides a partnership framework and families learn the modelled negotiation skills so they become more able to do them on their own. Multi-problem families rated caseworkers as most helpful when they were willing to help and be with the family, listened to clients and encouraged them (Benvenisti & Yekel, 1986 cited in Dawson & Berry*, 2002; Howard & Beckwith, 1996).

The rationale for effectiveness of material help is that, early in the relationship, it signals the caseworker's understanding of the family's needs, their positive intent and their ability to provide a solution quickly. It accords with the principles of 'starting where the family is at' and 'being responsive to the family's stated priorities'.

Focus on skills*: Many practitioners still focus on therapeutic insight rather than material needs and practical skill building more central to the requirements of vulnerable families (Macdonald, 2001; Whittaker, Schinke & Gilchrist, 1986, cited in Dawson & Berry, 2003). Skill building is more useful than the soft services of psychological counselling (Dawson & Berry, 2003).

Provide financial incentives as complete components of a program*:** This strategy seems to be context-dependent. The success of initial material assistance along with the success of paying participants for each successive wave of research participation (Giard et al.**, 2005; Senturia et al.**, 1999) may have provided the basis for giving incentives for each completed component of an intervention program (Katz et al.**, 2001).

Providing free treatment (Treloar et al., 2004) and vouchers for program level advancement that could be exchanged for retail items proved to be an effective incentive for successful progression in treatment with substance abusing communities (Villano, Rosenblum, Magura & Fong**, 2002; Higgins et al.**, 2002). Rent-free housing for continued abstinence was an effective incentive (Friedman et al.**, 2001) as were vouchers for a range of leisure activities and meals. These financial incentives reduced attrition and promoted positive outcomes (cited in Treloar et al.**, 2004).

However, it appears that the type of incentive may be important. For example, the use of baby products with pregnant, low income mothers as an incentive to enrol in a parenting program was far less successful (Katz et al.^{***}, 2001).

3.3.1.3 Easy access to services – little effort required by parents

Active community outreach^{}:** Provision of services in the local community or the home (assertive community outreach) does assist in maintaining engagement in programs for abusive and neglecting parents (Balgopal et al.^{*}, 1998) and homeless people with mental illness (Lehman et al.^{*}, 1999). With post-natal care where the intervention is clinic based, at least one initial home visit helps to engage the family (Naughton & Heath^{*}, 2001).

Visit on weekends or evenings^{}:** This was more convenient for some families (Senturia^{**}, 1998). This may be related to maternal employment. If mothers were employed this reduced the rate of attendance (Daro et al.^{***}, 2003) perhaps because of the time that the service was offered as well as the more limited time available generally.

Provide transport for centre-based treatment^{*}:** Provision of transport increases participation rates but this transport needs to be in the form of taxis or a car/van that picks up from the door rather than vouchers for public transport. The latter made no difference. Children need to be included. Katz et al. (2001) note that those most likely to drop out of treatment, even with free cabs, had an average of four children.

Assist to get ready^{*}: If the program is centre-based, retention rates improve if the caseworker arrives early and can help get children and parents ready (Katz et al., 2001). Getting three or four young children ready to go out for arrival at a specific time requires high levels of organisational skill and patience. It can be trying for even well-resourced and organised mothers, let alone those limited by mental health issues, cognitive impairment or issues with drugs and alcohol.

Provide free child care during the programs for parents^{2*}: The lack of free child care has been cited as a reason for non-attendance. It is assumed that by providing free child care, parents will attend either group or centre-based programs (Tomison, 1998) although impact on attendance rates has not rigorously evaluated.

Provide food and/or refreshments^{*}: The probability of parents attending an evening program is thought to be increased if food is provided at the meeting. In the early childhood field it is not uncommon to have information evenings for parents at the time they come to pick up a child. Food and drinks are provided for all the family so that attending the program does not contribute to an increased workload or expense for attending families (Dawson & Berry^{*}, 2003).

3.3.1.4 Maintaining contact

Keep multiple contact-points^{*}:** Organising a number of contacts at the initial meeting, through whom the family can be reached, (Katz et al.^{***}, 2001; Daro et al.^{**}, 2003; Giard et al.^{**}, 2005) can increase the retention rate significantly (from 86 per cent to 91 per cent, Senturia et al.^{**}, 1998). Obtaining permission to gain access to addresses through other government departments (eg health or education) makes it easier to trace families who move (Giard et al., 2005; Katz et al., 2001). Telephone directories (directories and reverse directories) were also used to keep track of families (Giard et al.^{**}, 2005).

Send a letter or phone beforehand to remind of appointment^{}:** This was successfully used by Naughton and Heath^{*} (2001) and Senturia^{**} (1999) who managed to retain interview contact with 89 per cent of families with an asthmatic child over a nine month period using a combination of techniques.

² There is some tension in easy access strategies as the same inducements are not available to all members of a community. For instance, if some families have free taxis and free child care, how does this sit with their neighbours who pay \$75 per day per child and have to organise their own transport? Sydney Day Nursery Services have offered 'scholarships' to preschool to reduce stigma and this may also reduce resentment.

More frequent contact:** This helps maintain contact at least until a relationship has developed between the caseworker and the family. With mental health issues, researchers suggest that even once a week might be too little, whereas with first time mothers the standard pattern starts off with weekly visits and reduces to fortnightly, followed by monthly or six weekly (Katz et al.**, 2001).

3.3.2 Agency level arrangements

Agencies can assist caseworkers by optimising the opportunity for them to implement what is thought to be most effective.

3.3.2.1 Systems

Need to be aware of services*: At the agency level it is clear that before families can access a service they need to be aware of it. Over half the respondents mentioned that lack of community awareness negatively affected accessibility. The most effective form of engagement in Kovacs' (2002) study was considered to be 'word of mouth'. It was most effective when coming from other families using the service.

The use of other agencies as 'ambassadors' for social services at a policy level, or using a combined service team from all agencies for this level of intervention may help reduce stigma.

In the United Kingdom, abuse is reported at a local level and all agencies are involved in receiving reports of abuse, so there is greater mutual reliance between agencies, than there is in systems where reports are more centralised and the domain of one agency. Where there is a stricter demarcation of service roles many agencies are unaware of the programs that other service agencies provide in their area. A survey of agencies in NSW indicated that service providers knew what programs their own agency offered, but were generally unfamiliar with the programs offered by other agencies or where they were located. Easy access to the location and details of programs offered by agencies in the area helps build this knowledge base amongst service providers as well as parents.

Multiple portals or gateways into a service: Agencies in the community need to be aware of the availability of all programs so that families are offered access to programs irrespective of which agency they approach initially (Giard et al., 2005).

Reduce eligibility criteria*: Many services offer programs which target specific subgroups, eg parents with an intellectual disability or children under the age of four years (Dawson & Berry, 2003). Removing eligibility criteria increases the rate of service participation for families. Eligibility criteria may result in families reporting exaggerated problems so they can access services (Aldgate & Statham*, 2001).

Few referral pathways*: The more referral 'pathways' that families experience, the more likely they are to drop out (Scott, 2003). The effort required to find and visit different buildings, work through a different bureaucracy and establish a relationship with yet another caseworker may prove too much of a hurdle for parents who are already feeling overwhelmed, or generally lacking interest in, or motivation for, what the 'authorities' might have to say.

Dedicated clinics:** The Early Intervention and Prevention Program in the United Kingdom established separate dedicated clinics to tackle specific problems in pre-school aged children (Naughton & Heath, 2001). Clinics in the United Kingdom which have been successful are:

- sleep clinic
- persistent crying clinic (which works on interpreting different cries)
- feeding difficulties clinic.

These clinics had a 74 per cent success rate in achieving the goal that parents specified at the initial interview. Attendance rates are also significantly higher in dedicated clinics than other services in the same area. In dedicated clinics, the failure to attend rate was 16 per cent and drop-out rate was six per cent which was about half the combined failure to attend rate of 37 per cent and drop-out rate of 10 per cent recorded in hospital outpatient services (Naughton & Heath, 2001).

The success of these services may in part be due to the terminology used to describe the clinics. This terminology implies a problem that the child has, rather than a problem that the parent has, that is, a clinic for a child who has trouble sleeping rather than a clinic for a mother who is not coping.

Services available in the community:** Each community needs to have easy geographic access to services. The Sure Start initiative suggested that services be located within 'pram pushing' distance (Joshi*, 2001). In Canada, if there were services within a kilometre of the school, developmental outcomes within that community were markedly improved (Janus & Offord**, 2001).

Evaluate outcomes not throughput:** It is also important to be careful how success is measured. Some services are assessed by client turnover, so statistically a service looks better if it takes on the easier clients with less complex and time consuming needs. This means that providers try to avoid those who are most in need of a child abuse prevention service in order to meet performance criteria (Giard et al., 2005).

3.3.3 Agency-caseworker interface

Manageable caseloads*:** The manageable caseload is generally considered to be about 20 to 25 families. However caseworkers dealing with families with multiple and complex needs should have caseloads of about 10 families (Baronet & Gerber, 1998). If caseloads are not manageable, caseworkers are more rushed and cannot spend the extra time to listen to a family in crisis without arriving late for the next family. Record keeping is less thorough and it is difficult to remember details of each family without blurring the boundaries.

Staff training:** A high level of education of caseworkers is associated with more consistent attendance at services by parents in child maltreatment cases (Dawson & Berry*, 2002). This finding relates to Mueller and Pekarik's** (2000) study in the United States where 62 per cent of the caseworkers reported a doctoral degree in psychology and 25 per cent had a masters degree in psychology or social work. Other studies have shown, however, that having a bachelor degree is effective in contributing to the success of a program (Corcoran*, 2000). Olds' studies suggest nurses may have higher retention rates than home visitors without college degrees. It remains unclear how home visitors with other educational degrees such as social work, public health or social sciences fare (McGuigan, Katzev & Pratt, 2003).

Train staff in programs that are culturally appropriate*: Recipe-style programs aimed at middle class Anglo-Australians (or often Anglo-Americans) are unlikely to be successful because they fail to engage, or retain, high risk or ethnic minority families (Hamner & Turner, 2001).

Supervision of caseworkers:** The retention rates of 71 home visitors across 12 sites and 1093 families were compared in a study by McGuigan, Katzev and Pratt (2003). They found that the more hours that caseworkers were supervised, the greater the retention rate of mothers.

Brokerage funds:** Caseworkers need to be able to access funds quickly to deliver to families. Around \$350 per year per family needs to be available (though some may need more than others) (Spice, 2002; Dawson & Berry, 2001). If caseworkers are to provide an initial positive service that entails, for instance, a repair or a purchase, they need to be able to access the money within a short space of time without weeks of red tape*.

Joint protocols*: Working with other agencies is seen as important. Tomison (1995) suggests having joint protocols that can be easily understood across agencies. This has been adopted successfully in the United Kingdom (Aldgate & Statham, 2001). Services were positively affected by information exchange and better coordination between services. It has been suggested that there be standardised assessment and data storage across agencies, with regular meetings and joint training (Aldgate & Statham, 2001).

One caseworker per family: In the United Kingdom, the caseworker for the family may come from Social Services, Health or Education, but any one of them could take the lead in a case (Aldgate & Statham, 2001). This caseworker remains the same person whether it is the oldest child's foster care placement or the youngest child's behaviour problems in class, similar to the ACT model (Baronet & Gerber, 1998).

Similar background:** Some programs select their visitors from similar backgrounds as the families they are dealing with, eg the Community Mothers Program (Barker, 2004). People tend to relate to others more easily if they are perceived as 'similar' to themselves³. Programs that *match* participants and providers in terms of parenting status, age and ethnicity were significantly more likely to retain families longer in the program (Daro et al.***, 2003).

Stability of caseworker*: Senturia et al.* (1999) found the use of the same interviewer for successive waves of data was a positive contributor to the high retention rate for the research project on families with asthmatic children. Using the same caseworker for the family is considered to be conducive to building a trusting relationship (Aldgate & Statham, 2001).

Toll-free number:** Providing a toll-free number increases the likelihood that families will ring so that contact can be maintained (Giard et al., 2005).

³ This can backfire if parents see the 'visitor' as a failure themselves (Barker, 2004 personal communication).

4. Conclusion

Most studies concentrate on only one or two strategies to recruit and retain families. This has resulted in a collection of small scale studies offering single factor, often contradictory explanations for participant decisions (Daro, McCurdy, Falconnier & Stojanovic, 2003). Few of these strategies have been evaluated.

Some strategies have been found to be useful in some cases and should be utilised by caseworkers and in the Early Intervention Program design to improve outcomes.

It is important to make services attractive to families. If they feel threatened or if by attendance, they are labelled as failures, they will feel uncomfortable attending. Other agencies will also not refer to a program unless they see merit in it, so relationships need to be built within the service provider community.

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