Document Title:	**An Experimental Evaluation of a Family Strengthening Intervention to Enhance Post-release Adjustment for Reentering Fathers and Improve Child Well-Being**
Author(s):	**Mindy E. Scott, Ph.D., Kimberly Turner, Ph.D., Heather Wasik, April Wilson, Ph.D., Jenita Parekh, Ph.D., M.P.H., Elizabeth Karberg, Ph.D., Makedah Johnson**
Document Number:	**250568**
Date Received:	**February 2017**
Award Number:	**2009-IJ-CX-0009**

SUMMARY OVERVIEW
Submitted to: The National Institute of Justice (NIJ)

Project Title: An Experimental Evaluation of a Family Strengthening Intervention to Enhance Post-release Adjustment for Reentering Fathers and Improve Child Well-Being

Award #: 2009-IJ-CX-0009

Submission Date: December 30, 2016

Authors:
Mindy E. Scott, Deputy Program Area Director, PhD
Phone: 240-223-9324, Email: mscott@childtrends.org

Kimberly Turner, Research Scientist, PhD
Phone: 240-223-9223, Email: kturner@childtrends.org

Heather Wasik, Research Analyst
Phone: (240) 223-9317, Email: hfish@childtrends.org

April Wilson, Research Scientist, PhD
Phone: 240-223-9271, Email: awilson@childtrends.org

Jenita Parekh, Research Scientist, PhD, MPH
Phone: (240) 223-9375, Email: jparekh@childtrends.org

Elizabeth Karberg, Research Scientist, PhD
Phone: 240-223-9336, Email: ekarberg@childtrends.org

Makedah Johnson, Research Assistant
Phone: 240-223-9328, Email: mjohnson@childtrends.org

Grantee Address:
Child Trends
7315 Wisconsin Ave, Suite 1200W
Bethesda, MD 20814

This project was supported by Award No. 2009-IJ-CX-0009 awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions, or recommendations expressed in this publication are those of the authors and do not necessarily reflect those of the Department of Justice.

Executive Summary

In 2009, the National Institute of Justice awarded Child Trends a grant to conduct an experimental evaluation of the Strengthening Families Program for Parents and Youth 10-14 (SFP) for fathers returning from prison. The SFP is a seven-session intervention aimed at improving family relationships, parenting skills, and social and life skills among youth ages 10 to 14, and has been found to be effective among low-income families. However, this intervention has not been evaluated with a reentering population. The current evaluation focused on assessing the impact of adding a family-focused intervention to existing reentry services for fathers residing in the Midwestern part of the United States that traditionally focus on job training and economic stability.

Paternal incarceration has been found to have negative consequences for children at all developmental stages, resulting in negative emotional and behavioral functioning with implications for long-term well-being and achievement, as well as a higher risk of criminality. Despite growing evidence of the negative implications of parental incarceration for both children and parents and the challenges associated with prisoner reentry, few family-focused reentry programs have been rigorously evaluated. This study addresses this important gap in the scientific knowledge by testing the impacts of a family strengthening intervention for reentering fathers and their children. This report presents key findings from the evaluation including information on the demographics of the families in the program, the program's implementation and effectiveness, and recommendations for improving future family strengthening programs for reentering fathers and their families.

Study Findings

Eighty families participated in the SFP evaluation, including 80 fathers, 55 other caregivers, and 80 children. About half of the fathers lived with the participating child, and more than half of the participating caregivers were the biological mothers of the participating child. Participating fathers reported stable living arrangements and generally good health, but also tended to be unemployed and reported high levels of family stress at the beginning of the study. While incarcerated, the great majority of fathers (86 percent) had some contact (verbal, written, or, less frequently, in-person) with their children.

Taken together, participants—fathers, caregivers, and youth—assigned to the SFP treatment group fared better on some outcomes and not as well on others, relative to those in the control group when tested at 7 weeks and 6 months after beginning the intervention. For example, fathers in the treatment group had better overall well-being than those in the control group, but nonresident fathers in the treatment group tended to report less engagement with their children than those in the control group. Differences were not always statistically significant (likely due to small sample sizes). However, effect sizes suggest potentially moderate associations between participation in the SFP intervention and outcomes for fathers, caregivers, and youth. The most notable impact findings include:

- SFP fathers were more likely to be employed and to pay child support seven weeks after the program began, compared with fathers assigned to the control group.

- Caregivers in the treatment group reported closer relationships with the participating child six months after the program began.
- Although fathers in the treatment group reported less contact with children, youth in the intervention reported more frequent contact with nonresident fathers compared to youth in the control group.
- Fathers receiving the SFP tended to report less in-kind support (e.g., buying clothes, paying for medical expenses) for their child after participating in the program. However, this may be counterbalanced by an observed increase in formal child support payments among treatment group fathers. It might also reflect SFP fathers rating themselves lower on certain outcome measures like provision of in-kind support because they had raised their standards for themselves after participating in the program.

A process evaluation was also conducted to better describe the intervention, to address barriers and facilitators to program participation, and to assess father and caregivers' perspectives regarding successful intervention components and implementation approaches. These findings are important for informing and promoting successful program sustainability and replication. Some key themes from the process study include:

- Fathers and caregivers felt that they learned valuable interpersonal skills through the SFP, including improved communication skills and strategies for setting boundaries and thinking before reacting.
- Both fathers and caregivers felt that a missing component of the intervention was a focus on the stability and quality of the relationship between fathers and caregivers.
- About one third (30 percent) of fathers randomly assigned to the SFP were unable to attend the program and only 25 percent completed all sessions due to work conflicts and other conflicts such as family illness and other family obligations. However, most fathers made substantial efforts to attend the majority of sessions, and retention rates for both fathers and caregivers improved over time.

Study Conclusions, Limitations, and Recommendations

The findings from the SFP evaluation point to a number of conclusions and recommendations, though small sample sizes, low attendance, and high attrition limit the interpretation of findings:

- Positive results were observed in the impact and process evaluations despite challenges recruiting families into the program. It may be that barriers to enrollment (e.g. probation restrictions that prevented fathers from attending on weekends, caregiver refusal for children to participate) may have excluded some fathers who could benefit most from the program, and a greater number of significant results in this study would likely have occurred with a larger sample size.
- Other program components that may promote participant engagement in family strengthening programs include providing transportation, offering flexible program sessions or makeup sessions, and providing more out-of-class activities for families.
- Study limitations include small sample sizes with only 40 treatment and 40 control families, despite ongoing adjustments to improve recruitment and retention. Among those

who did enroll, low attendance was a challenge, though it did improve over time. Finally, attrition limited sample sizes even further.34 percent of fathers did not complete the 7-week follow-up and 48 percent did not complete the 6-month follow-up. Although these limitations reduce the utility of the findings for criminal justice policy and practice, others in the field implementing and evaluating similar interventions can learn from this study to ensure that future programming sufficiently recognizes and addresses barriers to reentering fathers' participation in family strengthening programs.

- The process evaluation provides other (preliminary) data that can help shape future studies. For example, the focus groups suggested that fathers overall found the program to be engaging and an important source of support, which helped them improve their relationship with their child. However, it is also evident that fathers and caregivers both found that the communication dynamics between parents/caregivers were not adequately addressed in the program. Future interventions that address parents' relationship dynamics (co-parenting and romantic) may be more successful in engaging both fathers and caregivers.
- In the future, program participation might be even greater if family strengthening services were institutionally recognized by organizations that work with parents returning from prison and better integrated with other reentry services. Supporting family relationships after incarceration can benefit fathers, children, and families. Therefore, more reentry organizations may want to consider adding a family component to more traditional reentry services as a way to further secure fathers' role in the lives of their children and to promote father and child well-being and overall family functioning.

Background

The incarceration of a parent or guardian is an adverse childhood experience—a potentially traumatic event that can have negative, lasting effects on health and well-being.[i] An overwhelming majority (99 percent) of incarcerated parents are fathers.[ii] Research suggests that paternal incarceration increases internalizing and externalizing behavior problems[iii] among children and adolescents, including antisocial and delinquent behaviors,[iv,v] and is associated with adverse academic outcomes, including lower non-cognitive school readiness among boys[vi] and early grade retention (not promoting a child to the next grade).[vii] Paternal incarceration is also associated with adverse outcomes in early adulthood. Young adults who had an incarcerated father in childhood have lower levels of educational attainment[viii] and experience poorer mental health outcomes, including an increased incidence of depression, post-traumatic stress disorder, and anxiety.[ix]

A growing body of evidence suggests that when fathers are positively involved with their children, such as frequently playing with younger children[x] and talking through decisions and problems with older children,[xi] their children have fewer internalizing and externalizing behavior problems.[xii] Paternal involvement may be particularly important to promote among fathers who do not live with their children because studies consistently find there is more variability in nonresident father involvement than in resident father involvement.[xiii,xiv] There is a strong correlation between incarceration and father-child nonresidence. While only 36 percent of incarcerated fathers lived with their children in the month before their arrest,[xv] even fewer move back into their children's homes after release. Therefore, it is of critical importance to support father-child relationships during incarceration and after release.

Fathers who lived with their children prior to incarceration are more likely to have contact (e.g., telephone, mail, personal visits) with their children while in prison (86 percent of fathers in prison); half of these fathers had at least weekly contact with their children. Fathers who did not live with their children before their incarceration were less likely to have any or weekly contact with their children.[xv] Formerly incarcerated nonresidential fathers were also significantly less likely to see their children than other nonresidential fathers. Yet, more than 40 percent of mothers reported that their children's nonresidential, formerly incarcerated fathers had visited with the child in the past month, seeing their child an average of two to three times per week.[xvi] For residential fathers, recent incarceration is also linked to sharp declines in positive parenting behaviors, which is mainly associated with changes in the fathers' relationship with their children's mother. Paternal incarceration can also negatively affect mothers' parenting, although these findings are less consistent across studies.[xvii,xviii] Family strengthening and parenting initiatives can help reintegrate fathers into the lives of their children, strengthen parenting behaviors, improve father involvement, and reduce recidivism.

Upon release, many returning individuals face large financial obligations including child support, restitution, and other court-related fees.[xix] Additionally, formerly incarcerated men and women can be prohibited from accessing some of the supports they may need most, including living in public housing and receiving government services, such as Temporary Assistance for Needy Families (TANF), food stamps, and educational benefits.[xx] These challenges often have repercussions for partners and children as well. One study found that mothers with a currently or

recently incarcerated partner were 50 percent more likely to face housing insecurity than other mothers. This finding applied to families in which the father had lived with his partner and child(ren) prior to his incarceration, and is partially attributed to the loss of the fathers' financial contribution.[xxi]

Studies suggest that positive father-child relationships and paternal involvement can positively influence child outcomes in terms of reduced risky behaviors and delinquency, and benefit all family members.[xxii, xxiii] However, incarcerated fathers have unique needs and different barriers to maintaining relationships with their children.[xxiv] Upon reentry, fathers may continue to have more difficulty relating to their children if their role in the family changes during and after incarceration.[xxv] Men who have not enjoyed emotionally close relationships with their children prior to incarceration may also have difficulty expressing affection and caring for children when released from prison as father-child closeness and contact often erode during incarceration. Many reentering fathers have also been recipients of ineffective parenting and therefore lack the training needed to develop skills for appropriate interaction with their children.[xxvi]

It may be particularly critical to offer parenting education and services during reentry. Most reentry services focus on employment and education, but family strengthening is also an important component for reducing recidivism. Some studies suggest that providing services involving families to recently released prisoners may result in positive outcomes for former returning individuals, including reduced risky behaviors and recidivism.[xxvii] Thus it may be critically important to teach fathers who are rebuilding relationships interrupted by incarceration about how to attend to and empathize with their children after release. Although parenting programs have increased in popularity for parents (fathers and mothers) during incarceration, programs for reentering parents are more limited. Moreover, despite the challenges of prisoner reentry, few programs have been rigorously evaluated to determine the effectiveness of approaches for reentering parents to rebuild relationships with children, nor have considered the consequences of such approaches for both fathers and children. The current project fills this gap by addressing two complementary objectives:

- **Objective 1:** To conduct an outcomes evaluation to determine the shorter- and longer-term impact of a parenting intervention designed for reentering fathers to rebuild relationships with their children on *father and child well-being* and *family functioning* with measurement upon program enrollment, at program completion (at seven-weeks), and with a six-month follow-up from program enrollment.
- **Objective 2:** To conduct a process evaluation that will provide context, clarification and understanding of the outcome evaluation results in the context of reentry, and an opportunity to replicate and extend practices that work best with reentering fathers.

Study Overview

To meet these objectives Child Trends conducted an experimental outcomes evaluation of the Strengthening Families Program for Parents and Youth 10-14 (SFP). SFP is a 7-week evidence-based intervention that aims to promote positive relationships, behaviors, and skills among families with children that range from 10 to 14 years old (see the SFP logic model in Appendix

A). Dr. Karol Kumpher & Dr. Virginia Molgaard, co-Principal Investigators at Iowa State University, developed the SFP curriculum in 1994. Initially, the SFP was created by Dr. Kumpher as a 14-week implementation for high-risk families with children ages 6 to 11, with the purpose of providing an intervention for families with substance-abusing parents to improve family relationships and reduce risky behaviors among youth. Evaluations of the SFP 6-11 intervention produced positive results for families of different ethnic groups, which demonstrate the curriculum's adaptability to various familial and cultural circumstances.[xxviii] The SFP curriculum was developed later for older children (ages 10 to14) with a similar purpose of promoting healthy family relationships and parenting skills—while reducing the likelihood of youth engagement in negative behaviors, such as substance use or misuse and delinquency.[xxix] In addition, the SFP also aims to improve youth's social skills, emotional development, and academic performance.[xxx] Overall, the SFP intervention has made a significant difference for families globally by promoting healthy relationships and behaviors that equip both parents and youth with the skills and knowledge to improve current circumstances and future outcomes.

Previous studies of the SFP suggest that the intervention is effective in preventing substance use and other risky behaviors among youth and enhancing family level functioning. Specifically, previous evaluations of SFP among 6th graders found that participants of the program had reduced substance use in 11th and 12th grade.[xxxi] Another study found that participation in the program was positively associated with a reduction in substance use in 6th grade, increased school engagement in 8th grade, and positive academic performance in 12th grade.[xxxii] Improvements were also found among caregivers who participated in SFP. Caregivers reported an increase in positive parenting and family level functioning and a reduction in depression symptoms from pre to post test, with some effects remaining four months later.[xxxiii]

In the current study, the SFP was implemented in a community center and was offered to fathers recently released from jail or prison (within the last 24 months) alongside basic reentry services, which included case management, employment/training opportunities, and referrals for services to overcome other barriers to employment such as substance abuse, domestic violence, and housing assistance. The control group received the full set of basic reentry services, but did not receive the SFP program. The SFP curriculum is designed to include up to three family members: the fathers, a focal child aged 10 to 14, and another caregiver (mother, stepmother, grandmother, aunt, etc.) of the child. At each of the seven program sessions, fathers, children, and other caregivers have a one-hour lesson separately (e.g., all of the fathers in one room, all of the children in another room), and then the groups come together for a one-hour family lesson. The lessons included father/caregiver sessions on positive change, communication and listening, and coping; child sessions on reinforcing positive behaviors, problem solving, conflict resolution and decision-making, and communication; and family sessions on communications skills, discipline, limit-setting, and problem solving.

Evaluation Design

The SFP evaluation began in spring 2012 with the hiring and training of facilitators and other evaluation staff, including an onsite evaluation coordinator. One pilot cohort and five additional cohorts were recruited between November 2012 and March 2015. It took an average of about four months to recruit each complete cohort, which comprised 16 to 20 families per cohort. A

pilot study was conducted with the first cohort prior to the full impact study to test all implementation and evaluation procedures, including recruitment, enrollment, random assignment, survey administration, and program delivery procedures. Data from the pilot cohort are not included in the final analyses.

Program administrators utilized multiple approaches to recruit participants. For example, program staff and facilitators and current clients referred prospective participants. The evaluation coordinator also reviewed all client files to identify eligible clients, and then reached out to invite them to an orientation meeting via email, phone calls, mailing out flyers, and text messages. Fathers' eligibility was determined based on a number of specific criteria:

- Released from jail/prison within the last 24 months
- Father of a child between ages 10 and 14
- Never charged or convicted as a sex offender
- Never charged or convicted, or been the subject of a substantiated report of child or domestic abuse or child neglect
- Never participated in any systematic training offered using the Strengthening Families Program curriculum
- Parental rights had not been terminated
- No requirements for supervised visits with the focal child
- No reported mental or emotional health condition for which the father was not currently receiving treatment.

Staff also gave presentations on the program and passed out flyers at multiple community events (e.g., a local heath and community fair) and other programs provided by the reentry organization (e.g., job readiness classes). Participants who expressed interest in the program at these events were asked to complete a referral form. The evaluation coordinator then reviewed this information to determine eligibility. If eligible, the client was invited to attend an orientation session.

For each of the fathers selected to participate in the study, a *focal child* was also identified. One focal child was selected from all of the children identified by the father as eligible to participate. If more than one child was eligible, fathers were asked to select the child with the most recent birthday. Fathers were also encouraged to identify and recruit another adult who shares caretaking responsibility for the focal child, whether this is the child's biological mother, the father's significant other (if different from the child's mother), or a grandparent/relative. Participants who are unable to identify or recruit an additional adult were still permitted to take part in the SFP evaluation.

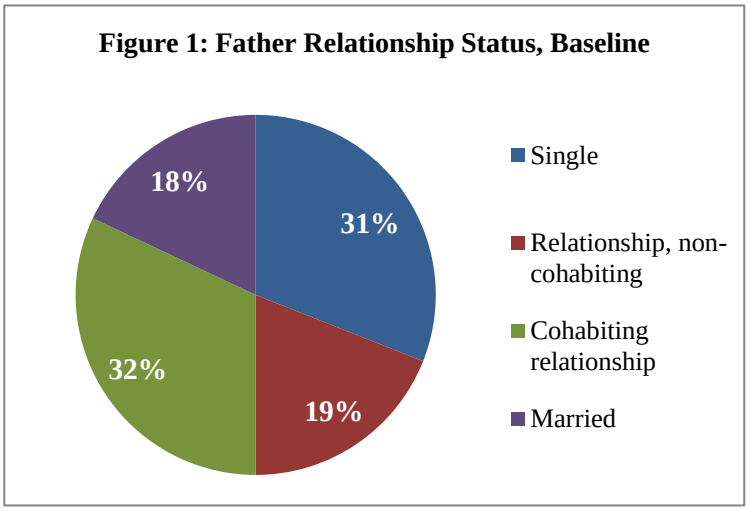
Sample characteristics

Eighty families participated in the SFP evaluation, including 80 fathers, 55 other caregivers, and 80 children. On average, the focal children were 11.6 years old, and 59 percent of the children were female. Among the other caregivers, 65 percent were the focal child's biological mother, 8 percent were stepmothers, 6 percent were a significant other of the child's father, 8 percent were

grandmothers, and 14 percent described themselves as another person who is like a mother to the child.

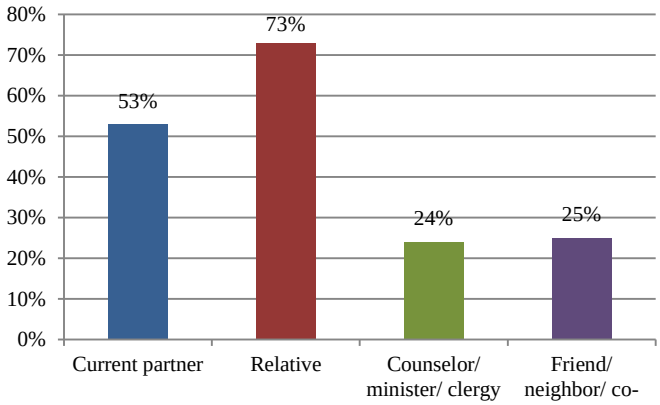
As shown in Figure 1, at the time they enrolled in the study, half of fathers were in a co-residential relationship, with 18 percent married and 32 percent in an unmarried cohabiting relationship. Roughly one-third (31 percent) of fathers were single and 19 percent were in a non-cohabiting relationship. Just over half (56 percent) lived with at least one child (biological, step, or unrelated), and 51 percent lived with the focal child. Prior to incarceration, 55 percent of fathers lived with the focal child.

Figure 1: Father Relationship Status, Baseline



Fathers lived in relatively stable housing, with 86 percent reporting that they lived in a house, apartment, or mobile home. One quarter (25 percent) of fathers were employed. Fathers reported many barriers to finding employment, with the most common barrier being their criminal history (86 percent of fathers reported this was a barrier). Transportation and little work experience or skills were also common barriers (38 percent and 20 percent, respectively). Thirty percent of fathers had attended some college and 90 percent of fathers had a high school degree or GED.[1]

Figure 2: Percent of Fathers Reporting Sources of Social Support, Baseline

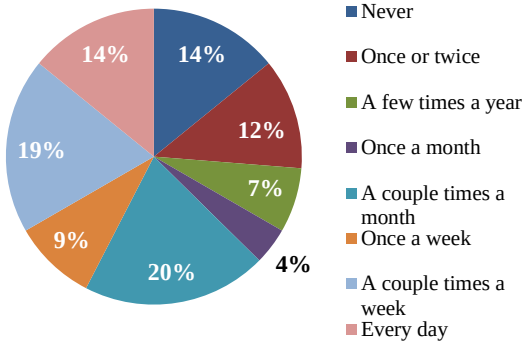


Fathers' self-reported health was generally good, with 53 percent in very good or excellent health, 38 percent in good health, and 10 percent in fair health. However, family stress was high, with only three percent of fathers reporting no family stress in the past month, 47 percent reporting a little stress, 40 percent some, and 10 percent a lot of stress. Most fathers felt they had some social support available (Figure 2): about three-quarters of fathers (73 percent) felt they had at least one relative they could turn to in an emergency. Just over half (53 percent) also felt they could turn to their current partner, and about one-quarter of fathers felt they could turn to a counselor/minister/clergy or a friend/neighbor/coworker (24 percent and 25 percent, respectively).

[1] Percent of fathers without a high school degree could be underestimated due to discrepancies in the way education was measured between cohorts.

While incarcerated, 14 percent of fathers never spoke to the focal child, 19 percent spoke to the child once/twice or a few times a year, 25 percent once/twice per month, 28 percent once/twice per week, and 14 percent spoke to the child every day, which is similar to what other studies of incarcerated father-child contact find.[xxxiv] Most frequently this communication was done over the phone or through mail; 71 percent of fathers spoke to their child on the phone at least once and 61 percent communicated through mail. A smaller percentage of fathers, 38 percent, saw their child during an in-person visit.

Figure 3: Frequency of Father-Child Contact while Incarcerated



Impact evaluation design

Eligible fathers enrolled in the study were randomly assigned to receive the SFP program in addition to basic reentry services provided by the site. The control group received the full set of basic reentry services, but did not receive the SFP program. Baseline surveys were administered to all fathers, focal children, and participating caregivers at the time of enrollment and prior to random assignment. Follow-up surveys were administered 7 weeks after the program began (at the last session for treatment group) and 6 months later. Information from the baseline survey is used to describe the families enrolling in the SFP and to determine whether fathers assigned to the treatment group were similar to those assigned to the control group on key background characteristics (baseline equivalence). Responses to the 7-week and 6-month follow-up surveys were used to assess whether fathers and their families assigned to receive SFP services reported significantly better outcomes than those in the control group across multiple outcome domains. Targeted outcomes fall into five domains (father well-being, father-caregiver relationship, father-child relationship, caregiver-child relationship, and child well-being) and were selected based on those most likely to be affected by the SFP intervention.

As shown in Table 1, the random assignment design was confirmed by testing whether fathers assigned to the treatment and control groups were similar in terms of age, race, relationship status, employment status, and whether they lived with the focal child. The groups did not differ in these characteristics.

Table 1. Baseline equivalence

Variable	Treatment Group	Control Group	Difference	*p*-value
Age				1.00
Younger than 35 (%)	25.0	25.0	0.0	
35 or older (%)	75.0	75.0	0.0	
Race/ethnicity				0.21
Black, non-Hispanic (%)	90.0	80.0	10.0	
Other (%)	10.0	20.0	-10.0	
Relationship status				0.18
Single (%)	29.0	32.5	-3.5	
Non-cohabiting relationship (%)	10.5	27.5	-17.0	
Cohabiting relationship (%)	36.8	27.5	9.3	
Married (%)	23.7	12.5	11.2	
Employment status				0.21
Employed	81.1	68.4	12.7	
Not employed	18.9	31.6	-12.7	
Live with child				0.80
Lives with child	50.0	47.1	2.9	
Does not live with child	50.0	52.9	-2.9	

Attrition. As shown in Table 2, about one-third (34 percent) of fathers did not complete the 7-week follow-up and 48 percent did not complete the 6-month follow-up. There were a small number of participants who completed the 6-month follow-up but did not complete the 7-week follow-up. Comparing the baseline father characteristics of those who did and did not participate in the 7-week follow-up, we find those who dropped out of the study were older and more likely to be in a cohabiting or married relationship than those who participated in the 7-week follow-up survey. Fathers who did not participate in the 6-month follow-up were older than those who did participate. The baseline socio-demographic characteristics of fathers were statistically comparable between those who did and did not participate in the follow-up surveys.

Table 2. Group Sample Sizes at Three Time Points

Condition/ Sample	Baseline (n)	7-Week Follow-Up (n)	% Attrition Between Time 1 and Time 2	6-Month Follow-Up (n)	% Attrition Between Time 1 and Time 3
Fathers					
Treatment	40	26	35%	21	48%
Control	40	27	33%	21	48%
Total	80	53	34%	42	48%
Mothers/Other Caregivers					
Treatment	27	16	41%	11	59%
Control	28	15	46%	13	54%
Total	55	31	44%	24	56%
Children					

Treatment	40	26	35%	18	55%
Control	40	23	43%	15	63%
Total	80	49	39%	33	59%

Process evaluation design

Program implementation refers to the set of policies, procedures, and practices used to execute a program.[xxxv] These policies and procedures play a vital role in service delivery, client outcomes, and program sustainability. Therefore, evaluating program implementation components such as staff training, staff-client relationships, participant engagement, and participant satisfaction with the program helps to determine and ensure a program's efficiency and effectiveness, and can provide more meaning and depth to the observed impact results. Child Trends collected program implementation data for the SFP through focus groups with fathers and caregivers, interviews with SFP staff, and through detailed attendance data.

Methods

Impact evaluation measures and methods

Table A in Appendix B summarizes the specific outcome measures assessed for fathers, caregivers, and children. Outcomes were assessed for all participants with valid responses to the items that make up each outcome measure. Scales and indices were created for some outcome measures. Scales were created by taking the average across a set of correlated items, and indices were created by adding responses across items to create a sum score. It is important to note that some outcomes have individual missing cases and that some outcomes were limited to nonresident fathers. The sample size for each outcome is presented in the results tables.

T-tests and chi-squared tests were conducted to examine between-group differences 7 weeks and 6 months following the intervention. Between-group effect sizes were also calculated and are reported as Cohen *d* estimates, which represent the mean difference between the treatment and control group in standard deviation units (reported as absolute values). Effect size can provide additional and practical insight to significance tests, as tests of significance are dependent on sample size. Cohen *d* estimates of 0.2, 0.4, and 0.7 suggest small, moderate and large effect sizes, respectively.

Process evaluation methods

Participant focus groups. Child Trends staff conducted four focus groups with program participants, two for fathers and two separate groups for caregivers. A total of fourteen fathers and four caregivers participated in the groups. Caregivers who participated in the focus groups were a mix of biological mothers and non-biological caregivers.

The focus groups were conducted to learn more about the experiences and needs of fathers and caregivers in the SFP program. The focus groups lasted approximately 1.5 hours. Fathers and caregivers were asked open-ended questions to encourage group discussion, and monetary

incentives (a $25 gift card), and refreshments were provided. Child Trends staff recorded the focus groups with permission of participants, and analyzed summary notes for common themes. Focus group participants provided written and verbal consent to participate in the focus groups, and were informed of their rights as study participants. Participants were assured that their names and other identifying information would not be used in the summary report. Although the information provided during the focus groups may not be fully representative of all SFP participants, the findings provide insights into the experiences and opinions of the families who participated.

Participant recruitment, retention, and engagement. Implementation successes and challenges related to recruitment, retention, and engagement were assessed through staff interviews and through the use of detailed attendance records for all participants assigned to receive the SFP intervention. At each session, facilitators noted which family members participated and when possible, provided notes about why or why not individual participants attended. A dataset was created to analyze individual and family-level engagement in the intervention. The qualitative notes provide additional context related to barriers to participation. Only two SFP staff were available for interviews, but the findings from the interviews overlapped considerably with the qualitative notes provided with the attendance data.

Results

Impact evaluation

The impact results below are organized around each specific reporter (fathers, caregivers, and youth). For each reporter, a summary of the overall findings at 7 weeks and 6 months across all outcome domains is provided, followed by detailed domain-specific results tables.

Taken together participants—fathers, caregivers, and youth—assigned to the SFP treatment group had different outcomes than those in the control group. Those in the treatment group fared better than those in the control group on some indictors and fared not as well on others. These differences were not always statistically significant (likely due to small sample sizes) but some effect sizes suggest potentially moderate associations between participation in the SFP intervention and outcomes for fathers, caregivers, and youth across ranging domains.

Fathers. Some differences in outcomes for fathers who were in the treatment and control conditions were present seven weeks after the intervention (Tables 3-6). More than 50 percent of fathers in the treatment group were employed 7 weeks after the intervention compared to about 30 percent of fathers in the control group. Nonresident fathers—those who did not live with the focal child—in the treatment and control groups were equally likely to have a child support order, but those in the treatment group were more likely to pay child support at 7 weeks (p= 0.05; Cohen d = 0.8). No nonresident fathers in the control group reported paying child support in the 7-week follow-up. Nonresident fathers in the treatment group reported providing less in-kind support than those in the control group, with moderate to strong effects sizes across both time periods.

Fathers in the treatment group reported fewer depressive symptoms and less parental stress than those in the control group. Although not statistically significant, the mean difference between these groups can be considered meaningful because the difference is more than 30 percent of the standard deviation, which translates to a moderate effect size (Cohen d = 0.3 and 0.4 at 7 weeks, respectively).

Fathers in the treatment group reported somewhat higher parental cooperation than those in the control group (with a moderate effect size, Cohen d = 0.4 at 6 months). Fathers' reports of participation in shared activities with their children and having a close relationship were statistically comparable across the two conditions. Some of the differences between the treatment group and the control group were unexpected, with fathers in the treatment group engaging in fewer shared activities and having less close relationships with their children than those in the control group at 6 months. However, these differences were not significant and had small effect sizes. Fathers in the treatment and control groups also reported comparable levels of children's self-regulation and behavior problems, with generally small effect sizes. The only notable exception was fathers' reports of self-regulation at 7 weeks. Fathers in the treatment group reported slightly lower levels of self-regulation for their children compared to fathers in the control group, with a moderate effect size (Cohen d= 0.3).

Fathers in the treatment group were less likely to live with the focal child at the 7-week follow-up but were more likely to live with the focal child 6 months following the intervention when compared to those in the control group; however, neither of these differences were statistically significant. At the 6-month follow-up, nonresident fathers in the treatment group were less likely to pay child support than those in the control group, and the effect size is moderate in this case (Cohen d= 0.4). Nonresident fathers in the treatment group were again less likely to provide in-kind support than those in the control group (p<0.05); those in the treatment group on average provided in-kind support "hardly ever," whereas those in the control group did so "sometimes" on average. The mean difference was 0.7 units on a 3-point scale, which is approximately 90 percent of a standard deviation.

Although the characteristics between the treatment and control group are statistically equal across the other outcomes, the mean difference between the treatment and control group can be considered as evidence of moderate relationships between participation in the SFP intervention and several outcomes, including depressive symptoms, father-child contact, paying child support and parental cooperation (at 6 months) (Cohen d > 0.3 respectively).

Table 3. Impacts on Father Well-Being, Father Report

	7-Week Follow-Up						6-Month Follow-Up					
Measure	**Treatment Group**	**Control Group**	**Difference**	***p*-value**	**Cohen's *d* Effect Size**	**N**	**Treatment Group**	**Control Group**	**Difference**	***p*-value**	**Cohen's *d* Effect Size**	**N**
Employment (%)	54.2	29.6	24.6	0.08†	0.50	51	52.4	38.1	14.3	0.35	0.28	42
Depressive Symptoms	0.47	0.68	-0.21	0.15	0.41	52	0.40	0.57	-0.17	0.22	0.38	42
Parental Stress	0.38	0.55	-0.16	0.29	0.29	53	0.53	0.54	-0.01	0.93	0.03	40

Notes: †=p<.10 marginal significance

Table 4. Impacts on Father-Caregiver Relationship, Father Report												
	7-Week Follow-Up						6-Month Follow-Up					
Measure	Treatment Group	Control Group	Difference	*p*-value	Cohen's *d* Effect Size	N	Treatment Group	Control Group	Difference	*p*-value	Cohen's *d* Effect Size	N
Parental Cooperation	2.77	2.68	0.11	0.61	0.15	47	2.89	2.63	0.26	0.17	0.43	41

Table 5. Impacts on Father-Child Relationship, Father Report												
	7-Week Follow-Up						6-Month Follow-Up					
Measure	Treatment Group	Control Group	Difference	*p*-value	Cohen's *d* Effect Size	N	Treatment Group	Control Group	Difference	*p*-value	Cohen's *d* Effect Size	N
Live with Focal Child (%)	41.7	53.9	-12.2	0.39	0.24	50	52.4	47.6	4.8	0.76	0.09	42
Father-Child Contact[a]	2.0	1.5	0.5	0.11	0.65	27	1.60	1.91	-0.31	0.44	0.34	21
Child Support Order[a] (%)	21.4	23.1	-1.7	0.92	0.04	27	20.0	18.2	1.8	0.92	0.04	21
Paid Child Support[a] (%)	26.7	0.0	26.7	0.05†	0.78	27	11.1	27.3	-16.2	0.37	0.39	20
Father In-Kind Support[a]	1.38	1.96	-0.58	0.06†	0.77	27	1.28	2.02	-0.75	<0.05*	0.92	21
Shared Activities	7.38	7.22	0.16	0.78	0.08	53	6.80	7.33	-0.53	0.51	0.21	41
Closeness	3.62	3.70	-0.08	0.43	0.22	53	3.65	3.69	-0.04	0.71	0.12	41

Notes: †=$p< 0.10$ marginal significance; *$p< 0.05$, significant
[a] Nonresident fathers only.

Table 6. Impacts on Child Well-Being, Father Report												
	7-Week Follow-Up						6-Month Follow-Up					
Measure	Treatment Group	Control Group	Difference	*p*-value	Cohen's *d* Effect Size	N	Treatment Group	Control Group	Difference	*p*-value	Cohen's *d* Effect Size	N
Behavior Problems	0.68	0.65	0.03	0.82	0.06	53	0.69	0.75	-0.06	0.60	0.17	41
Self-Regulation	1.63	1.80	-0.17	0.29	0.29	52	1.66	1.64	0.02	0.89	0.04	41

Caregivers. No statistically significant differences were found between caregivers in the treatment and control groups 7 weeks following the intervention (Tables 7-8). However, when effect size is considered, there are potentially moderate relationships between SFP participation and two outcomes: parental cooperation and children's behavior problems as reported by the caregiver. Those in the treatment group reported greater parental cooperation than those in the control group; however, those in the treatment group also reported more behavioral problems

among children. The between-group mean difference for parental cooperation and child behavior problem outcomes was roughly half of the respective standard deviation, which translates to a moderate effect size.

At the 6-month follow-up, caregivers in the treatment group reported closer relationships with the focal child than those in the control group, and this difference was marginally statistically significant ($p< 0.10$) and roughly 80 percent of the standard deviation. Although all of the other outcomes are statistically nonsignificant between caregivers in the treatment and control groups, there is modest evidence to suggest moderate relationships between treatment status and shared activities. Caregivers in the treatment group engaged the focal child in more shared activities than those in the control group 6 months after the intervention.

Table 7. Impacts on Father-Caregiver Relationship, Caregiver Report

	7-Week Follow-Up						6-Month Follow-Up					
Measure	**Treatment Group**	**Control Group**	**Difference**	***p*-value**	**Cohen's *d* Effect Size**	**N**	**Treatment Group**	**Control Group**	**Difference**	***p*-value**	**Cohen's *d* Effect Size**	**N**
Parental Cooperation	2.81	2.42	0.39	0.22	0.47	29	2.53	2.67	-0.14	0.68	0.18	21

Table 8. Impacts on Child Well-Being, Caregiver Report

	7-Week Follow-Up						6-Month Follow-Up					
Measure	**Treatment Group**	**Control Group**	**Difference**	***p*-value**	**Cohen's *d* Effect Size**	**N**	**Treatment Group**	**Control Group**	**Difference**	***p*-value**	**Cohen's *d* Effect Size**	**N**
Shared Activities	8.19	8.31	-0.12	0.84	0.08	29	8.50	7.91	0.59	0.46	0.33	21
Closeness	3.78	3.73	0.05	0.74	0.12	31	3.95	3.59	0.36	0.09†	0.77	21
Behavior Problems	0.94	0.69	0.25	0.23	0.46	29	0.77	0.77	-0.00	0.97	0.01	21
Self-Regulation	1.56	1.67	-0.11	0.58	0.21	29	1.37	1.45	-0.08	0.65	0.21	20

Notes: † $p<.10$ marginal significance

Youth. Among youth participants (Tables 9-11), there were no statistically significant differences in the outcomes of those in the treatment and control groups 7 weeks following the intervention across all child well-being outcomes considered. However, children in the treatment group tended to report more risky behaviors and lower social competence than their counterparts in the control group. The mean difference in the risk index and the social competence of those in the treatment and control groups are both roughly a third of its respective standard deviation, resulting in small to moderate effect sizes. Youth participants in the treatment group also report lower academic competence than those in the control group, and the effect size is moderate (d = 0.4).

Youth in the treatment group reported being less close with their caregiver and fewer caregiver-shared activities at 7 weeks, but more closeness and greater participation in shared activities at 6 months.

At the 6-month follow up, youth in the treatment group with a nonresident father had more frequent contact with their fathers than those in the control group ($p < 0.001$, Cohen $d = 3.1$); all youth in the treatment group had at least weekly contact with their fathers, but this was not the case for the control group. The between-group differences for youth were not statistically significant for any other outcomes considered; however, there is evidence of potentially moderate relationships between treatment status and a range of outcomes, including social competence, closer relationships with their fathers and other caregivers. That is, children in the treatment group reported they felt more close to their fathers ($d = 0.47$), reported more warmth and communication with their father ($d = 0.33$) reported feeling closer to their caregiver ($d = 0.40$) and engaging in more activities with their caregiver ($d = 0.37$) than the children in the control group.

Table 9. Impacts on Father-Child Relationship, Child Report

	7-Week Follow-Up						6-Month Follow-Up					
Measure	**Treatment Group**	**Control Group**	**Difference**	***p*-value**	**Cohen's *d* Effect Size**	**N**	**Treatment Group**	**Control Group**	**Difference**	***p*-value**	**Cohen's *d* Effect Size**	**N**
Father-Child Contact[a]	1.53	1.54	-0.01	0.99	0.01	28	2.56	0.58	1.98	<0.001**	3.05	15
Father Shared Activities	6.44	6.32	0.12	0.89	0.04	47	6.56	6.13	0.42	0.69	0.14	33
Father Closeness	3.48	3.43	0.05	0.85	0.06	46	3.44	3.00	0.44	0.19	0.47	33
Father Warmth and Communication	2.52	2.42	0.10	0.69	0.12	47	2.46	2.16	0.30	0.35	0.33	33

Notes: ** *p< 0.001*

[a] Nonresident fathers only.

Table 10. Impacts on Caregiver-Child Relationship, Child Report

	7-Week Follow-Up						6-Month Follow-Up					
Measure	**Treatment Group**	**Control Group**	**Difference**	***p*-value**	**Cohen's *d* Effect Size**	**N**	**Treatment Group**	**Control Group**	**Difference**	***p*-value**	**Cohen's *d* Effect Size**	**N**
Caregiver Shared Activities	7.69	8.00	-0.31	0.64	0.13	49	7.22	6.07	1.16	0.30	0.37	33
Caregiver Closeness	3.78	3.80	-0.02	0.86	0.05	48	3.69	3.32	0.37	0.27	0.40	32
Caregiver Warmth and Communication	2.82	2.74	0.08	0.48	0.21	48	2.50	2.33	0.16	0.53	0.23	32

Table 11. Impacts on Child Well-Being, Child Report												
	7-Week Follow-Up						6-Month Follow-Up					
Measure	Treatment Group	Control Group	Difference	*p*-value	Cohen's *d* Effect Size	N	Treatment Group	Control Group	Difference	*p*-value	Cohen's *d* Effect Size	N
Academic Competence	1.16	1.66	-0.50	0.13	0.45	49	1.28	1.20	0.08	0.82	0.08	33
Risky Behaviors	1.46	.87	.59	0.24	0.34	49	1.17	1.07	0.10	0.81	0.08	33
Social Competence	2.13	2.34	-0.21	0.21	0.36	48	2.12	2.25	-0.13	0.52	0.23	31
Internalizing Problems	7.67	7.96	-0.28	0.85	0.05	49	7.78	6.73	1.04	0.63	0.17	33
Behavior Problems	0.67	0.80	-0.13	0.42	0.23	49	0.60	0.66	-0.06	0.71	0.13	33
Self-Regulation	1.81	1.90	-0.09	0.63	0.14	49	1.93	1.83	0.10	0.64	0.17	33

Process Evaluation Findings – Focus Groups

Focus group findings are organized by overarching themes and represent both father and caregiver views.

The meaning of being a "responsible father." Fathers in the program described the struggles they faced with their own parents, particularly those related to absenteeism, lack of affection, verbal abuse, and lack of guidance on how to be a man. Participants described a "responsible father" as not only a financial provider, but also a source of love, understanding, and emotional support. Caregivers, in the same light, described a "responsible father" as a "strongman figure" who teaches his children about respect for women and love for family.

> *"I always had my kids' best interests in mind at all times. I never wanted them to have less, be less, or do less. This program helped me put myself back…on the right track…it took some of the selfishness out of me…I'm a parent now." – Father*

While fathers in the program did not receive this guidance from their own fathers, they expressed a conscious desire to teach their children, "so they don't go through the same mistakes ... [and] to break that cycle." Part of breaking the cycle, fathers acknowledged, involved focusing on self-improvement to be a better father, which SFP helped address.

> *"The goal itself [of SFP] is to strengthen the family and be open to communication and understand and that's exactly what it did for us."*
>
> *– Caregiver*

The value of listening. Some of the most valuable lessons fathers and caregivers learned were how to hear their child's perspective, set boundaries with their child, and think before reacting.

"There was a time when…all I would do is scream at her and get agitated with her really quick, be short with her… [Now,] she's more open with me, she asks things of me when—before she couldn't ask for anything…but now she's changing a lot because of that, so I'm learning a lot of myself." – Father

"I do more listening now because my teenagers are always coming up with something. They come to me with situations now that they know I'll listen." – Caregiver

Fathers also became more attuned to language they used with their children—such as [telling a boy,] "you're acting like a little girl"—that might affect a child's self-esteem. Caregivers noticed an improvement in the fathers' parenting behaviors, especially related to communication, using new strategies (learned in the program), and spending time with family. Fathers and caregivers both felt the program taught their children to better understand their perspective as well.

"The kids listen too because they were seeing what we were going through and they would just listen…We're coming home from work and trying to clean and get dinner and they [see] what we go through" – Caregiver

Feels like family. Additionally, a valuable part of the program was the bond formed with other participants in the program. For fathers, bonding with other fathers provided a haven for social and emotional support as well as belonging. Fathers and caregivers both requested more opportunities outside the SFP classes to bond with other participants, such as outdoor activities and family field trips.

"It feels more like family…you open up more around people that you may not know. The guys that I'm here with, I view them as big brothers or uncles." – Father

"Yes, it was good. It wasn't like we were coming to a program but like we were coming to a family. We all got together and talk[ed] and had fun. The kids love coming."

– Caregiver

More focus on the parental relationship. While the SFP model is designed to have both parents/caregivers participate, it does not directly address relationship dynamics between parents. Fathers noted that while they learned some co-parenting strategies, for many, the relationship with the mother remained a challenge. Although SFP is designed around having both parents participate, not all mothers/caregivers were willing to participate. Fathers in the focus groups noted the mothers' absence as a problem,

"Yes, there are some issues with the children, but if the two parents don't agree how to raise children correctly, you can bump heads and the kids know how to play that. We have a good system, but it could be better… It probably would have been better if they had a relationship program…because we have some issues…"– Caregiver

and reported that more participation by mothers in the program was needed to address the father-mother relationship.

Both caregivers and fathers noted the struggles they faced in their relationships with the other biological parent and suggested the program could include strategies to improve relationships between parents.

> *"I don't see the relationship between the father and mother changing until she participates…you can take all this knowledge and let her know, but it's nothing. In my opinion, my relationship with the mother did not change, but the relationship with the child, it's great." – Father*

Caregivers noted that some of the relationship struggles stemmed from the issues incarcerated fathers brought home with them upon reentry, in addition to feelings of anger and resentment over the extra responsibilities the caregivers assumed when the father was away.

> *"With the situation the guys are coming from, I know it's a program for them to get back in touch with their children after being away but that leaves out the other half that we also had to go through not having [a] significant other as well. They have to readapt to coming back into society and the right track. But what happened to us? We still have unresolved issues that we can't express without using our anger because we're upset about the years they were away. We settled things with the kids, but under the skin we still have issues."*
>
> *– Caregiver*

The focus groups suggest that fathers overall found the program to be engaging, an important source of support, and that it helped them improve their relationship with their child. However, it is also evident that fathers and caregivers both found that the communication dynamics between parents/guardians were not adequately addressed in the program. The next section on participant engagement among the SFP treatment group reflects these themes from the focus groups.

Process evaluation findings – participant recruitment, retention, and engagement

Barriers to recruiting, engaging, and retaining participants in the SFP intervention were encountered throughout the study. Despite the multitude of techniques used to increase participation, recruitment remained a challenge throughout the duration of the study. Staff noted that some of the most challenging barriers to recruitment included limiting the target population to fathers released from jail/prison in the last 24 months, requiring that a child also participate in the program and restricting the age of participating children to 10 to 14 years, work conflicts, probation restrictions that prevented fathers from accessing services on weekends (house arrest restrictions for example), a lack of interest in participating in the control group, and a lack of time to participate in additional programming beyond the existing reentry services already provided at the site. Interview and focus group data also suggest that the strained relationship between the father and caregiver affected participation of the caregivers.

Throughout the duration of study recruitment, the evaluation team brainstormed and implemented new strategies to increase recruitment. For instance, financial incentives were increased for participating in the study (i.e., individuals received $25 for completing each survey and the family received a $50 gift card if they attended all seven sessions). The evaluation coordinator also worked with some fathers and families to enroll them in the study on an individual basis if they were unable to attend the group orientation meetings. In addition, the orientation programs were initially offered every other Saturday but the frequency was increased to weekly session so more families would be able to attend. Additional methods for contacting families also were added (e.g., a shift from only emails and calls to emails, calls, and text messages as well as mailing flyers).

Analyses of attendance were conducted for 40 families and 107 individuals across 5 cohorts that were assigned to the treatment condition (see Table 12). Participants attended an average of 2.5 of the 7 treatment sessions, although this differed by family member. Fathers were most likely to attend at least 1 treatment session (n = 28) and caregivers were least likely to attend at least one session (n = 13; X^2= 12.73, $p < 0.01$). Moreover, fathers attended more sessions on average (M = 3.2), than children (M = 3.0) or caregivers (M = 1.3), and more fathers (n = 10) and children (n = 10) attended all seven treatment sessions than caregivers (n = 1).

Slightly more than half (n = 54) of the participants in the treatment group did not attend any sessions, so additional analyses were conducted of attendance only for participants who attended at least 1 session. Individuals attending at least one session attended an average of 4.5 sessions. Children (M = 4.8) and fathers (M = 4.5) attended more sessions, on average, than caregivers (M = 3.9).

The majority of participants who did not attend any sessions were caregivers (n = 27, or 50 percent of the missing participants). To help differentiate caregivers who did not attend any sessions because they did not enroll in the evaluation from those who enrolled but never attended a session, additional analyses were conducted limiting the sample to treatment condition families with enrolled caregivers. In the treatment condition, 27 caregivers were officially enrolled (68 percent of the possible 40 caregivers). Of those 27 caregivers, 16 did not attend any sessions (59 percent). The remaining 11 who attended at least one session attended an average of 4.1 sessions, which approached the average number of sessions fathers (n = 17; M = 4.5) and children (n = 15, M = 4.9).

The program was designed for families, not just individuals, so family level attendance was also analyzed. On average, families (at least one member of a family) attended 2.5 treatment sessions. Among families where at least one family member attended a session (n = 28), family members attended an average of 3.6 sessions. Among families with a caregiver enrolled that attended at least 1 session (n = 11), at least one family member attended an average of 5.3 sessions. Fathers were the only family members to attend sessions alone, although this was uncommon (n = 4). The majority of families attended in groups of two, most often the father and child (n = 15). Ten families attended at least one session as a whole (all three family members). Among families with a caregiver enrolled (n = 27) where the caregiver attended at least 1 session (n = 11), 9 (82 percent) attended at least one session as a whole family.

There are notes from program staff for 24 participants about why they stopped attending program sessions or other important notes. A plurality of families had notes about positive behaviors such as: perfect attendance, making substantial efforts to attend, making efforts to convince caregivers to attend, and visible improvements in the father-child relationship and positive child behaviors over time (n = 12). Among those with information about attrition, seven participants stopped attending treatment sessions because of work conflicts, although three attended sessions in more than one cohort (e.g., returned to the program), which speaks to participants' commitment to and engagement in the program in light of conflicts and difficulties attending all sessions. Another two fathers returned to prison and therefore could no longer attend program sessions. Two participants could not attend because of other family conflicts (caring for a sick parent in one case; in another, the child was accepted to a sports team that played on Saturdays and the father became the coach). One family dropped out of the program and was lost to follow-up (thus program staff did not know why).

Table 12. Attendance data

	%/Mean (N)
Individuals attending at least 1 treatment session	
Fathers	70% (28)
Caregivers	33% (13)*
Children	63% (25)
Average number of sessions attended**	
Families	5.3 (11)
Individuals	
Fathers	4.5
Caregivers	4.1
Children	4.9
Individuals attending all treatment sessions***	
Fathers	25% (10)
Caregivers	4% (1)
Children	25% (10)
Families attending program sessions as a whole	25% (10)

* Two caregivers attended a treatment session but were not officially enrolled in the evaluation.
**Among families with a caregiver enrolled in the evaluation and attended at least 1 treatment session.
***Among those enrolled in the evaluation.

Discussion, Limitations, and Conclusions

The SFP holds promise for improving outcomes for families after fathers exit the prison system. In general, fathers, caregivers, and youth who received the program fared better on some outcomes and not as well on others relative to families in the control group. Compared to those not in the program, fathers in the program were more likely to be employed and pay child support seven weeks after the program began; caregivers reported a closer relationship with their child six months later; and youth reported more frequent contact with their nonresidential father six months after the program started. Other findings, although not significant, also showed generally positive impacts from participating in the SFP program, and frequently had at least a moderate effect size. Furthermore, reports from focus groups suggest that fathers and caregivers may be deriving other benefits, such as a strong desire to be a good parent and an increased social support system comprised of other families in the program.

These positive results emerged despite challenges recruiting families into the program. It remains a possibility that the barriers to enrollment may have excluded some fathers who could benefit most from the program, and a greater number of significant results in this study would likely have occurred with a larger sample size. As described, recruitment was particularly challenging because of specific program requirements (e.g., limiting the target population to fathers released from jail/prison in the last 24 months, having a child participate, limiting the age of the child), other time constraints for families (e.g., work conflicts), father-caregiver strained relationships, and probation restrictions that prevented fathers from accessing services on weekends (e.g., house arrest restrictions). The study team identified some strategies that improved recruitment across the duration of the study, such as providing financial incentives, implementing individualized recruitment, offering additional orientation meetings, and expanding and diversifying the recruitment techniques. Although recruitment improved, it remained a consistent challenge for program implementers and the study team. Program participation might be even greater if these types of programs were institutionally recognized by organizations working with parents returning from prison and better integrated into other reentry services. For instance, program enrollment might increase if these programs were discussed with prisoners prior to reentry and if attending these programs was an acceptable activity to participate in when under house arrest.

Although not always statistically significant or substantively meaningful (based on the calculated effect sizes), some findings contrasted with the primarily positive results of the SFP. For example, fathers in the program reported providing less in-kind support post-intervention compared with fathers in the control group. However, SFP fathers were more likely than control group fathers to pay their formal child support orders following the program. The decline in in-kind support may have been counterbalanced by this improvement in formal child support payments among treatment group fathers or more awareness on the part of the SFP fathers about their expectations for contributing to the well-being of their children to child well-being. SFP fathers may have rated themselves lower on certain outcome measures like provision of in-kind support after completing the program because they had raised their standards for themselves as providers for their children and were less likely to over report their contributions.

Encouraging families to participate in a program together can benefit parents and children, particularly as a way to connect children to their fathers after periods of separation such as during incarceration. Nevertheless, bringing the family together to participate in this type of program can be challenging, and these challenges were reflected in program attendance. A relatively small number of families attended sessions together (with father, caregiver, and child), and some family members were not able to attend any lessons. Nevertheless, positive results emerged even with limited participation, which suggests the program may have even more significant impacts if attendance were improved further. Some consistent barriers to attendance included difficulty with transportation, work conflicts, and family obligations. It may be that this type of program needs to provide transportation to participants and possibly provide flexible lesson times (e.g., offer a couple options for same lesson). In addition, suggestions from the focus group highlight the importance of having more out-of-class activities for families. These activities may help families further connect with one another and possibly increase their investment in the program as a whole. In the future, it also may be useful to survey parents explicitly about the factors that would make them more likely to attend each lesson.

Other suggestions from the implementation evaluation provide additional insight into the program. As a whole, fathers and caregivers felt that they learned valuable interpersonal skills through the SFP, such as setting boundaries for children, thinking before reacting, and improving communication in general. Fathers in the program also thought about their role as a responsible father and how to be a better father. They considered how their own upbringing influences their parenting, and many expressed a desire to truly listen and be there for their children, even if those behaviors were not modeled in their upbringing. Parents also appreciated the bonds they formed with other parents in the program and wish they had more opportunities to interact with them.

During the focus groups, multiple fathers and caregivers described challenges with establishing and maintaining positive relationships between parents. Caregivers, for example, specifically noted the need for a relationship program to address the strains on the father-caregiver relationship when the father returns from prison. Fathers also talked about similar challenges with their relationship with the mother or other caregiver. In the future, an important program enhancement may be to provide more a direct focus on improving the different dimensions of the father-mother relationship (as co-parents, but also as romantic partners in some cases) as well as to teach different strategies for navigating strained relationships. It is important to note that these strained relationships between fathers and caregivers also contributed to recruitment challenges.

Study limitations include small sample sizes with only 40 treatment and 40 control families, despite ongoing adjustments to improve recruitment and retention. Among those who did enroll, low attendance was a challenge, though it did improve over time. Finally, attrition limited sample sizes even further. Although these limitations reduce the utility of the findings for criminal justice policy and practice, others in the field implementing and evaluating similar interventions can learn from this study to ensure that future programming sufficiently recognizes and addresses barriers to reentering fathers' participation in family strengthening programs.

In conclusion, this evaluation study presents some preliminary, yet promising findings from the impact and process evaluations that suggest that interventions like the SFP can provide a

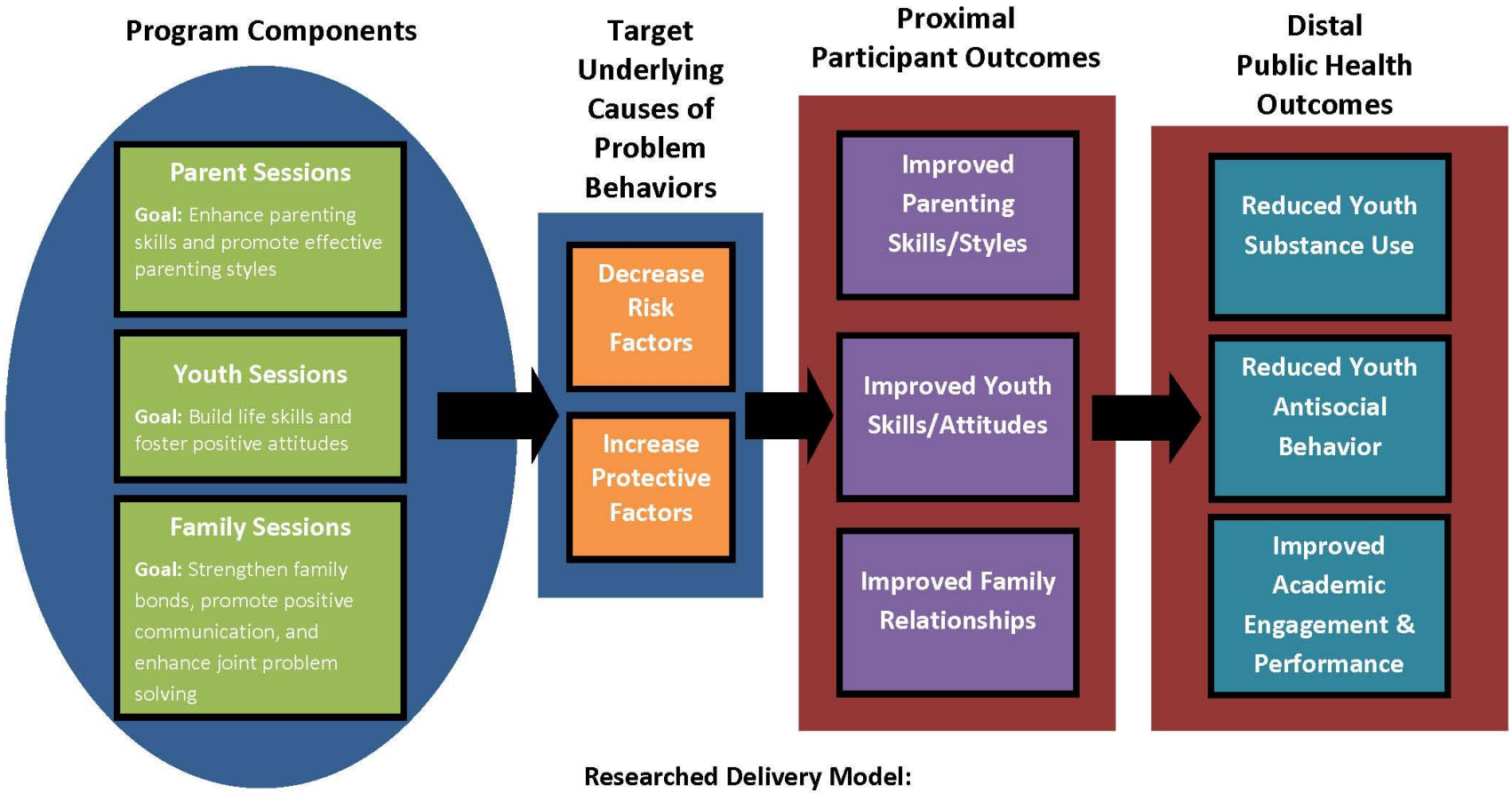
valuable opportunity for fathers returning from prison to connect with their children, other family members, and other men and families in their community who are facing similar challenges upon reentry. Strengthening family relationships after incarceration can benefit fathers, children, and families. Therefore, more reentry organizations may want to consider adding a family component to more traditional reentry services as a way to further secure fathers' role in the lives of their children, and promote father and child well-being and overall family functioning. However, to fully understand the reentry process, the needs of fathers and their families, and how programs and policies can best serve these families, future evaluations would benefit from larger sample sizes and greater retention. Knowledge gained from this study, along with future work will help the criminal justice system, social service agencies, and communities work collaboratively to better meet the needs of reentering fathers and their families.

APPENDIX A

Strengthening Families Program: For Parents and Youth 10-14 (ISFP or SFP 10-14)

The original version of this program was developed through Project Family by the Social and Behavioral Research Center for Rural Health at Iowa State University.

Logic Model created by the Evidence-based Prevention and Intervention Support Center (EPISCenter) at the Pennsylvania State University



Researched Delivery Model:

•targets youth ages 10 to 14 and their caregivers •goal of serving 10 families per program •delivered once weekly for 7 weeks •a scripted curriculum with interactive video instruction •led by three facilitators •parent and youth sessions run concurrently followed by a joint family session for approximately two hours of instruction •a family meal is recommended prior to program delivery to promote bonding and facilitator modeling

$$ It has been shown that for every dollar spent on implementation of SFP 10-14, there is a return of up to $9.60 and a cost benefit of $5,923 per youth. $$

Iowa State University, Institute for Social & Behavioral Research - Spoth, R., Guyll, M., & Day, S. (2002)

APPENDIX B

Table A. Outcome Measures				
Measure	**Single Item/ Scale/Index**	**Questions/Items**	**Coded Response Categories**	**Reporters**
Measures of Father Well-Being				
Employment	Single Item	What best describes your situation now? • Employed full-time • Employed part-time • Employed temporarily (Full-time or part-time) • Looking for work • On layoff from a job • Waiting for a new job to begin	0= Not employed (Looking, layoff, or waiting) 1= Employed (Full-time, part-time, or temp)	Father
Depressive Symptoms	Scale *Possible range: 0-3*	During the last 30 days, how often did you feel… a. So sad nothing could cheer you up? b. Nervous? c. Restless or fidgety? d. Hopeless? e. That everything was an effort? f. Worthless?	0=None of the time 1=Some of the time 2=Most of the time 3=All of the time	Father
Parental Stress	Scale *Possible range: 0-3*	During the past month, how often have you felt… a. That your child is harder to care for than most? b. That your child does things that are really irritating? c. You are giving up more than you ever expected for your child? d. Angry with your child?	0=None of the time 1=Some of the time 2=Most of the time 3=All of the time	Father

Measures of Father-Caregiver Relationship				
Parental Cooperation	Scale *Possible range: 0-4*	Please indicate how often these questions are true for you. a. When you and your child's father/mother/caregiver talk about how to raise the child, how often is the conversation hostile or angry? b. When your child complains about his/her father/mother/caregiver, how often do you agree with him or her? c. How often do you and your child's father/mother/caregiver have different ideas as to how to raise him/her? d. How often is the relationship between you and your child's father/mother/caregiver tense? e. How often would you say your child's father/mother/caregiver helps you in raising your child? (reverse coded) f. When you need help with your child, how often do you go to his/her father/mother/caregiver? (reverse coded)	0=Always 1=Often 2=Sometimes 3=Rarely 4=Never	Father Caregiver
Measures of Father-Child Relationship and Caregiver-Child Relationship				
Live with Focal Child	Single Item	Do you currently live with the child all the time?	0=No 1=Yes	Father
Father-Child Contact	Single Item	Some dads/kids see their kids/dads every day and some dads/kids don't. In the last month, how often did you see or talk to your child/dad? **Only asked of fathers/children who do not live with child/father all the time.*	0=Never 1=Hardly Ever 2=Sometimes 3=Often	Father Child

Child Support Order	Single Item	Do you have a legal agreement or child support order that requires you to provide financial support for your child?	0=No 1=Yes	Father
Paid Child Support	Single Item	In the past month, did you actually pay child support for this child?	0=No 1=Yes	Father
Father In-Kind Support	Scale *Possible range: 0-3*	How often have you done any of the following for your child? a. Bought clothes, diapers, toys, or presents for your child b. Paid for the child's medical insurance, doctor's bills, or medicine c. Given the child's mother extra money to help out, not including child support d. Helped pay for child care expenses	0=Never 1=Hardly ever 2=Sometimes 3=Often	Father
Shared Activities	Index *Possible range: Fathers and Caregivers: 0-11 Children: 0-10*	In the last month, which of the following things have you done with your child/father/mother/caregiver? a. Gone shopping b. Played a sport c. Gone to a religious service or church-related event d. Talked about your/his/her friends or things you have/he/she has done with friends e. Gone to a movie, play, museum, concert, sports event, or other event or activity f. Spent time together playing games, watching TV, listening to music, or just hanging out g. Talked about your/his/her school work or grades h. Participated in activities or events at school* i. Worked on homework for school or studied together j. Talked about other things you are/he/she is doing in school k. Ate a meal or went to a restaurant together	0=No 1=Yes	Father Caregiver Child

		**This item was not asked to child respondents.*		
Closeness	Scale *Possible range: 0-4*	How close do you feel to your child/father/mother/caregiver?	0=Not close at all 1=Not very close 2=Somewhat close 3=Quite close 4=Extremely close	Father Caregiver Child
		How much do you care about your child/father/mother/caregiver?	0=Not at all 1=Very little 2=Somewhat 3=Quite a bit 4=Very much	
Measures of Child Well-Being				
Behavior Problems	Scale *Possible range: 0-3*	All kids act in different ways depending on how they're feeling. How often do the following behaviors describe you/the child participating in the program with you now or within in the past month? a. I/They act too young for my/their age. b. I/They argue a lot. c. I/They have trouble concentrating or paying attention. d. I/They brag a lot. e. I/They cannot sit still. f. I am/They are disobedient at school. g. I am/They are afraid of doing badly. h. I/They pick on others.	0=None of the time 1=Some of the time 2=Most of the time 3=All of the time	Father Caregiver Child
Self-Regulation	Scale *Possible range: 0-3*	And how often do each of the following statements describe you/the child participating in the program with you now or within the past month? a. I/They wait my/their turn during activities. b. I/They cope well with disappointment or frustration. c. I/They accept it when things do not go my/their way. d. When I/they get upset, I/they whine or complain.	0=None of the time 1=Some of the time 2=Most of the time 3=All of the time	Father Caregiver Child

		(reverse coded) e. I/They control my/their temper when there is a disagreement. f. I/They stop and calm down when I am/they are frustrated or upset. g. I/They think before I/they act. h. I/They do what I am/they are asked to do. i. I/They stick with an activity until it is finished.		
Academic Competence	Scale *Possible range: 0-3*	In the last month, how often have you had trouble doing the following things? a. Getting along with your teachers. b. Paying attention in school. c. Getting your homework done. d. Getting along with other students.	0=None of the time 1=Some of the time 2=Most of the time 3=All of the time	Child
Risky Behaviors	Index *Possible range: 0-16*	In the last year, how many times have you… a. Skipped school, cut classes without your parents' permission, or refused to go to school? b. Been suspended from school? This includes both in-school and out-of-school suspensions. c. Been expelled from school? d. Run away from home? In the last month, how many times did you… a. Purposely damage or destroy property that did not belong to you? b. Steal something from a store, person or house, or that did not belong to you worth 50 dollars or more? c. Get into a fight and hit, kicked, or hurt someone? d. Get in trouble with the law, that is, arrested or threatened with arrest?	0=Never 1=Once 2=More than once	Child
Social Competence	Scale *Possible range: 0-3*	How often do you think each of the following statements is true of you? a. I show respect for teachers and neighbors. b. I get along well with other kids.	0=None of the time 1=Some of the time 2=Most of the time 3=All of the time	Child

		c. I try to understand people's feelings. d. I try to work out problems with classmates, family, or friends.		
Internalizing Problems	Index *Possible range: 0-33*	Kids experience many different feelings. How often do the following statements describe how you feel now or within the past month? a. I am shy. b. I feel like crying. c. Bad things happen to me. d. I can't do anything right. e. I feel tired. f. Nothing is fun for me. g. I worry about things. h. I have bad dreams. i. I have trouble sleeping. j. Lots of things scare me. k. I feel unhappy or sad.	0=None of the time 1=Some of the time 2=Most of the time 3=All of the time	Child
Father/ Caregiver Warmth and Communication	Scale *Possible range: 0-3*	How often would you say that the following statements are true about you and your father/mother/caregiver? a. Your father/mother/caregiver is warm and loving toward you. b. Your father/mother/caregiver praises and encourages you. c. When you do something wrong that is important, your father/mother/caregiver talks about it with you and helps you understand why it is wrong. d. You are satisfied with the way your father/mother/caregiver and you communicate with each other. e. Overall, you are satisfied with the relationship with your father/mother/caregiver.	0=None of the time 1=Some of the time 2=Most of the time 3=All of the time	Child

[i] Sacks, V., Murphey, D., & Moore, K. (2014). Adverse childhood experiences: National and state-level prevalence. Child Trends publication #2014-28. Retrieved from: http://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

[ii] Murphey, D. & Cooper, P.M. (2015). *Parents Behind Bars: What Happens to Their Children?* Child Trends publication: #2015-42. Retrieved from: http://www.childtrends.org/wp-content/uploads/2015/10/2015-42ParentsBehindBars.pdf

[iii] Murphey, D. & Cooper, P.M. (2015). *Op. cit*.

[iv] Haskins, A.R. (2015). Paternal incarceration and child-reported behavioral functioning at age 9. *Social Science Research, 52*, 18-33.

[v] Murray, J., Farrington, D. P., & Sekol, I. (2012). Children's antisocial behavior, mental health, drug use, and educational performance after parental incarceration: a systematic review and meta-analysis. *Psychological bulletin*, *138*(2), 175.

[vi] Haskins, A.R. (2014). Unintended consequences: Effects of paternal incarceration on child school readiness and later special education placement. *Sociological Science, 1*, 141-158.

[vii] Turney, K., & Haskins, A.R. (2014). Falling behind? Children's early grade retention after paternal incarceration. *Sociology of Education, 87*(4), 241-258.

[viii] Miller, H.V., & Barnes, J.C. (2015). The association between parental incarceration and health, education, and economic outcomes in young adulthood. *American Journal of Criminal Justice*.

[ix] Lee, R. D., Fang, X., & Luo, F. (2013). The impact of parental incarceration on the physical and mental health of young adults. *Pediatrics 131*(4), e1188-e1195.

[x] Fletcher, R., StGeorge, J., & Freeman, E. (2013). Rough and tumble play quality: Theoretical foundations for a new measure of father-child interaction. *Early Child Development and Care*, *183*(6), 746-759.

[xi] Carlson, M. J. (2006). Family structure, father involvement, and adolescent behavioral outcomes. *Journal of Marriage and Family*, *68*(1), 137-154.

[xii] Sarkadi, A., Kristiansson, R., Oberklaid, F., & Bremberg, S. (2008). Fathers' involvement and children's developmental outcomes: A systematic review of longitudinal studies. *Acta paediatrica*, *97*(2), 153-158.

[xiii] Coley, R. L., & Hernandez, D. C. (2006). Predictors of paternal involvement for resident and nonresident low-income fathers. *Developmental Pscyhology*, *42*(6), 1041-1056.

[xiv] Healthy Marriage & Responsible Fatherhood (HMRF). (2015). *5 Things to Know about Diversity in Fatherhood & Fathering.*HMRF Report. Retrieved from: https://hmrf.acf.hhs.gov/resources/what-does-the-literature-say-a-guide-to-recent-responsible-fatherhood-research/

[xv] Glaze, L. E., & Maruschak, L. M. (2008). *Parents in prison and their minor children*. Washington, DC: Bureau of Justice Statistics.

[xvi] Geller, A. (2013). Paternal incarceration and father–child contact in Fragile Families. *Journal of Marriage and Family*, *75*(5), 1288-1303.

[xvii] Turney, K. (2014). The consequences of parental incarceration for maternal neglect and harsh parenting. *Social Forces*, *92*(4), 1607-1636.

[xviii] Turney, K. & Wildeman, C. (2013). Redefining relationships: Explaining the countervailing consequences of paternal incarceration for parenting. *American Sociological Review*, *78*(6), 949-979.

[xix] McLean, R., & Thompson, M. (2007). Repaying debts. New York, NY: Council of State Governments Justice Center.

[xx] Sacks, V., Murphey, D., & Moore, K. (2014). Op. cit.

[xxi] Geller, A., & Franklin, A.W. (2014). Paternal incarceration and the housing security of urban mothers. *Journal of* Marriage and Family, 76, 411-427.

[xxii] Haskins, A.R. (2015). *Op. cit.*

[xxiii] Haskins, A.R. (2014). *Op. cit.*

[xxiv] Loper, A. B., & Tuerk, E. H. (2006). Parenting programs for incarcerated parents: Current research and future directions. *Criminal Justice Policy Review, 17*(4), 407-427.

[xxv] Magaletta, P. R., & Herbst, D. P. (2001). Fathering from prison: Common struggles and successful solutions. *Psychotherapy: Theory, Research, Practice, Training, 38*(1), 88-96.

[xxvi] Rudel, C. H., & Hayes, M. C. (1990). Behind no bars. *Children Today*, *19*, 20-23.

[xxvii] Jeffries, J., Menghraj, S., & Harrington, C. F. (2001). *Serving incarcerated and ex-offender fathers and their families: A review of the field*. New York: Vera Institute of Justice.

[xxviii] Molgaard, V., Kumpfer, K. L. & Spoth, R. (1994). The Iowa strengthening families program for pre and early teens. Ames, IA: Iowa State University.

[xxix] Iowa State University: Extension and Outreach. (2016). *Strengthening Families Program: For Parents and Youth 10-14*. Retrieved from: http://www.extension.iastate.edu/sfp10-14/.

[xxx] Iowa State University: Extension and Outreach. (2016). *Op. cit.*

[xxxi] Spoth, R., Redmond, C., Shin, C., Greenberg, M., Feinberg, M., & Schainker, L. (2013). PROSPER Community-University Partnership Delivery System Effects on Substance Misuse through 6½ Years Past Baseline from a Cluster Randomized Controlled Intervention Trial. *Preventive Medicine, 56*(0), 190–196.

[xxxii] Spoth, R., Randall, G. K., & Shin, C. (2008). Increasing School Success Through Partnership-Based Family Competency Training: Experimental Study of Long-Term Outcomes. *School Psychology Quarterly : The Official Journal of the Division of School Psychology, American Psychological Association, 23*(1), 70–89.

[xxxiii] Miller, A. L., Perryman, J., Markovitz, L., Franzen, S., Cochran, S., & Brown, S. (2013). Strengthening incarcerated families: Evaluating a pilot program for children of incarcerated parents and their caregivers. *Family relations*, *62*(4), 584-596.

[xxxiv] Glaze, L. E., & Maruschak, L. M. (2008). *Op. cit.*

[xxxv] Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature (Louis de la Parte Florida Mental Health Institute Publication# 231). *Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network*.