Adolescent Pregnancy Prevention in Group Homes: Recruiting and Retention Considerations

Youths in child welfare and juvenile justice systems participate in sexual risk behaviors at higher rates and are greater risk for pregnancy than the general youth population.[1,2] However, evidence-based interventions addressing the unique needs of this population are lacking. In 2010, the Oklahoma Institute for Child Advocacy was funded to implement and evaluate the Power Through Choices (PTC) adolescent pregnancy prevention intervention. The PTC intervention is a 10-session sexual health education curriculum designed specifically for youths aged 13 to 18 years who are involved in the foster care and juvenile justice systems. The PTC study was one of seven projects that participated in the Evaluation of Adolescent Pregnancy Prevention Approaches study, a major federal effort to provide empirical evidence regarding effective interventions to reduce adolescent pregnancy in the United States.

The PTC study is a cluster randomized controlled trial involving youths (n = 1036) recruited from 44 residential group homes in California (n = 19 homes), Maryland (n = 10 homes), and Oklahoma (n = 15 homes). We collected data from youths at baseline, immediately after the intervention, and 6 and 12 months after the intervention. We designed the PTC study to assess short- and long-term outcomes as well as potential psychosocial mediators of behavior change. Full details on the study protocol and findings are reported elsewhere.[3–5]

Lessons learned from the study can inform future sexual health research of system-involved youths in the areas of recruiting group homes and youth participants, and tracking and retaining a mobile population.

RECRUITING GROUP HOMES AND YOUTH PARTICIPANTS

Recruiting group care homes for study participation typically involved a 6-month period of planning and relationship building. The first step was to contact the state child welfare and juvenile justice agencies responsible for the homes. The project coordinator explained the PTC intervention and evaluation to the supervising agencies including how the intervention might meet the organization's mandate to deliver independent living skills. Gaining support from the supervising agencies was critical for recruitment of the individual group care homes. Of the 72 eligible homes, 44 (61%) homes participated in the study. Major reasons for homes not participating were resistance to sexuality education that was not abstinence-only based, too few youths in the target age range, and challenges addressing scheduling demands within the residential setting.

In addition, early in the study, some homes initially opted not to participate because of the chance they could serve as a control group home for the entire study. The research team decided to allow homes to be re-randomized to treatment or control after all participants aged out of or were removed from the home. Other evaluation approaches, such as the stepped-wedge design, allow all study participants to eventually receive the intervention, and the design may be the best option when there is only a small number of clusters available for randomization.[6] However, the stepped-wedge design takes considerably longer to execute because each cluster serves as a control before receiving the intervention.[6]

Another potential issue specific to our study is that, compared with when youths were in the control condition, youths are older when they receive the intervention, which is problematic because sexual risk behaviors increase with age. Therefore, studies with long interventions or follow-ups and outcomes that increase with age may not be well-suited for the stepped-wedge design. We chose the cluster randomized controlled design because we had a sufficient cluster of homes to randomize, an opportunity to re-randomize, and we followed the youths for 12 months after the intervention for data collection purposes. Future studies with system-involved youths will need to carefully consider the most feasible and ethical approach to ensure that all group care homes have an opportunity to participate in the intervention.

We anticipated substantial issues related to obtaining adult consent for the youths' participation in the study. Obtaining adult consent was particularly challenging and time consuming because the youths were living in the group homes with no readily available parent or other adult with authority to provide consent. Therefore, consent was typically obtained from the

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youth's legally authorized representative who often was the youth's caseworker. The strategies we employed to obtain consent were collaborating with state child welfare or juvenile justice systems to identify a single contact authorized as a legally authorized representative to sign consents for all youths in a home; negotiating to have a state communication system send out notification to all agency caseworkers giving permission to sign consent forms; and, when parental consent was required, embedding the consent process into group-home intake procedures. Streamlining the consent process was beneficial as only 22 eligible youths did not have legally authorized representative or parental consent and 98% of eligible youths assented to participate in the study.

TRACKING AND RETAINING A MOBILE STUDY POPULATION

The PTC study participants were challenging to retain in the study for several reasons, such as youths aging out of the system or being incarcerated. In addition, more than half of the youths in the PTC study were in the juvenile justice system.[5] These youths were often in the group homes for a shorter time and typically did not have the same ongoing interaction with a caseworker compared with youths in the child welfare system. Despite multiple challenges, the retention rates were 92%, 82%, and 85% for the immediate postintervention, 6-month, and 12-month surveys, respectively. Seventy-three percent of the youths completed all 4 surveys.

We employed several strategies to track and retain this mobile population. We worked closely with caseworkers who often provided updated contact information to assist data collectors with tracking and retaining the youths. Group home staff were also important as they helped schedule data collection for the most opportune time of the day when youths would be present and they encouraged youths to attend data collection sessions. Data collection staff brought snacks and project promotional items for group home staff as well as for youth participants every time they visited a group home. Conversation during the visits helped to establish rapport, gain support for the study, and obtain valuable information—for example, that specific youths would soon be discharged or moved to another home.

Numerous other strategies contributed to our high retention rate.[7] However, the single most important factor was the hiring, training, and retention of staff who were dedicated to retention activities. The importance of a high participant retention rate for study validity was thoroughly explained and emphasized to retention staff. It was also very beneficial that these individuals possessed excellent social skills as well as persistence and a detailed-oriented personality necessary to consistently execute the retention protocol. In addition, it was essential to limit turnover of retention staff. Staff turnover not only leads to a gap in retention activities but also requires repeating staff training and re-establishing rapport with group home staff, caseworkers, and study participants. During this time, youths may be lost to follow-up.

In summary, the PTC study was able to effectively evaluate an adolescent pregnancy intervention with a vulnerable and difficult-to-reach population by implementing innovative recruitment and tracking procedures. Youths living in out-of-home settings in child welfare and juvenile justice systems have complex lives. Future research should consider assessing additional factors specific to system-involved youths, such as exposure to adverse childhood experiences, to more fully characterize the population and evaluate the potential impact of childhood trauma and the level of system involvement on an intervention's effectiveness. AJPH

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