Engaging High Risk Families in Home Visiting Programs
A Rapid Review

Daiva Tirilis, Analyst, Research & Policy
May Yao, Acting Supervisor
Debbie Chang, Manager

January 2018
# Table of Contents

*Key Messages* ................................................................................................................................. 1
*Executive Summary* ......................................................................................................................... 2
1  *Issue* ........................................................................................................................................... 4
2  *Context* ........................................................................................................................................ 5
3  *Literature Review Question* .......................................................................................................... 6
4  *Literature Search* .......................................................................................................................... 7
5  *Relevance Assessment* .................................................................................................................. 7
6  *Results of the Search* .................................................................................................................... 8
7  *Critical Appraisal* ........................................................................................................................ 8
8  *Description of Included Studies* .................................................................................................... 8
9  *Synthesis of Findings* ................................................................................................................... 12
10  *Applicability and Transferability* .............................................................................................. 19
11  *Recommendations* ...................................................................................................................... 22

*References* ....................................................................................................................................... 24

*Appendices* ...................................................................................................................................... 26

*Appendix A: 2016 HBHC Program Participation Data* ................................................................. 27
*Appendix B: Search Strategy* ........................................................................................................... 29
*Appendix C: Literature Search Flowchart* ...................................................................................... 34
*Appendix D: NICE adapted AACODS Checklist* .......................................................................... 35
*Appendix E: Data Extraction Tables* ............................................................................................. 39
Key Messages

1. To effectively recruit and retain high risk families in ongoing home visiting programs, both program design and staff approaches must be considered.

2. To increase client recruitment, design home visiting programs to provide multiple opportunities for program entry.
   - Additional program design features include: promoting a welcoming and inclusive program, and meeting in safe, family-friendly spaces.

3. To increase client recruitment, contact new client within 48 hours to ensure a quick initial response from staff.
   - Additional staff approaches include: contacting clients frequently and being non-stigmatizing.

4. To increase client retention, design home visiting programs to provide continuity of care, flexible programming, and case management meetings.
   - Additional program design features include: collaborating with agencies, promoting social connectedness, offering incentives, building workforce capacity, and evaluating client outcomes.

5. To increase client retention, develop quality relationships, use family-centred practices, and contact and follow up with clients regularly.
   - Additional staff approaches include: conveying trust, being culturally responsive, and providing strength-based and solution-focused strategies.
Executive Summary

Research Question

What strategies engage high risk families in ongoing, active participation in home visiting programs?

Context

The Healthy Babies Healthy Children (HBHC) program offers home visiting services to vulnerable families. In the past year, only 38 per cent of families identified “with risk” completed an In-Depth Assessment to confirm their level of risk. As well, only half of the families discharged from HBHC completed the program.

Methods and Results

A search of published literature and grey literature provided 972 results. An additional report was identified by searching the reference lists of relevant articles. Five articles were reviewed in full. A guideline and two grey literature reports were included.

Synthesis of Findings

Engagement strategies are implemented at the program or staff level.

Recruitment Strategies

To increase client recruitment, design home visiting programs to provide multiple opportunities for program entry. Staff should ensure a quick response within 48 hours for new, eligible clients. Additional retention strategies include promoting inclusiveness, meeting in a safe space, providing frequent contact, and being non-stigmatizing.
Retention Strategies

To increase client retention, design home visiting programs to provide continuity of care, flexible programming, and case management meetings. Staff should form quality relationships with clients, use family-centred practices, and maintain regular follow-up. Additional retention strategies include collaborating with other agencies, promoting social connectedness, offering incentives, building workforce capacity, and evaluating client outcomes. Staff should convey trust, be culturally sensitive, and provide strength-based and solution-focused strategies.

Recommendations

To improve client recruitment, HBHC should:

1. Provide multiple opportunities for program entry during key transition periods.

2. Ensure a quick response with families after the initial contact and before the In-Depth Assessment.

To facilitate client retention, HBHC should:

3. Provide continuity of care to establish a trusting relationship.

4. Provide flexible program design with a family-centred approach.

5. Conduct case management meetings between supervisor, nurse and family visitor.

6. Ensure staff develop quality relationships with clients and regularly assess the quality of those relationships.
1 Issue

The Healthy Babies Healthy Children (HBHC) program offers home visiting services to vulnerable families. Eligible families are those who are identified “with risk” for poor child development on the HBHC Screen\(^1\) and have risk confirmed\(^2\) through an In-Depth Assessment\(^3\) (IDA). The program is voluntary and families must consent to participate. Actively engaging high risk families\(^4\) in preventive interventions is challenging. (1)

Active engagement refers to families participating in (i.e., recruitment) and completing (i.e., retention) programs that would benefit them. (1)

Local data indicate that high risk families in Peel who would benefit from HBHC services are not entering the program. Families disengage at various times during the recruitment process: for example, when booking an assessment, completing the assessment, or accepting entry into the program. Many families who accept the program do not stay long enough to complete their goals. The focus of this rapid review is to identify strategies to engage high risk families to enter and complete the home visiting program.

---

\(^1\) The HBHC Screen helps to identify families and children who may be with risks that compromise healthy child development and parenting.

\(^2\) According to the HBHC Guidance Document (2012), “confirmed with risk (moderate/high-risk) describes a situation where there are several significant risk factors that work together to negatively impact healthy child development and the family demonstrates a need to be linked to health and/or social services in the community” (p. 58).

\(^3\) The objective of the IDA is to confirm risk in high risk families who would most benefit from targeted interventions.

\(^4\) According to the HBHC Guidance Document (2012), high risk populations include, but are not limited to young, first-time, low-income mothers or new immigrant families.
2 Context

In 2011, there were 96,500 infants and children under the age of six in Peel. (2) During that year, there were 15,827 births. (2) Families in Peel, who have a child less than six years old and who consent, are screened for risk factors. Those identified “with risk” are offered the HBHC program. The majority of clients are identified through universal screening in hospitals in the immediate postpartum period. When families are hesitant to consent to the HBHC Screen, a HBHC hospital liaison nurse meets them at the bedside to provide further information about the program.

Program data indicate issues with recruitment of high risk families into the home visiting program in Peel. In 2016, of the 6,162 Peel families who were identified “with risk” based on the HBHC Screen, 55 per cent did not have an IDA booked to confirm their level of risk (20% declined; 20% unreachable; upon further screening 15% did not meet criteria). Only 38 per cent of families identified “with risk” completed an IDA to confirm risk. Of the 2,773 families with a booked IDA, 15 per cent did not complete the assessment (9% declined; 5% unreachable; 0.5% other reasons such as family moved). Based on the IDA, 1,004 families were identified as high risk; however, 26 per cent did not enter the home visiting program (22% declined; 1% unreachable; 4% other reasons). (3) (See Appendix A.)

In addition to recruitment issues, there are program retention concerns related to ongoing client participation and completion of the home visiting program. Recommended practice is for families to be visited for six to 18 months. In 2016, only 25 per cent of HBHC families received visits for this recommended duration. Of the 795
HBHC families who were discharged (i.e., no longer enrolled) from the home visiting program in 2016, 50 per cent did not complete the program (33% declined; 9% unreachable; 5% family moved; 4% other reasons). Of the 7,645 booked home visits, seven per cent were missed because the client was not home. In order to complete the HBHC program, staff need regular contact with clients. Based on 11,800 telephone and voicemail interactions with these families, 16 per cent of these interactions resulted in cancelled appointments. (3) (See Appendix A.)

In summary, HBHC program data identify areas for improvement related to recruitment and retention of high risk families. Today, HBHC focuses on meeting the needs of families who are the highest risk. HBHC continues to implement engagement strategies and innovative solutions to improve outcomes for families with young children. This includes having HBHC staff engage and support clients at Teen Prenatal Supper Clubs and promote the home visiting program in hospitals. HBHC staff meet clients in their homes or where they feel most comfortable, such as in the community. When appropriate, clients are provided with bus fares to access community referrals. However, additional strategies are needed to increase participation in and completion of the home visiting program.

3 Literature Review Question

What strategies engage high risk families in ongoing, active participation in home visiting programs?
P – high risk families
I – strategies that engage clients
C – no comparison
O – ongoing active participation in home visiting programs (e.g., recruitment, participation, retention, program completion)

4 Literature Search

An iterative literature search was conducted. The final search was conducted in June 2016 and included two electronic databases: MEDLINE and CINAHL. Additionally, searches were conducted in Health Evidence, as well as in the National Institute for Health and Care Excellence (NICE) and Google for grey literature. Reference lists of potentially relevant reviews were also searched. The final search strategies are included in Appendix B.

5 Relevance Assessment

One reviewer screened titles and abstracts for inclusion. When relevance was unclear, a second reviewer was consulted. The search results were assessed for relevance based on the following criteria:

- Inclusion criteria: focused on high risk families; engagement interventions, strategies or approaches; home visiting programs; synthesized literature; English language; published between 2006 and 2016.
• Exclusion criteria: effectiveness of home visiting on outcomes; clinical settings; developing countries.

6 Results of the Search

The literature search resulted in 972 titles following the removal of duplicates. After title screening, abstracts of 22 articles were reviewed for relevance. Five articles were reviewed in full. One guideline and two grey literature reports were included. Refer to Appendix C for details of the search results.

7 Critical Appraisal

The AGREE II tool (4) and the NICE Adapted AACODS (Authority, Accuracy, Coverage, Objectivity, Date, Significance) Checklist (5) were used for critical appraisal (see Appendix D). Two reviewers independently appraised the reports in consultation with the knowledge broker and supervisor. Disagreements were resolved through discussion until consensus was reached. Overall, the guideline (6) was assessed as strong using AGREE II. One report (7) was strong using the NICE adapted AACODS but received partial scores for accuracy and coverage (i.e., limits and inclusion criteria). The other report (8) was assessed as moderate using the NICE adapted AACODS and received a partial rating for accuracy (i.e., limited description of methods) and an ‘unclear’ rating for objectivity (i.e., bias).

8 Description of Included Studies

One guideline and two grey literature reports were included:
There was no study overlap between the guideline and grey literature reports.

**NICE (2012): Social and emotional wellbeing: Early years (6)**

The objective of this high-quality guideline was to determine how the social and emotional wellbeing of high risk children can be supported through home visiting, childcare, and early education. It included evidence from three systematic reviews, economic modelling, the testimony of expert witnesses, and commissioned reports. Most of the literature was from the United Kingdom. The population of interest was high risk children under five years of age and their parents. High risk children were defined as those who are at risk of, or who are experiencing, social and emotional problems and needed additional support. The outcomes in this guideline focused on social and emotional wellbeing based on antenatal and postnatal interventions which included home visiting, early education, and childcare.

Evidence relevant to engagement in home visiting was from a systematic review of UK studies. The systematic review focused on 1) evaluation studies on the effectiveness of
early years programs and interventions to promote social and emotional health; and 2) process studies on factors influencing delivery and implementation of interventions. Included studies were quality assessed. The systematic review included interventions in the home and early years education settings. The reported outcomes were child wellbeing, child development, child behaviour, parent wellbeing, maternal depression/mental health, parenting, social support, family relationships, home environment, neighbourhood, parent behaviours, breastfeeding/feeding practices, and service use. The review included evidence on 1) the uptake of early intervention services, 2) parent experiences of services and ongoing engagement of early interventions, and 3) staff-parent relations in home based interventions. Refer to Appendix E for further detail on data extraction.

**Moore et al. (2012): Sustained home visiting for high risk families and children: A literature review of effective processes and strategies (7)**

The objective of this grey literature report was to identify 1) service delivery features that were associated with better outcomes for families, and 2) effective ways of engaging and working with parents and families who are experiencing adversity. This report did not describe the types of studies included, but the extensive reference list includes single studies, reports, and policy briefs. The included studies were not assessed for quality. The authors used a narrative review style to synthesize literature from various disciplines. The population of interest was prenatal women as well as families with children up to five years of age; many of the included studies focused on two to three year olds. The outcomes in this report focused on engaging and retaining families
experiencing adversity. The report authors examined program design (e.g., continuity of care) and process features of effective home visiting interventions. Process features included: relationship building, developing partnerships between professionals and parents, goal-setting, providing choices, building parental competencies, and providing sensitive care (e.g., cultural awareness). Refer to Appendix E for further detail.

**Katz et al. (2006): What interventions are effective in improving outcomes for children of families with multiple and complex problems? (8)**

The objective of this grey literature report was to identify effective interventions and strategies to improve outcomes for children and families with multiple and complex problems. It included research reviews which were supplemented with primary research papers (5 reviews, 10 reports, 2 books, and 3 primary studies). Most of the literature was from the United States, with effort to incorporate Australian research. The included studies were not quality assessed. See Appendix E for full data extraction in detail.

The population of interest was defined as:

*Families with children aged 0-5 years who are experiencing multiple problems, which might be problems for the parents, for the children, or for the whole family. Examples of problems include problems relating to housing, finances, ill health, childcare, substance abuse, family violence, and abuse, poor educational outcomes, truancy (p.33).*

The outcomes in this report included recruitment and retention for home visiting programs. Home visiting intervention features included assessing client needs and
responding to them, building relationships, recruiting new clients, preventing drop outs, and designing programs to meet families’ needs.

9 Synthesis of Findings

Active engagement strategies are defined as those aimed at increasing recruitment and/or retention of families in home visiting programs. These strategies are implemented through program design or staff approaches (see Table 1).

Table 1: Synthesis of strategies to engage high risk families in home visiting programs

<table>
<thead>
<tr>
<th>Program Design</th>
<th>Recruitment</th>
<th>Retention</th>
</tr>
</thead>
</table>
|                | • Provide multiple opportunities for program entry  
|                | • Provide continuity of care  
|                | • Ensure a quick initial response  
|                | • Establish quality relationships  |
|                | • Promote a welcoming and inclusive program  
|                | • Provide flexible program design  
|                | • Provide frequent contact with clients  
|                | • Use family-centred practices  |
|                | • Offer the opportunity to meet in safe, family-friendly spaces  
|                | • Conduct case management meetings  
|                | • Be non-stigmatizing  
|                | • Convey trustworthiness, commitment and empathy  |
|                | • Offer incentives  
|                | • Be responsive and culturally sensitive  |
|                | • Build workforce capacity  
|                | • Provide strength-based and solution-focused strategies  |
| Staff Approaches | • Conduct case management meetings  
|                | • Evaluate client outcomes  |
Due to the breadth of findings, specific strategies most relevant to Peel's context are presented in bold.

**Recruitment Strategies**

**To increase client recruitment, design home visiting programs to provide multiple opportunities for program entry.**

Home visiting programs should have multiple gateways into service (8), opportunities to use programs during key transition periods (8), and provide soft entry points\(^v\) where parents can access support to more specialized services. (7) Programs should allow time for recruitment. (8) Participants should not be pressured and entry at a later stage should be offered. (7) Providing information at the right time, such as after birth, helps enable participation since families' circumstances and needs may change. (6)

*Additional program design features*

To increase client recruitment, promote a welcoming and inclusive program. Welcoming programs use trusted organizations as ambassadors (8), obtain feedback from other parents (6), advertise and are publicized in the community (6,7). Advertising should be examined as to whether it is stigmatizing to participants or the community. (6,7) Inclusive programs ensure eligibility criteria do not exclude those who could benefit from the service. (8) Programs should use multiple, intensive, and targeted recruitment and retention strategies for hard to reach populations. (7) This includes

\(^v\) Soft entry points refers to offering targeted programming in a non-stigmatizing way to parents in their own communities (e.g., through outreach services like mobile playgroups) or through neutral, universal services (e.g., maternal and child health centres, child care centres, schools, and libraries) (8).
promoting the program in organizations working with high risk families and through informal methods (e.g., community events and flyers). (7)

Client participation may also be increased by offering to meet in safe and family-friendly spaces (e.g., in or outside the home) and/or by providing transportation subsidies. (7)

**To increase client recruitment, contact new clients promptly to ensure a quick initial response from staff.**

A quick response from staff within 48 hours of the initial referral is recommended. (8)

*Additional staff approaches*

Client recruitment is also supported by having frequent (e.g., weekly) contact with clients by phone or in person. (8) To recruit clients, staff should treat parents in a non-stigmatizing and supportive way. (8) Uptake of home visiting programs is influenced by parents’ perceived needs, confidence levels and desire for practical support. (6) Participation is also influenced by families’ culture and language. (6) Parental perception of the quality of the intervention can be affected when parents worry about staff prying into their personal lives. (6) If a program targets ‘disadvantaged’ families, this label may accentuate the sense of failure the family is likely experiencing. (8)

**Retention Strategies**

**To increase client retention, design home visiting programs to provide continuity of care, flexible programming, and case management meetings.**
Continuity of care helps maintain the client-provider relationship. (7) Changes, especially frequent staff changes, undermine the formation of a trusting relationship and should be avoided. (7) Parents do not like fragmented visits. (6)

Flexible programming helps to engage and retain clients. Changing the length or frequency of visits, and providing flexible hours, including evenings and weekends, allows working parents, partners, and other family members to participate. (6-8) When a client is disengaged and may consider dropping out, staff should change the content being delivered and/or offer a break from the program. (6) During breaks from the program, the nurse should maintain regular communication with parents. (6)

It is key that staff are flexible to the needs of the client by ensuring services are delivered at a suitable, non-disruptive time. (6) Time commitment could be a barrier to retention when families have difficulty fitting the intervention into their routine or experience multiple demands. (6) Personal reasons can affect retention such as losing interest in the program, missing too many home visits, moving out of the area, infant illness, and other commitments. (6)

Programs should provide a coherent and transparent case management approach that links therapeutic, health, social, and educational services. (7) Case management meetings should include regular audits to ensure consistency and quality of program delivery. (6)
**Additional program design features**

Collaborating with agencies to enable effective referrals can increase client retention. It is critical that programs collaborate and develop partnerships with agencies and early years practitioners to ensure families receive coordinated services. (6-8) This includes developing strong reciprocal linkages with psychologists, therapists, family support workers and other professionals to simplify referrals to crisis interventions, child protection services, and other relevant services. (6-8) It is easier for families to participate in other services when they are taking part in one program. (6)

Promoting social connectedness can also increase client retention. Clients engage in programs that promote social connections through diverse types of informal supports and formal services. (7) Parents value the support of a peer home visitor, especially when they have limited social support; having support in difficult times allows parents to vent frustrations and develop life skills and confidence. (6) However, parents’ negative perceptions of formal supports (e.g., the risk of losing their children) may prevent them from participating in services. (6,7)

Clients may be more engaged if they receive incentives, such as rewards for participating (e.g., money, gifts, or vouchers), or transportation assistance (e.g., bus tickets). (7)

Building workforce capacity among home visiting staff can increase client retention. Home visiting staff need to be skilled and responsive. (7,8) When staff are trained, supported, and supervised sufficiently they are able to cope with clients’ problems and
deal with resistance. (7) Mentoring by experienced staff and reflective practice builds workforce capacity. (7,8)

Client outcomes should be evaluated to monitor the impact of client engagement rather than counting the number of clients in the program. (7)

**To increase client retention, develop quality relationships with clients, use family-centred practices, and maintain regular and frequent contact.**

Establishing a therapeutic relationship vi with clients is an important factor in client retention. (6-8) This includes public health nurses (PHNs) initially getting to know the client and settling into the relationship, developing mutual trust, and establishing positive, non-judgmental rapport. (6,7) Through regular interactions parents feel more at ease. (6) Clients like when staff are honest and use an open-minded approach where they do not impose their views. (6)

PHNs and family visitors need to continually assess the quality of their relationships vii (7); younger women might view a health visitor as authoritative. (6) Staff need to communicate effectively, demonstrate caring, establish confidentiality, and adopt a non-expert approach with clients (e.g., avoid the “I know what’s best for you” stance) by acknowledging that parents are the experts of their own life and children.

---

vi Based on the Registered Nurses Association of Ontario Nursing Best Practice Guideline, *Establishing Therapeutic Relationships (2006)*, therapeutic relationship is defined as “an interpersonal process that occurs between the nurse and the client(s). Therapeutic relationship is a purposeful, goal directed relationship that is directed at advancing the best interest and outcome of the client.” (p.13)

vii The Moore report extracted this data from Susan Jack’s theory on maternal engagement. Based on a presentation to HBHC on engagement and working with high risk families in home visitation, public health nurses and family visitors should ask clients at the fourth or fifth home visit what is working well and not well, as well as inquiring about what the client likes in order to assess the quality of the relationship. Staff should role model healthy relationship behaviour by responding positively and incorporating the clients’ feedback into practice. (Tirilis, Daiva. Presentation by: Susan Jack. 2017 Feb 1)
(6,7) Staff should not mislead or disappoint clients by making promises they cannot keep. (7)

Family-centred practices lead to retention when the focus is on the needs of the parents and children, and parents feel in control in the decision-making process related to their goals. (6-8) Staff should ensure both parents participate in home visits, as well as other family members, if appropriate. (6) When involving the whole family, PHNs should focus on developing the father-child relationship. (6) While it takes time for fathers to become engaged, they enjoy participating in the program. (6)

To keep clients engaged in the program, staff need to follow up with clients after each missed appointment, as well as those at risk of dropping out. (7,8) Staff should have frequent contact with the client (e.g., weekly) through meetings or phone calls to reduce attrition. (8) Families who are in need of additional support should have a nurse visit a set number of times over a sustained period of time. (6) Follow-up should include at least three phone calls, providing appointment reminders by telephone or letter, personal contact to pass on relevant information, and conveying the desire and expectation of meeting the client at the next home visit. (7,8) As many contact addresses and telephone numbers as possible should be recorded since participants, such as young mothers, may have transient living arrangements. (7)
Additional staff approaches

It is important that staff convey trustworthiness, commitment, and empathy when interacting with clients. Using verbal encouragement and non-punitive communication with clients conveys empathy and builds trust. (7,8)

Responsive and culturally sensitive staff can also increase client retention. Staff should take into account parents’ first language. (6) Staff who are culturally responsive adopt ethnical awareness of issues, customs, ethnic background of interveners and communication (e.g., translation services). (7) An example of a culturally specific approach is matching clients with staff from similar cultural backgrounds (7). Strategies for addressing cultural issues and challenges include valuing diversity, understanding the dynamics of difference, making cultural adaptations, conducting ongoing cultural self-assessment, and institutionalizing cultural knowledge (7). Staff also need to be sensitive to a wide range of attitudes, expectations and approaches related to parenting. (6)

Clients are engaged when staff use strength-based and solution-focused approaches. Strength based approaches involve focusing on clients’ skills and proficiencies, rather than their shortfalls. (7,8)

10 Applicability and Transferability

An adapted applicability and transferability (A&T) worksheet (9) was used to consider the findings and recommendations in our local context. A summary of key points from
the facilitated discussion that occurred on March 22, 2017 with internal stakeholders is provided below:

• **Social Acceptability:** Since the program is voluntary, staff identified concerns about how many times they should contact clients. Client and staff perspectives could vary about how much follow-up is appropriate.

Texting to confirm home visiting appointments could be considered. Staff currently use texting for clients with disabilities. Clients with basic cell phone functions who might not be able to afford phone minutes could benefit.

HBHC’s performance measurement indicators focus on number of families visited per month, not the number of times staff contact them. Following up is time consuming and could affect the number of home visits staff can undertake.

• **Resources:** Recruiting and retaining high risk clients could require additional resources. High risk caseloads affect the length of time for each home visit and duration of time in the program, as well as require more documentation and staff attention. However, time and resources could be offset if fewer clients cancel or miss appointments.

HBHC policy and infrastructure currently permit staff to work weekday evenings to meet client needs, but this seldom happens. No policy exists regarding coverage for weekend service. Language in the current collective agreement could accommodate weekend programming, but the availability and capacity of community services and
HBHC program support would need to be considered. Clients who return to work and are not available during the day could benefit from flexible home visiting hours.

- **Organizational expertise and capacity:** The recommendations validate recent HBHC program modifications to engage high risk families. Currently, the program is collaborating with other Regional programs (e.g., Teen Prenatal Supper Club, Healthy Smiles, Ontario Works) to promote the HBHC program, recruit clients, and enable reciprocal program entry. To provide multiple opportunities for program entry, HBHC should consider collaborating with other Family Health services (e.g., breastfeeding clinics, Healthy Start) and external stakeholders (e.g., physicians, obstetricians, midwives, and community agencies servicing hard to reach families).

PHNs already develop therapeutic relationships with clients. To evaluate the quality of these relationships, a process needs to be developed. Staff would likely accept training on effectively assessing the strength of their therapeutic relationships with clients. Staff believe that training on cultural awareness should be a priority, especially since new staff members may not have any formal cultural sensitivity training.

- **Political Acceptability:** Engaging high risk families is consistent with the Region of Peel - Public Health’s strategic program priority, *Nurturing the Next Generation*. This also fits within the Region of Peel’s Early Growth and Development service outcome: Children in Peel are supported to achieve their mental and physical potential.
In summary, front-line staff and management in Family Health agreed with the recommendations. The HBHC program has already made progress with engaging high risk families consistent with the findings of this review.

11 Recommendations

To improve client recruitment in home visiting, it is recommended that the HBHC program:

1. Provide multiple opportunities for program entry during key transition periods. This includes collaborating with internal programs and external agencies to promote the program and increase access through soft entry points.

2. Provide a quick initial response to families after the HBHC Screen and before the In-Depth Assessment (IDA).

To facilitate client retention in home visiting, it is recommended that the HBHC program:

3. Provide continuity of care to establish a trusting relationship. This includes frequent contact with clients.

4. Provide flexible program design with a family-centred approach, such as services on evenings and weekends based on family needs, and involving fathers.

5. Conduct case management meetings between supervisor, PHN, and family visitor.
   a. Develop a standardized process to follow up with clients who are at risk of dropping out.
b. Utilize strength-based and solution-focused approaches so that PHNs are responsive to client needs. Some training may be required.

6. Ensure staff develop relationships with clients and continually assess the quality of those relationships.
   a. Develop a standardized process to assess the quality of staff-client relationships.
   b. Investigate if there is any formal training or other strategies that could be used to improve cultural sensitivity.
References


Appendices

Appendix A: 2016 HBHC Program Participation Data

Appendix B: Search Strategy

Appendix C: Literature Search Flowchart

Appendix D: NICE adapted AACODS Checklist

Appendix E: Data Extraction Tables
Appendix A: 2016 HBHC Program Participation Data

"With Risk" HBHC Screening Tools (Based on 2 yes) 6162

- In-Depth Assessment Booked 2773
- In-Depth Assessment Not Booked 3389
  - Declined 1258
  - Unable to contact 1207
  - Other 924

- In-Depth Assessment Completed 2362
  - In-Depth Assessment Not Completed 411
    - Declined 247
    - No contact 151
    - Other 13

- High Risk In-Depth Assessment 1004
  - Accept Home Visiting Program 739
    - Declined Home Visiting Program 216
    - Unable to contact 12
    - HBHC Services Not Appropriate 33
    - Moved 3
    - Referred to Another Public Health Unit 1
Home Visit Interactions
E.g. Home visits, phone, voicemail 19445

Face to Face Home Visits 7645
  Completed 7037
    No Show 506
  Not Completed 608
  Other (Decline, Not Found, etc) 102

Telephone 6360
  Canceled Appointment* 1850
    By staff 1278
    By client 612

Voice Message 5440

Discharged 795

Home Visiting Program Completed 396
  Decline further HBHC Services 259
  HBHC Services Not Appropriate 24
  Moved 42

Home Visiting Program Not Completed 399
  Not Able to Contact 68
  Referred to Another Public Health Unit 3
  Referred to Another Agency 3

*Canceled Appointment includes telephone interactions and voice message interactions (completed or not completed)
Appendix B: Search Strategy

Searches conducted in June 2016.

MEDLINE

Database: Ovid MEDLINE(R) <1946 to June Week 2 2016>
Search Strategy:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>exp attitude to health/</td>
<td>335787</td>
</tr>
<tr>
<td>2</td>
<td>exp attitude of health personnel/</td>
<td>132272</td>
</tr>
<tr>
<td>3</td>
<td>exp trust/</td>
<td>6945</td>
</tr>
<tr>
<td>4</td>
<td>exp nurse-patient relations/</td>
<td>32422</td>
</tr>
<tr>
<td>5</td>
<td>exp professional family relations/</td>
<td>12897</td>
</tr>
<tr>
<td>6</td>
<td>exp &quot;patient acceptance of healthcare&quot;/</td>
<td>192781</td>
</tr>
<tr>
<td>7</td>
<td>exp patient participation/</td>
<td>20099</td>
</tr>
<tr>
<td>8</td>
<td>engag*.tw.</td>
<td>95639</td>
</tr>
<tr>
<td>9</td>
<td>retention*.tw.</td>
<td>123904</td>
</tr>
<tr>
<td>10</td>
<td>or/1-9</td>
<td>676620</td>
</tr>
<tr>
<td>11</td>
<td>or/1-7</td>
<td>474975</td>
</tr>
<tr>
<td>12</td>
<td>exp Nursing Research/</td>
<td>48343</td>
</tr>
<tr>
<td>13</td>
<td>exp Public Health Nursing/mt, og, st [Methods, Organization &amp; Administration, Standards]</td>
<td>1233</td>
</tr>
<tr>
<td>14</td>
<td>exp Community Health Nursing/mt, og, st [Methods, Organization &amp; Administration, Standards]</td>
<td>6908</td>
</tr>
<tr>
<td>15</td>
<td>exp Nursing Staff/</td>
<td>58909</td>
</tr>
<tr>
<td>16</td>
<td>exp Evidence-Based Nursing/</td>
<td>2718</td>
</tr>
<tr>
<td>17</td>
<td>nurse*.tw.</td>
<td>202334</td>
</tr>
<tr>
<td>18</td>
<td>or/12-17</td>
<td>265122</td>
</tr>
<tr>
<td>19</td>
<td>or/12-16</td>
<td>106374</td>
</tr>
<tr>
<td>20</td>
<td>exp house calls/</td>
<td>2774</td>
</tr>
<tr>
<td>21</td>
<td>home visit*.tw.</td>
<td>5909</td>
</tr>
<tr>
<td>22</td>
<td>care visit*.tw.</td>
<td>3210</td>
</tr>
<tr>
<td>23</td>
<td>health visit*.tw.</td>
<td>3419</td>
</tr>
<tr>
<td>24</td>
<td>*Home Nursing/</td>
<td>5087</td>
</tr>
<tr>
<td>25</td>
<td>or/20-24</td>
<td>18898</td>
</tr>
<tr>
<td>26</td>
<td>or/20-23</td>
<td>13900</td>
</tr>
</tbody>
</table>
27  10 and 18 and 25 (1321)
28  limit 27 to yr="2005-Current" (713)
29  remove duplicates from 28 (704)
30  review*.tw. (1332856)
31  meta analys*.tw. (76013)
32  synthes*.tw. (718286)
33  guideline*.tw. (205659)
34  or/30-33 (2200916)
35  29 and 34 (92)

***************************

CINAHL

<table>
<thead>
<tr>
<th>Search ID#</th>
<th>Search Terms</th>
<th>Search Options</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>S33</td>
<td>S29</td>
<td>Limiters - Published Date: 20050101-20161231; Geographic Subset: Asia, Australia &amp; New Zealand, Canada, Continental Europe, Europe, Mexico &amp; Central/South America, UK &amp; Ireland, USA; Language: English</td>
<td><a href="#">View Results</a> (390) <a href="#">View Details</a> <a href="#">Edit</a></td>
</tr>
<tr>
<td>S32</td>
<td>S29 AND S31</td>
<td>Search modes - Boolean/Phrase</td>
<td><a href="#">View Results</a> (19) <a href="#">View Details</a> <a href="#">Edit</a></td>
</tr>
<tr>
<td>S31</td>
<td>TI &quot;review&quot; OR &quot;meta analys&quot;</td>
<td>Search modes - Boolean/Phrase</td>
<td><a href="#">View Results</a> (90,943) <a href="#">View Details</a> <a href="#">Edit</a></td>
</tr>
<tr>
<td>S30</td>
<td>S6 AND S20 AND S28</td>
<td>Search modes - Boolean/Phrase</td>
<td><a href="#">View Results</a> (550) <a href="#">View Details</a> <a href="#">Edit</a></td>
</tr>
<tr>
<td>S29</td>
<td>S6 AND S20 AND S27</td>
<td>Search modes - Boolean/Phrase</td>
<td><a href="#">View Results</a> (874) <a href="#">View Details</a> <a href="#">Edit</a></td>
</tr>
<tr>
<td>S28</td>
<td>S22 OR S23 OR S24 OR S25 OR S26</td>
<td>Search modes - Boolean/Phrase</td>
<td><a href="#">View Results</a> (81,507) <a href="#">View Details</a> <a href="#">Edit</a></td>
</tr>
<tr>
<td>S27</td>
<td>S21 OR S22 OR S23 OR S24 OR S25 OR S26</td>
<td>Search modes - Boolean/Phrase</td>
<td><a href="#">View Results</a> (189,583) <a href="#">View Details</a> <a href="#">Edit</a></td>
</tr>
<tr>
<td></td>
<td>Search terms</td>
<td>Search modes - Boolean/Phrase</td>
<td>View Results</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------</td>
<td>-------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>S26</td>
<td>evidence-based nursing*</td>
<td></td>
<td>(8,742)</td>
</tr>
<tr>
<td>S25</td>
<td>nursing research</td>
<td></td>
<td>(31,068)</td>
</tr>
<tr>
<td>S24</td>
<td>nursing staff</td>
<td></td>
<td>(21,327)</td>
</tr>
<tr>
<td>S23</td>
<td>community health nurs*</td>
<td></td>
<td>(24,185)</td>
</tr>
<tr>
<td>S22</td>
<td>public health nurs*</td>
<td></td>
<td>(3,185)</td>
</tr>
<tr>
<td>S21</td>
<td>AB nurse*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S20</td>
<td>S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19</td>
<td></td>
<td>(162,281)</td>
</tr>
<tr>
<td>S19</td>
<td>TI retention</td>
<td></td>
<td>(4,098)</td>
</tr>
<tr>
<td>S18</td>
<td>TI engag*</td>
<td></td>
<td>(4,892)</td>
</tr>
<tr>
<td>S17</td>
<td>trust*</td>
<td></td>
<td>(20,434)</td>
</tr>
<tr>
<td>S16</td>
<td>professional-family relations*</td>
<td></td>
<td>(11,476)</td>
</tr>
<tr>
<td>S15</td>
<td>patient participation*</td>
<td></td>
<td>(2,290)</td>
</tr>
<tr>
<td>S14</td>
<td>patient acceptance of health care</td>
<td></td>
<td>(28)</td>
</tr>
<tr>
<td></td>
<td>Search modes - Boolean/Phrase</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>S13</td>
<td>nurse-patient relations*</td>
<td>View Results (19,893) View Details Edit</td>
<td></td>
</tr>
<tr>
<td>S12</td>
<td>attitude to health professional</td>
<td>View Results (862) View Details Edit</td>
<td></td>
</tr>
<tr>
<td>S11</td>
<td>attitude to health</td>
<td>View Results (41,519) View Details Edit</td>
<td></td>
</tr>
<tr>
<td>S10</td>
<td>AB accept*</td>
<td>View Results (38,325) View Details Edit</td>
<td></td>
</tr>
<tr>
<td>S9</td>
<td>AB retention</td>
<td>View Results (9,703) View Details Edit</td>
<td></td>
</tr>
<tr>
<td>S8</td>
<td>AB engag*</td>
<td>View Results (26,234) View Details Edit</td>
<td></td>
</tr>
<tr>
<td>S7</td>
<td>S2 OR S3 OR S4 OR S5</td>
<td>View Results (10,349) View Details Edit</td>
<td></td>
</tr>
<tr>
<td>S6</td>
<td>S1 OR S3 OR S4 OR S5</td>
<td>View Results (13,349) View Details Edit</td>
<td></td>
</tr>
<tr>
<td>S5</td>
<td>AB house call</td>
<td>View Results (105) View Details Edit</td>
<td></td>
</tr>
<tr>
<td>S4</td>
<td>AB health visit*</td>
<td>View Results (4,907) View Details Edit</td>
<td></td>
</tr>
<tr>
<td>S3</td>
<td>AB care visit*</td>
<td>View Results (4,030) View Details Edit</td>
<td></td>
</tr>
<tr>
<td>S2</td>
<td>AB home visit*</td>
<td>View Results (3,356) View Details Edit</td>
<td></td>
</tr>
<tr>
<td>S1</td>
<td>home visit*</td>
<td>View Results (6,482) View Details Edit</td>
<td></td>
</tr>
</tbody>
</table>
Health Evidence

Engagement AND Limit:

- Population = High Risk Group (e.g., adolescent parents, elderly, homeless, substance users), Low Socioeconomic Status
- Topic Area = Reproductive Health & Healthy Families

Returned 2 results

Grey Literature

<table>
<thead>
<tr>
<th>Source</th>
<th>Search Terms</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICE</td>
<td>Home visiting</td>
<td>Social and emotional wellbeing: early years <a href="https://www.nice.org.uk/guidance/ph40/resources/social-and-emotional-wellbeing-early-years-pdf-1996351221445">link</a></td>
</tr>
<tr>
<td>Google</td>
<td>Nurse perceptions of family home visiting programmes in Australia and England</td>
<td>Sustained home visiting for high risk families and children: A literature review of effective programs <a href="http://www.rch.org.au/uploadedFiles/Main/Content/ccch/resources_and_publications/Home_visiting_lit_review_programs_revised_Nov2012(1).pdf">link</a></td>
</tr>
<tr>
<td>Google</td>
<td>McDonald +“Sustained home visiting for high risk families and children”</td>
<td>Sustained home visiting for high risk families and children: A literature review of effective processes and strategies <a href="http://www.rch.org.au/uploadedFiles/Main/Content/ccch/resources_and_publications/Home_visiting_lit_review_RAH_processes_final.pdf">link</a></td>
</tr>
<tr>
<td>Google</td>
<td>Myfanwy MacDonald +Australia +parenting research centre</td>
<td>Are disadvantaged families “hard to reach”? Engaging disadvantaged families in child and family services <a href="https://aifs.gov.au/cfca/publications/are-disadvantaged-families-hard-reach-engaging-disadva">link</a></td>
</tr>
</tbody>
</table>

*Reference list identified Katz guideline
Appendix C: Literature Search Flowchart

What strategies engage high risk families in ongoing, active participation in home visiting programs?

(June 2016)

MEDLINE (704)
CINAHL (390)
Health Evidence (2)
NICE (1)
Google (3)

Total identified articles: 1100

Removal of duplicates (128)

Primary relevance assessment (972)

Not relevant (950)

Potentially relevant articles (22)

Primary studies (18)

Relevance assessment of full document (5)

 Reviewed reference list
1 new & relevant article

Not relevant (2)

Total relevant articles (3)

Guideline (1) Grey literature reports (2)

Quality assessment of relevant reports (3)

2 Strong 1 Moderate

Adapted from: healthevidence.org Keeping Track of Search Results: A Flowchart. [Retrieved January 13, 2010]
Appendix D: NICE adapted AACODS Checklist

1.9 Checklist: grey literature

<table>
<thead>
<tr>
<th>Study identification</th>
<th>Question no:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include author, title, reference, year of publication</td>
<td>Yes/Partly/No/Unclear/NA</td>
</tr>
</tbody>
</table>

| Guidance topic: | Checklist completed by: |

<table>
<thead>
<tr>
<th>Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying who is responsible for the intellectual content.</td>
</tr>
<tr>
<td>Individual author:</td>
</tr>
<tr>
<td>• Associated with a reputable organisation?</td>
</tr>
<tr>
<td>• Professional qualifications or considerable experience?</td>
</tr>
<tr>
<td>• Produced/published other work (grey/black) in the field?</td>
</tr>
<tr>
<td>• Recognised expert, identified in other sources?</td>
</tr>
<tr>
<td>• Cited by others? (use Google Scholar as a quick check)</td>
</tr>
<tr>
<td>• Higher degree student under 'expert' supervision?</td>
</tr>
<tr>
<td>Organisation or group:</td>
</tr>
<tr>
<td>• Is the organisation reputable? (e.g. WHO)</td>
</tr>
<tr>
<td>• Is the organisation an authority in the field?</td>
</tr>
</tbody>
</table>

| Does the item have a detailed reference list or bibliography? |

<table>
<thead>
<tr>
<th>Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the item have a clearly stated aim or brief?</td>
</tr>
<tr>
<td>Does the item meet its aims?</td>
</tr>
<tr>
<td>Does the item have a stated methodology?</td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Has the item been peer reviewed?</td>
</tr>
<tr>
<td>Has the item been edited by a reputable authority?</td>
</tr>
<tr>
<td>Is the item supported by authoritative, documented references or credible sources?</td>
</tr>
<tr>
<td>Is the item representative of work in the field?</td>
</tr>
<tr>
<td>If no, is it a valid counterbalance?</td>
</tr>
<tr>
<td>Is any data collection explicit and appropriate for the research?</td>
</tr>
<tr>
<td>If the item is secondary material (e.g. a policy brief of a technical report), does it provide an accurate, unbiased interpretation or analysis of the original document?</td>
</tr>
<tr>
<td><strong>Coverage</strong></td>
</tr>
<tr>
<td>Are any limits to the item clearly stated?</td>
</tr>
<tr>
<td><strong>Objectivity</strong></td>
</tr>
<tr>
<td>Is the author’s standpoint clear?</td>
</tr>
<tr>
<td>Does the work seem to be balanced in presentation?</td>
</tr>
<tr>
<td><strong>Date</strong></td>
</tr>
<tr>
<td>Does the item have a clearly stated date related to content?</td>
</tr>
<tr>
<td>If no date is given, but can be accurately ascertained, is there a valid reason for its absence?</td>
</tr>
<tr>
<td>Has key contemporary material been included in the bibliography?</td>
</tr>
<tr>
<td><strong>Significance</strong></td>
</tr>
<tr>
<td>Is the item meaningful (i.e. does it incorporate feasibility, utility and relevance)?</td>
</tr>
<tr>
<td>Does it add context?</td>
</tr>
<tr>
<td>Does it enrich or add something unique to the research?</td>
</tr>
<tr>
<td>Does it strengthen or refute a current position?</td>
</tr>
<tr>
<td>Would the research area be lesser without it?</td>
</tr>
<tr>
<td>Is it integral, representative, typical?</td>
</tr>
</tbody>
</table>
Notes for Checklist: grey literature

For all questions:

- answer ‘yes’ if the study fully meets the criterion
- answer ‘partly’ if the study largely meets the criterion but differs in some important respect
- answer ‘no’ if the study deviates substantively from the criterion
- answer ‘unclear’ if the report provides insufficient information to judge whether the study complies with the criterion
- answer ‘NA (not applicable)’ if the criterion is not relevant in a particular instance.

For ‘partly’ or ‘no’ responses, use the comments column to explain how the study deviates from the criterion.

Definition:

The Fourth International Conference on Grey Literature held in Washington, DC, in October 1999 defined grey literature as: ‘that which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers.’ [sic]

Grey literature includes theses or dissertations (reviewed by examiners who are subject specialists); conference papers (often peer-reviewed or presented by those with specialist knowledge) and various types of reports from those working in the field. All of these fall into the ‘expert opinion’.

Sources:

AACODS: archived at the Flinders Academic Commons.

Coverage:

All items have parameters that define their content coverage. These limits might mean that a work refers to a particular population group, or that it excluded certain types of publication. A report
could be designed to answer a particular question, or be based on statistics from a particular survey.

Objectivity:

It is important to identify bias, particularly if it is unstated or unacknowledged.

Date:

For the item to inform your research, it needs to have a date that confirms relevance. No easily discernible date is a strong concern.

Significance:

This is a value judgment of the item, in the context of the relevant research area.
## Appendix E: Data Extraction Tables

### DATA EXTRACTION FOR GUIDELINES

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Social and emotional wellbeing: early years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authors, Data, Country</td>
<td>National Institute for Health and Care Excellence (NICE), 2012 UK</td>
</tr>
<tr>
<td>AGREE II Quality Assessment</td>
<td>Strong (6/7) and recommended for use by three independent appraisers (DT, MY &amp; JM). The guideline scored well on scope and purpose, stakeholder involvement, rigour of development and clarity of presentation. Information was missing for applicability or editorial independence. There were no statements on monitoring criteria or that the views of the funding body did not influence the content of the guideline.</td>
</tr>
</tbody>
</table>

### Details of the guideline

<table>
<thead>
<tr>
<th>Focus &amp; Objective(s)</th>
<th>To define how the social and emotional wellbeing of high risk children aged under 5 years can be supported through home visiting, childcare and early education.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Audience</td>
<td>The guidance is for all those responsible for ensuring the social and emotional wellbeing of children under 5 years of age. This includes those planning and commissioning children's services in local authorities (including education), the NHS, and the community, voluntary and private sectors. It also includes: GPs, health visitors, midwives, psychologists and other health practitioners, social workers, teachers and those working in all early years settings (including childminders and those working in children's centres and nurseries).</td>
</tr>
</tbody>
</table>

### Included Evidence

The evidence in the guideline includes: 2 reviews of the evidence on effectiveness (effectiveness of home visiting and family based interventions; effectiveness of delivery and implementation of home visiting and family based interventions); and early education and child care interventions, a review of risk factors, economic modelling, the testimony of expert witnesses and commissioned reports.

Included evidence was assessed for quality (++: All or most of the criteria have been fulfilled; +: some of the criteria have been fulfilled; - : few or no criteria fulfilled. The conclusions of the study are thought likely or very likely to alter).

### Details of interventions included in the guideline

<table>
<thead>
<tr>
<th>Population</th>
<th>High risk children aged under 5 years and their parents. The term 'high risk' is used to describe children who are at risk of, or who are experiencing, social and emotional problems and who need additional support.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventions</td>
<td>Antenatal and postnatal:</td>
</tr>
<tr>
<td></td>
<td>• Home visiting</td>
</tr>
<tr>
<td></td>
<td>• Early education</td>
</tr>
<tr>
<td></td>
<td>• Childcare</td>
</tr>
</tbody>
</table>

### Outcomes

Social and emotional wellbeing

### Results of the guideline

<table>
<thead>
<tr>
<th>Relevant Recommendations</th>
<th>Recommendation 3: Antenatal and postnatal home visiting for high risk children and their families (p.13-14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Health visitors or midwives should offer a series of intensive home visits by an appropriately trained nurse to parents assessed to be in need of additional</td>
</tr>
</tbody>
</table>
relevant to engagement in home visiting were extracted

<table>
<thead>
<tr>
<th>Evidence supporting relevant recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: Only findings relevant to engagement in home visiting were extracted (p.59-64)</td>
</tr>
</tbody>
</table>

From evidence review #2, *Promoting the social and emotional wellbeing of high risk pre-school children (0-5 yrs): UK evidence review*, which provides evaluation studies on the effectiveness of early years programs and interventions to promote social and emotional health and process studies on factors influencing the effectiveness of delivery and implementation of interventions.

**Evidence statement 2.PS1: Engaging families and the take up of early interventions services**

Overall

Moderate evidence from ten papers suggests that the uptake of early interventions among high risk families is influenced by mothers' perception of benefits, timely provision of information about the interventions, personal circumstances and views, the reputation of the services, recruitment procedures, perceptions about quality of interventions.

Mothers' perception of benefits

Five papers (four [+] and one [-]) reported that a perceived lack of need influenced parents’ decision not to take up home visiting. In some cases their needs were seen

---

<viii>It is not clear from current evidence how many home visits are needed. The Family Nurse Partnership, an evidence-based, intensive home visiting programme, provides weekly or fortnightly home visits for 60–90 minutes throughout most stages of the programme (with more in the early stages and less later).</viii>
as being fulfilled by support from friends, family, or other services. The 'wrong type of support' was described by one (+) paper with parents needing practical support rather than other support.

**Timely provision of information about the interventions**

Parental lack of knowledge regarding the content and potential benefits of available services was reported in four papers (three [+ ] and one [- ]). One good quality (+) paper described how mothers were unclear regarding what a programme offered, with women not understanding or not remembering information. Some women reported that the offer of the programme might have been preferred after the birth of their baby.

**Personal circumstances and views**

Two (+) papers described the influence of personal choice with some women changing their minds or not being interested in a programme, and one (+) paper highlighted that needs changed over time. Waiting lists for interventions meant that some women no longer needed the service when it was offered to them.

Three papers of mixed quality (one [-] and two [+]) described the influence of personal circumstances and views in influencing uptake. These included personal and family reasons and perceived cultural and language differences. Personal choice may also be influenced by the confidence levels of parents. Two papers (both [+]) described how personal time factors could present barriers to uptake; with difficulty fitting the intervention into a personal routine or multiple demands.

**Recruitment procedures**

Four mixed quality papers (two [+ ] and two [-]) highlighted the importance of marketing, outreach, and recruitment processes for programmes. Studies suggested the use of key workers and targeted publicity, door-knocking, making use of referral partners and ongoing invitations. Two good quality papers (both [+]) suggested the influence of the reputation of early education programmes in uptake. The reputation and feedback from other parents could be influential, and also a perceived stigma that services were 'for certain groups'.

**Perceptions about quality of interventions**

Two good quality papers (both [+]) described parental worries regarding staff prying into their personal lives and concerns for their child.

**Evidence statement 2.PS2: Parents experience of services and ongoing engagement in early interventions**

**Overall**

Moderate evidence from eleven papers suggests that ongoing engagement with early interventions among high risk families is influenced by timing of the programme, the involvement of parents and personal reasons.

**Timing of the programme**

Three papers (all [+]) highlighted that making a large time commitment to in-home support programmes could be a barrier to engagement. One (+) paper reported that parents did not like the frequency of visits or fragmented visits. The timing of visits was noted as a problem in one (+) study with mothers feeling disrupted by the timing and scheduling of visits. Two studies (one [+ ] and one [-]) reported that flexibility on the part of the visitor to the needs of the client to ensure the service
was delivered at a suitable time, was key.

**The involvement of parents**

One (+) paper suggested that a home visitor should be proactive in recognising warning signs of losing a client, offering the family a break from the programme, changing the content delivered, and working with families to meet their needs and achieve goals. Another (+) paper highlighted that it made it easier for families to engage in other services once they were taking part in one programme.

**Personal reasons**

Four (all [+] papers described personal reasons for not engaging with a service such as losing interest in the programme, missing too many appointments, moving out of the area, infant illness and other commitments.

**Evidence statement 2.PS3: Home-based interventions and staff-parent relationships**

**Overall**

Moderate evidence from eight papers suggests that the nature of the relationship between staff and parents is an important factor influencing the ongoing engagement of high risk families in home-based interventions.

The importance of building relationships was highlighted in six papers (five [+] and one [-]) with regular interaction resulting in parents feeling at ease and being able to 'open up', and with home visitors acting as a mentor, friend, and teacher. Women reported that they liked that home visitors did not impose their views, and took an honest, open, humane and egalitarian approach. Some younger women however reportedly viewed a health visitor intervention as somewhat authoritarian, almost like advice from parents and some women were worried about how they may be perceived by home visitors, believing that they were being checked up on, and were concerned about visitors passing judgment on their lifestyle and parenting skills. One (+) paper found fathers were pleased with the programme but took a few sessions to become engaged.

Support was a theme described in all six papers. Parents reported that having someone there to listen and provide additional support was beneficial, visitors offered assistance in difficult times, allowed parents to vent frustrations, and encouraged parents to develop life skills and confidence.

Parents valued the support of a peer home visitor, especially if they had little existing social support, with some women describing how they were reluctant to seek emotional support from family or friends.
DATA EXTRACTION FOR GREY LITERATURE REPORT

Grey Literature Report
Sustained nurse home visiting for families and children: A review of effective processes and strategies
http://www.rch.org.au/uploadedFiles/Main/Content/cccchdev/CCCH-right@home-LR1-May-processes-2012.pdf

Authors, Date, Country
Moore TG, McDonald M, Sanjeevan S, Price A, 2012 Australia

ACCODS Quality Assessment ‘Strong’ (5/6) quality assessment and recommended for use by two independent appraisers (DT & JM). The report received partial scores for accuracy and coverage (i.e., limits and inclusion criteria).

Details of the report
Focus & Objective(s)
To identify service delivery process features that are associated with better outcomes for families, as well as identify effective ways of engaging and working with parents and families who are experiencing adversity.

Target Audience
Practitioners, service managers and policy makers who work with families with complex and multiple problems.

Included Evidence
Data was extracted from 11 articles (single studies, reports and a policy brief) on effective strategies for engaging and retaining families experiencing adversity. While no detail or quality on individual studies is provided, references ranged from 1982-2012 and the reference list is extensive.

Details of interventions included in the report
Population
The review authors identified that the population included prenatal women to children 5 years of age, but predominantly studies were on children aged 2-3 years old.

Interventions
- Relationship building
- Partnerships between professionals and parents
- Goal-setting, providing choices
- Building parental competencies
- Providing sensitive care (e.g., cultural awareness)
- Program design features (e.g., continuity of care)

Outcomes
This report focused on engaging and retaining families experiencing adversity.

Findings from the report

Relevant Strategies
Note: Only findings relevant to engagement in home visiting programs were extracted

Effective strategies for engaging and retaining families experiencing adversity (p.42-50)

Best practices in engaging families experiencing adversity using community-based intervention services: (1 policy brief)
- Use strength-based approaches
- Use solution-focused strategies
- Use family-centred practices
- Be culturally responsive
- Be relationship-based
- Provide accessible and family-friendly environments.

Required qualities of the nurse to bring to the relationship with the parent and family (1 study)

Phases of the relationship:
- Entry work. Entry work is the process of obtaining access to the client and the home. Facilitating factors include the nurse having met the mother antenatally, addressing identified needs or problems and previous positive client experiences with health visitors. Blocking factors included clients’ perceptions that the visiting service was not required or if they did not value the service provided.
- Getting to know the client. The aim is for the nurse to identify the position and
base beliefs of the client so that suggestions made are compatible with the perceptions and values of the client. Nurses’ tolerance of diversity in their clients, acceptance of individual client values and receptiveness to a broad range of perceived needs were important in establishing a relationship.

- **Setting in the relationship.** Three conditions are central to the process of setting up the relationship:
  - Legitimacy (convincing the client that the service is of value to them in order to warrant continuing contact)
  - Normalcy (compatible views on basic principles and values between the nurse and client)
  - Activity (agreement on how the actions will proceed).

The establishment of trust also enables the client to open up and express their needs.

- **Developing mutual trust and creating connectedness.** One study found that mothers judged a nurses’ trustworthiness according to whether they perceived the nurse as reliable, whether they maintained their confidentiality and were accepting. Those who did not possess the aforementioned qualities were perceived as not interested, bureaucratic or judgmental. Mothers felt more connected when they felt the nurse had experienced similar personal situations to themselves.

**Effective general strategies for supporting families** (3 reports, 3 studies)

Qualities of patient-provider relationships (2 studies)
- Continuity of the patient-provider relationship
- Effective communication
- Demonstration of caring
- Perceived competence
- Establish a positive, non-judgmental relationship with all children and parents
- Proactively engage and sensitively follow-up with children and parents who are at risk of ‘dropping out’

Based on the limited empirical evidence and ‘practice wisdom’, antenatal and universal early childhood services need to: (1 study)
- Be affordable and well publicized
- Be geographically accessible
- Provide outreach and support with transport
- Provide a family-friendly and culturally inclusive physical environment
- Employ skilled and responsive staff working from a family-centred, culturally sensitive perspective
- Promote social connectedness through informal supports
- Establish strong reciprocal links with other relevant services (universal and specialist).

Services can be most helpful to families who are experiencing adversity through: (1 study)
- **Diversity of forms of support.** There is a need to preserve a diversity of support because people use informal, semi-formal and formal services for different reasons.
- **Role of formal services.** The formal service sector has continuing relevance especially to the families experiencing greatest adversity.
- **Need for multi-level interventions.** Multiple risk factor situations mean that strategies to address these accumulated and complex situations need to be
multi-level to be effective. Support to families in poor environments needs to operate on a number of dimensions, tackling stressors simultaneously at the individual, the family and the community level.

- **Danger of ‘negative’ support.** The concept of ‘negative support’ may be very useful in understanding why parents do and do not access different sorts of help and support in parenting. There were strong indications that ‘support’ is not always perceived in an entirely positive light; there is a fine dividing line between help and interference. Losing control over one’s life (and one’s children) was perceived by parents to be a possible consequence of asking for help or support.

- **Helping parents to feel in control.** The best way to support parents in poor environments is to ensure that parents feel in control of the type of support they receive and the way in which it is delivered. External support that appears to undermine parents’ autonomy and which steps over the fine line that divides ‘help’ from ‘interference’ can end up being experienced as negative rather than positive and may simply add to, rather than relieve, stress.

**Strategies to recruit and re-engage participants** (1 report)

- Do not unduly pressure into participation, but offer program entry at a later stage if possible
- Aim for a high profile of the offered/advertised program services in the local community
- Conduct initial assessments in person, if possible in the participant’s home
- Follow-up each failed appointment by reminders in form of telephone, letter, or personal contact to ascertain reasons, to pass on homework and relevant information, and to convey the desire and expectation of meeting the participant at the next session
- Note down as many contact addresses/telephone numbers as possible, as participants (e.g., teenage mothers) may have mobile living arrangements (e.g., home, relatives’ and friends’ addresses, shelters, etc.).

**Strategies to minimize perceptual barriers to participation** (1 report)

- Establish a therapeutic alliance, conveying trustworthiness, commitment, confidentiality, empathy, partnership, etc.; avoid any changes, especially frequent changes, of the assigned personal intervener/therapist as this undermines the formation of a trusting relationship; do not mislead/disappoint participants by promises you cannot keep
- Involve the participants in decision-making relating to therapeutic aims/goals (e.g., find out what participants want, need, expect, and understand)
- Adopt a non-judgemental, non-threatening, non-expert approach (e.g., avoid the “I know what’s best for you” stance) by acknowledging that parents are the experts of their own life and children and have coped to their best ability however, note that some clients may prefer a confident, directive style, if they feel too overwhelmed to make any contributions on their own or if they perceive self-participation as weakness or incompetence on behalf of the therapist;
- Consider the cognitive ability of the participant when communicating (e.g., style of language, terminology, repetitions, rephrasing)
- Examine whether program advertising and attendance is stigmatizing in the eyes of participants or the local community
- Adopt a culturally and ethnically aware approach in terms of issues, customs, ethnic background of interveners and communication (e.g., interpreters)
- Provide a coherent and transparent case-management approach that links therapeutic, health, social and educational services, thereby minimizing bureaucracy, confusion and communication failures or lengthy waiting times
- Train, support and supervise interveners and researchers sufficiently to be able
to cope safely and effectively with the client problems and resistance they encounter.

**Strategies to minimize structural barriers to participation** (1 report)

- Reward participants in form of money, gifts, vouchers etc. for attendance of sessions or research assessments
- Provide free transport to sessions or ensure that the therapeutic base is in a central, convenient location
- Provide flexible timetables or opening hours (e.g., including evenings and weekends) that also enable working parents and fathers to attend
- Conduct home visits for participants’ convenience or to gain further insights into the clients’ life circumstances
- Provide an inviting, comfortable environment
- Provide childcare facilities if the child(ren) or siblings are not to be involved in the sessions
- Provide attractive meals and snacks on the premises or other useful services (e.g., laundry or nearly new toys, furniture and clothes exchange facilities)
- Provide crisis intervention, e.g., referral or backup services related to housing, health, financial difficulties, partner violence or other problems.

Program features: (1 report analyzing 57 intervention programs)

- **Safe, comfortable, non-stigmatising venues.** Programs repeatedly highlighted the importance of a welcoming, informal and safe environment.
- **Multiple, intensive, targeted recruitment and retention strategies for hard-to-reach populations.** Multiple recruitment strategies are needed to engage hard-to-reach populations, such as culturally and linguistically diverse individuals and families, young parents, fathers, Indigenous families and families with complex and multiple needs. The recruitment practices targeting hard-to-reach populations in this collection are a combination of both formal (e.g., approaching community leaders, other community organisations, advertising in local newspapers) and informal methods (e.g., door knocks, distributing flyers at shopping centres, chemists, community events, advertising in shopfronts, etc.).

For practices dealing with young parents, intensive and targeted recruitment processes are employed, involving home visits, personal approach, follow-up and individual, one-to-one support. Using peer educators and experienced/mature mentors are also effective in retaining young parents in the programs, together with using less structured programs and welcoming spaces (which also works with Indigenous and socially isolated families).

Among the socially excluded (young parents, parents with multiple needs and parents from communities experiencing considerable disadvantage), a facilitation approach that gives clients a voice in program activities and outcomes, empowers the parents and enhances program commitment. This approach ensures that the activities within the program respond to the needs and priorities of the families. Responding to the multiple needs of parents (in particular young parents) through parent education, home visiting and support, and connecting families to services (e.g., child care, education, etc.) produces positive outcomes.

- **Soft entry points.** Universal services are widely used to provide an important soft entry point of first contact, where parents can access support to more specialized services. Attaching targeted services to other, universally available services – such as schools, maternal and child health centres, churches, libraries and health clinics – is effective in engaging and working with hard-to-reach...
• **Culturally specific approaches.** In order to be responsive to the needs of culturally and linguistically diverse families and Indigenous families, service users are matched with staff/volunteers from similar cultural backgrounds.

• **Interagency and intersectoral collaboration and cooperation.** A whole-of-community approach that builds on existing services within the local community optimizes the use of institutional and human resources within the community.

• **Active assistance with access.** Lack of access to services imposed by distance and lack of transport is addressed by some programs through outreach services, using multimedia technologies to meet the needs of children with additional needs living in rural and remote areas, providing transport, implementing a hub-and-spoke approach to service delivery and through the establishment of learning hubs to deliver more specialized services.

• **Building relationships and establishing trust.** A recurring theme was the importance of relationship-building and rapport between workers and clients, which is thought to emanate from a strengths-based practice approach. An integral component of relationship building is trust. The cultivation of trust was acknowledged to be one (if not the key) ingredient to program effectiveness across the programs. Offering practical support that responds to parents’ most immediate needs is essential in winning and establishing trust and retaining contact with these families. Individual support offered during home visits is an essential ingredient in trust-building, particularly for Indigenous young mothers.

### Relationship building with the parent (1 study)

- Parents engage with public health nurses and family visitors through a basic social process of limiting family vulnerability, which has three phases: overcoming fear, building trust, and seeking mutuality. The personal characteristics, values, experiences and actions of the nurse and the mother determine the time it takes to negotiate each phase and ultimately to develop a connected relationship. Given the importance that mothers place on the development of an interpersonal relationship, it is important for home visitors continually assess the quality of their relationships with clients.
<table>
<thead>
<tr>
<th><strong>DATA EXTRACTION FOR GREY LITERATURE REPORT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authors, Data, Country</strong></td>
</tr>
<tr>
<td><strong>AACODS Quality Assessment</strong></td>
</tr>
</tbody>
</table>

### Details of the report

| **Focus & Objective(s)** | To provide practical lessons and interventions for working with families (including children 0-5 years of age) with multiple and complex problems. |
| **Target Audience** | Practitioners, service managers and policy makers who work with families with complex and multiple problems. |
| **Included Evidence** | Primarily included research reviews which were supplemented with primary research papers: 10 reports, 5 reviews, 2 books, and 3 primary studies. While no detail or quality on individual studies is provided, most of the literature was from the United States, but extra effort was made to incorporate Australian research. |

### Details of interventions included in the report

| **Population** | Families with children aged 0-5 years who are experiencing multiple problems, which might be problems for the parents, for the children, or for the whole family. Examples of problems include problems relating to housing, finances, ill health, childcare, substance abuse, family violence and abuse, poor educational outcomes, truancy. |
| **Interventions** | • assessment of client needs and responding to them (e.g., focus on the needs of parents and children)  
• building relationships  
• strategies to increase recruitment (e.g., multiple gateways for program entry)  
• strategies to address retention and dropping out (e.g., frequent contact with participants)  
• program design (e.g., length of sessions) |
| **Outcome** | Recruitment and retention in home visiting programs |

### Findings from the Report

**Practice Lessons on Retention and Engagement** (3 reviews, 4 reports, 1 book; methodological quality is unknown)

Parents should:
- be encouraged initially and throughout the program or service to participate
- be treated as full participants in the process
- have the opportunity to use services or programs during key ‘transition’ times, for example just after having a baby
- be treated in non-stigmatizing, supportive ways.

Strategies for practitioners and agencies to increase uptake and retention include the following:
- ‘tweaking’ program design to improve uptake and retention: for example, changing length or order of sessions
- adopt a strengths-based approach: focus on skills and proficiency rather than shortfalls
- ensure eligibility criteria for entry to programs or services are not excluding those...
who could benefit
- allow time for recruitment
- build workforce capacity, especially through experienced and trained staff
- ensure a quick response after initial referrals
- follow up in the absence of a response: at least three phone calls
- frequent contact, either through meetings or follow up phone calls
- ensure that goals and aims are communicated clearly
- focus on the needs of parents and children: ensure that support for the parent as well as the child is perceived
- have multiple gateways into a service, so there are plenty of opportunities for referral or finding out about the program or service
- community outreach, for example, home visits
- use a trusted organization or worker as an ‘ambassador’ for the new program or service
- evaluate outcomes not throughput.

**Practice Lessons on Implementation** (1 review, 5 reports; methodological quality is unknown)
Strategies for practitioners and agencies include the following:
- build trusting relationships that empower participants
- active engagement and responding to individual circumstances as required
- provision of support early on by providing concrete services, for example buying nappies
- use interactive models of learning that value parents’ own ideas and experience
- develop relationships with other agencies: ease of referrals and access to other services is critical
- verbal encouragement and non-punitive communication.