Creating Lasting Family Connections®

FATHERHOOD REENTRY PROGRAM

A Reentry Program certified by:

The Substance Abuse & Mental Health Services Administration (SAMHSA)
National Registry of Evidence-based Programs & Practices (NREPP)
2013

Developed by:

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CREATING LASTING FAMILY CONNECTIONS®

FATHERHOOD PROGRAM

The Creating Lasting Family Connections Fatherhood Program© was developed to help individuals who are experiencing or are at-risk for family dissonance resulting from the individual's physical separation due to incarceration. Most will return to their community. All will need help with reentry.

"CONTENTS"

NCJA National Criminal Justice Association
Justice Bulletin

Ninety-two percent of federal and state prisoners have children, and of these more than half of them have children under the age of 18. With so many incarcerated fathers who will eventually return to the community, there is an obvious need to not only focus on employment and housing, but also fatherhood and family reintegration. Compelling research indicates that effective reentry programs for men are critical to reducing recidivism, strengthening family connections and promoting social and economic well-being. One such program is the Creating Lasting Family Connections Fatherhood Program (Fatherhood Program), which works to address the needs of fathers, men in father-like roles, and men who are planning to become fathers who will reintegrate with their families following release. Developed by The Council on Prevention and Education Substances, Inc. (COPES), the initiative provides a $41 return on investment for every taxpayer dollar spent by the program.

Success

Based in Louisville Kentucky, the COPES Fatherhood Program has received national recognition from both the justice and public health sectors. In 2009, the program and its curriculum were identified as a promising program by the Administration for Children and Families (ACF), and in 2013 it was listed on the National Registry of Evidence-Based Programs and Practices (NREPP). In addition to being cost-effective, the program and its parent curriculum Creating Lasting Family Connections, have been shown to reduce recidivism by 60 percent, improve family engagement and enhance relationship building- skills. The program's overarching family connections curriculum has also been highlighted by the White House Office of National Drug Control Policy, The Office of Juvenile Justice and Delinquency Prevention, and has been nominated for review on The National Institute of Justice's CrimeSolutions.gov website.

Nuts and Bolts

Based on the Creating Lasting Family Connections curriculum, the Fatherhood Program is designed to strengthen families, enhance parenting skills, and minimize risks related to substance abuse, violence, risky sexual behavior, and recidivism. The adapted curriculum is specifically designed to cultivate an atmosphere of respect, inclusion, and sensitivity targeting the adult male population.

Using a multi-faceted strength-based approach, the curriculum is comprised of four highly interactive modules that are delivered in up to 20 weekly or bi- weekly two-hour group sessions by qualified trainers. With curriculum informed by adult learning theory, the program has been administered both in the community and in corrections settings and has served over 1,500 participants since 2005.

The program engages individuals immediately upon release (or conditional release) and offers services in the community. The program consists of three standard modules focusing on developing positive parental influences; raising resilient children; and Getting Real which focuses on communication skills. One additional optional module - the ABC 3 (D) Approach to HIV, Hepatitis and Other Sexually Transmitted Diseases Prevention - focuses on effective preventive measures, and healthy sexual expression practices. While in the program, participants have access to case management and community referral services. Regular fidelity checks are required and conducted through the collaborative efforts of trainers, administrators and community partners.

Funding

The program was initially funded through a Substance Abuse, HIV, & Hepatitis Prevention for Minority Populations in Communities of Color Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). Currently, funding comes from in-kind contributions from community partners; private donations; and funding from SAMHSA and the Administration for Children and Families, Office of Family Assistance. Current efforts aim to develop a comprehensive long term sustainability plan that will involve several local and national partnerships. Several grant extensions were awarded through 2015.

Moving Forward

The Fatherhood Program is one of the organization's evidence-based interventions, consistently demonstrating positive outcomes for participants and taxpayers alike. The influence and success of COPES's Family Connections and Fatherhood Programs have helped stimulate community awareness about the importance of family re-integration. While the program is currently grant funded, the organization hopes to institutionalize funding through dedicated private or public sources. The agency is also working towards the creation of a dedicated Family Recovery Support Center, which will not only provide new office and training space but will also provide 30 units of supportive and transitional housing, family support and reintegration services and supportive employment/job placement services. This expansion will help the agency expand the number of clients serviced and expand the types of residential offerings available to those re-entering from incarceration.

For more information about COPES, Inc. and the Creating Lasting Family Connections Fatherhood Program: Family Reintegration click here

SECTION 2:

Substance Abuse & Mental Health Services Administration (SAMHSA) Newsletters

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RECOVERY TO PRACTICE
Resources for Behavioral Health Professionals

E-Newsletter

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Featured Practice

The field of substance abuse prevention evolved struggling for an identity. As founding President of the National Association of Prevention Professionals and Advocates in the 1980s, one of the authors witnessed the tension between factions who wanted to (a) broaden the field's interests to include all mental/physical health and wellness issues and (b) remain focused solely on substance abuse. Although the association disbanded in the early 1990s, both views continue to have strong followings and ongoing influence. Generally, substance abuse prevention has evolved with a much broader vision across individual, family, and community domains. In recent years, substance abuse prevention has broadened to include environmental approaches across multiple disciplines.

As both substance abuse prevention and treatment develop and gather new science- and evidence-based practices, growing bodies of treatment and prevention professionals are recognizing their overlapping roles and potential synergies. Strader and Boyd (2002) illustrated how one prevention curriculum recognized by SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) was being effectively integrated into treatment settings. This strategy has proven highly effective when both the prevention curriculum developer and treatment providers recognized and addressed the intergenerational and chronic nature of addiction and the family's role in both the disease and in recovery. Members of the Institute for Research, Education and Training in Addictions have recently been advocating for the convergence of these two fields to national audiences through a

series of presentations, Webinars, and publications (Flaherty & Strader, 2012). Prevention and treatment providers can also benefit from recognizing that the entire healthcare paradigm is shifting in this direction as evidenced (and promoted) by the Affordable Care Act. Citing recent research including the 2006 Institute of Medicine report that supports the view of addiction as a chronic disease, when applying a Chronic Care Model to the treatment of substance use it then becomes possible for communities to dynamically integrate recovery principles and prevention practice in a process that continuously builds individual and community recovery capital in their vibrant application (Flaherty, 2006). We have begun calling this approach Prevention and Recovery-Informed Care.

Recovery, like all behavior change, takes place in an environment. Behavioral change appears to happen most readily in an environment of awareness, knowledge, and clarity supported by ongoing openness and honesty. Professional, peer, and family support is often required over a lifetime with chronic conditions. In the past, addiction treatment has often only created a short-term environment that helps initiate change. This new model holds the potential to extend the environment of change throughout the client's family, workplace, and community. Under the Prevention and Recovery-Informed Care model, treatment providers will more readily link with recovery, peer support, and wider community and environmental support, including self-help and Web-based technologies such as In The Rooms online recovery support and Altus Day2Day (relapse prevention technologies) to help people with addictions transition more successfully upon leaving controlled treatment settings. Coordinated prevention-informed activities and recovery support supply a holistic environment of change for the individual and his or her extended family, friends, workplace, peers, etc., who may also benefit from services across the entire continuum of care (from primary prevention, early intervention, recovery, and post-recovery care to lifelong relapse prevention and wellness). Prevention and Recovery-Informed Care leads to individual and family recovery, intergenerational prevention, and long-term recovery support and health promotion throughout the community.

Having 35 years of experience with prevention, we reverted back to this original line of thought in our foundation. In prevention programs, we were referring many parents to treatment, and, as expected, children fared better when their parents entered treatment. As we continued to use this model of primary prevention (plus referrals), we recognized that individuals in recovery were attracted to our prevention model for their children. The recovering adults experienced recovery supports in our prevention programming in addition to gaining positive prevention results with their children. This stimulated a new level of cooperation and integration between the prevention and treatment professionals in our community—so much so that state prisons asked us to design a program for those transitioning back into the community from prison.

We conducted a year-long needs assessment, gathering information from local, state, and national resources; local agencies serving the prison reentry and substance abuse recovery populations; and—most important—cultural input from reentry and recovery individuals through a series of surveys and focus groups. This research allowed us to design culturally relevant prevention programs (relapse and recidivism prevention) that met the expressed needs of adults in prison reentry and substance abuse recovery. The three most common requests were as follows: we need respect, relationship skills, and skills to obtain and keep a job.

Integrating this information with our existing prevention knowledge and skill, we designed two new curricula, the *Creating Lasting Family Connections (CLFC) Fatherhood Program: Family Reintegration*, for fathers, and the *CLFC Marriage Enhancement Program*,

for married and/or committed couples. The goal of this integrated prevention approach was ***connect-immunity*** (the more emotionally connected one is, the more immune to social disease one becomes). Details of the theoretical underpinnings of the CLFC program are discussed more fully elsewhere (Strader, Collins, & Noe, 2000). We set out to increase relationship skills as a basis of recovery support, to provide "soft" job skills, deepen awareness of chronicity and family recovery and intergenerational prevention, and provide referral and networking with aftercare programming and peer support. We integrated these Prevention and Recovery-Informed Care services with other services offered to reentry populations. Based on a study with fathers and another with married couples, participants showed statistically significant improvement in all nine targeted relationship skills (communication, conflict resolution, intrapersonal, interpersonal, emotional awareness, emotional expression, relationship management, relationship satisfaction, and relationship commitment; Shamblen, Arnold, McKiernan, Collins, & Strader, 2013). Two studies involving adult men demonstrated dramatic reductions in recidivism. Participants were three (2.94) times *less* likely to recidivate than comparison group participants in one study, and four (3.7) times *less* likely in the other (McKiernan, Shamblen, Collins, Strader, & Kokoski, 2012). Both interventions should be listed on SAMHSA's NREPP this month.

It was the integration of our prevention and treatment knowledge that led to this success. We started with the foundation of our evidence-based *CLFC* curriculum series (connect-immunity), which shares skills and information on how to (a) strengthen individuals and families, (b) increase awareness through self-reflection and review of family history, and (c) increase resiliency through emotional management, refusal skill training, and developing close, connected relationships built on clear understandings, open and honest communication, unconditional love, personal accountability, and ever-evolving levels of trust. Throughout the *CLFC* programs, we encouraged participants to consider sharing program material with their children for prevention, and many of them did.

Our prevention experience engendered our ability to bring an even broader approach of mutual responsibility to an individual with addiction and all people involved in that individual's life. Prevention often involves networking and developing community coalitions with multiple providers to access needed services (transportation, housing, child support, job readiness, job placement, and more).

Since prison reentry and recovering populations may have limited networks of support (e.g., family members, friends, counselors, ministers, probation officers, therapists, or other interested parties) that may be invested in their long-term success, we created a special approach to case management and recovery management called the Joint Intervention Meeting (JIM). JIMs involve a Prevention and Recovery-Informed Care model of encouraging, supporting, and setting up accountability partners for participants in early periods of recovery or reentry when the risks for behavioral slippage are typically high. *CLFC* program staff and partners indentified and interrupted early signs of behavioral slippage (risky behaviors). In essence, the JIM is the intentional intersection of community and personal networks to intervene in an individual's current patterns of risky behavior (treatment) and prevent future risky behavior (prevention) through mutual support, accountability, and referral to needed community services.

Conclusion

As in the recovery movement, the prevention field benefits greatly by viewing addiction as a long-term, chronic disease. Prevention and treatment professionals who also recognize addiction as a family disease with intergenerational tendencies can assist with developing community-wide networks of information and support. Prevention professionals often have experience

and tools to address the intellectual clarity, knowledge, and skills for the necessary behavioral changes needed across all the individual, family, workplace, and community domains, along with experience in working across the entire continuum of care from primary prevention, early intervention, treatment, and long-term recovery.

Prevention and treatment professionals can co-create individual, family, workplace, and community clarity about the lifelong chronic nature of addiction and the necessity of treating the disease with a long-term, holistic individual, family, and community approach. Prevention professionals often recognize the complex genetic, environmental, and lifestyle factors leading to addiction and how to prevent the progression from substance use to addiction. Prevention professionals also have the knowledge and skills to help individuals and families intervene in addiction, support recovery, and reconnect people to recovery support when relapse occurs.

Finally, prevention activity often brings in a positive focus on wellness and health, rather than sickness. Cutting-edge prevention and addiction professionals are recognizing and understanding that addiction is a chronic, family disease and that developing recovery and wellness is a holistic, environmental experience that takes place across individual, family, workplace, and community domains. The role of effective treatment and prevention professional practice is to teach and promote self-care versus "fighting" a disease at the individual level; self-care versus enabling attitudes and behaviors at the family and workplace level; and, systemic self-care, support, and health promotion through workplaces, peer support networks, school, media, employee assistance, and wellness programs and other environmental approaches at the community level.

As prevention and treatment continue to evolve in collaborative interaction to address addiction, we are seeing not only a broad intersection, but an even more complex and interactive pattern emerging for the future. The individual strands of best practice from prevention and treatment can be woven together into a strong rope for use along the pathway of hope for individuals, families, and communities. This rope of Prevention and Recovery-Informed Care may be used to climb back out of the valley of addiction, up and onto the flatlands of recovery, and beyond, as individuals ascend the peaks of wellness toward personal fulfillment and intergenerational improvement.

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Contact Us

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RECOVERY TO PRACTICE
Resources for Behavioral Health Professionals

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July 25, 2013
Issue 14

Featured Practice

Intersection of Treatment and Prevention: Prevention and Recovery-Informed Care, by Ted N. Strader, Christopher Kokoski, and Stephen R. Shamblen, Ph.D. Professional practitioners across diverse, yet interrelated, fields (i.e., substance abuse prevention, addiction treatment, psychiatry, psychology, psychiatric nursing, social work) are beginning to realize their intersection, leading to synergistic impacts when coordinating substance abuse prevention and addiction treatment activities. This intersection can be nurtured to be quite broad to serve as a central hub of hope, recovery, and wellness for individuals, families, and entire communities.

Since the early 1980s, we have been involved in the discussion, development, and promotion of both substance abuse treatment and prevention certification. As early advocates serving on the original Kentucky certification boards for treatment and prevention, we had unsuccessfully argued that prevention and treatment were so deeply interconnected that they should share one common certification body. However, in Kentucky and throughout the nation, the two fields have evolved independently.

Treatment began largely as a short-term, client-centered service conducted in controlled environments (i.e., hospitals, treatment centers, etc.). Consistent with the medical paradigm that largely treats acute disease, a short-term approach emerged. Unfortunately, that approach often produced relatively short-term positive outcomes. When clients left this controlled environment and returned to the community, relapse into substance abuse and other unhealthy behavior patterns was commonplace. As a result of these undesirable long-term outcomes, the recovery movement of 12-step meetings (e.g., Alcoholics Anonymous, Narcotics Anonymous), sponsors and other peer support activities were combined with treatment regimens to help addicts transition more successfully following treatment. More support and longer-term support resulted in greater success.

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Section 3:

Certifications:

National Registry of Evidence-based Programs & Practices (NREPP)

a. Creating Lasting Family Connections Fatherhood Program (CLFCFP)
b. Creating Lasting Family Connections Marriage Enhancement Program (CLFCMEP)
c. Creating Lasting Family Connections Core Program (CLFC)

Creating Lasting Family Connections Fatherhood Program: Family Reintegration (CLFCFP)

The Creating Lasting Family Connections Fatherhood Program: Family Reintegration (CLFCFP) is designed for fathers, men in fatherlike roles (e.g., mentors), and men who are planning to be fathers. The program was developed to help individuals who are experiencing or are at risk for family dissonance resulting from the individual's physical and/or emotional separation (e.g., incarceration, substance abuse, military service). Premised on social learning theory and on moderating risk and enhancing protective factors, CLFCFP is designed to modify the attitudes of participants and help them to (1) strengthen families and establish strong family harmony, (2) enhance parenting skills, and (3) minimize the likelihood of further personal problems (e.g., substance abuse, violence, risky sexual behavior, prison recidivism).

Two certified trainers implement the program with a group of 8-20 participants during 2-hour sessions that are held weekly or twice weekly over 8-20 weeks, for a total of 16-20 sessions. The program consists of three standard modules and one optional module:

- Developing Positive Parental Influences. This standard module is intended for participants who are interested in positively influencing youth. Participants are expected to develop a greater awareness of facts and feelings about chemical use, abuse, and dependency; to review effective approaches to prevention; and to develop a practical understanding of intervention, referral procedures, and treatment options. This module includes an examination of personal and group feelings and attitudes toward alcohol and drug issues, as well as an in-depth look at the dynamics of chemical dependency and its impact on marriages and families.
- Raising Resilient Youth. This standard module is intended to help participants in raising youth who can withstand life challenges and social and environmental pressures. In this module, participants learn and practice effective communication skills with their families, including listening to and validating others' thoughts and feelings and successfully managing personal thoughts and feelings. Participants also examine and enhance their ability to develop and implement expectations and consequences with others, including spouses, coworkers, friends, and children. Participants are taught how to include children's active participation in setting expectations and consequences. This encourages dialogue, which enhances a sense of competence, connectedness, and bonding between parent and child.
- Getting Real. This standard module encourages participants to examine their responses to the verbal and nonverbal communication they experience in their interactions with others. Participants receive personalized coaching on effective communication skills, including speaking with confidence and sensitivity, listening to and validating others, sharing feelings, and matching body language with verbal messages. This module promotes the skills of self-awareness and mutual respect while focusing on helping participants combine thoughts, feelings, and behavior in a way that leads them to generate powerful and meaningful messages to others.
- The ABC 3(D) Approach to HIV, Hepatitis and Other Sexually Transmitted Diseases Prevention. This optional module describes the primary modes of transmission of HIV, viral hepatitis, and other sexually transmitted diseases. The module concludes with a discussion of effective preventive measures to reduce or eliminate the risk of infection. Healthy sexual expression is recognized, discussed, and supported. During this component, participants are also offered free, confidential, on-site HIV testing.

Case management is a critical component of CLFCFP, and program implementers are strongly encouraged to have an understanding of how to assess the needs of participants and link participants to additional support services in the community. Before delivering the program, all trainers must become certified through a 6- to 8-day implementation training; also, it is recommended that trainers be a certified substance abuse prevention specialist and/or a certified alcohol and drug counselor.

In one study reviewed for this summary, CLFCFP was delivered to men and women. Both reviewed studies included all four CLFCFP modules. In one reviewed study, all participants had been recently released from prison, and in the other study, 78% of all participants had been released from prison. Participants in both reviewed studies also received substance abuse treatment services during incarceration.

Creating Lasting Family Connections programs have been developed for use with other targeted populations. The Creating Lasting Family Connections/Creating Lasting Connections program has been designed for use with families of high-risk youth, and the Creating Lasting Family Connections Marriage Enhancement Program has been designed for use with couples; these programs have been reviewed separately by NREPP.

Descriptive Information

Areas of Interest	Mental health promotion Substance abuse prevention Substance abuse treatment
Outcomes	**Review Date: January 2013**

	1: Recidivism 2: Relationship skills 3: Knowledge about sexually transmitted diseases 4: Intention to binge drink 5: Spirituality
Outcome Categories	Alcohol Crime/delinquency Family/relationships Quality of life
Ages	18-25 (Young adult) 26-55 (Adult) 55+ (Older adult)
Genders	Male Female
Races/Ethnicities	American Indian or Alaska Native Black or African American Hispanic or Latino White Race/ethnicity unspecified
Settings	Correctional Other community settings
Geographic Locations	Urban Suburban Rural and/or frontier
Implementation History	CLFCFP was first implemented in 2006 in two federally funded and evaluated projects in Louisville, Kentucky: the Connect-Immunity Project and the Jefferson County Fatherhood Initiative. CLFCFP is currently being implemented in two 3-year projects (one in Louisville, Kentucky, and one in Chicago, Illinois) funded by the Administration for Children and Families. Since 2006, approximately 1,200 participants have received the program.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: No Evaluated in comparative effectiveness research studies: No
Adaptations	No population- or culture-specific adaptations of the intervention were identified by the developer.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Selective Indicated

Quality of Research

Review Date: January 2013

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

McGuire & Associates & Pacific Institute for Research and Evaluation. (2011, March). Connect-Immunity Project: Final evaluation report.

McKiernan, P., Shamblen, S. R., Collins, D. A., Strader, T. N., & Kokoski, C. (2013). Creating Lasting Family Connections: Reducing recidivism with community-based family strengthening model. Criminal Justice Policy Review, 24(1), 94-122.

Study 2

McKiernan, P., Shamblen, S. R., Collins, D. A., Strader, T. N., & Kokoski, C. (2013). Creating Lasting Family Connections: Reducing recidivism with community-based family strengthening model. Criminal Justice Policy Review, 24(1), 94-122.

Pacific Institute for Research and Evaluation & McGuire & Associates. (2011, April). Promoting Responsible Fatherhood Initiative: COPES final evaluation report.

Outcomes

Outcome 1: Recidivism	
Description of Measures	Recidivism was assessed with data obtained from the Kentucky Department of Corrections at posttest (immediately following the end of the program) and at follow-up (from 3 to 6 months after the posttest assessment). These data indicated whether each participant had a revocation (e.g., parole or probation violation resulting in subsequent reincarceration), was arrested, or absconded.
Key Findings	A study was conducted with men and women who were recently released from prison and who received substance abuse treatment services during incarceration. Participants voluntarily participated in CLFCFP (intervention group) or in other programs typically offered to those being released from prison, such as residential reentry centers, training and job assistance, substance abuse treatment, and group-based substance abuse support (e.g., Alcoholics/Narcotics Anonymous) (comparison group). At the follow-up assessment, participants in the intervention group were 3.70 times less likely than participants in the comparison group were to recidivate (odds ratio = 0.27; $p < .01$). Another study was conducted with men who received substance abuse treatment services during incarceration and who voluntarily participated in CLFCFP (intervention group) or in other programs typically offered to those being released from prison, such as residential reentry centers, training and job assistance, substance abuse treatment, and group-based substance abuse support (e.g., Alcoholics/Narcotics Anonymous) (comparison group). Most of the participants (78%) had been released from prison at the time of their study participation. From posttest to the follow-up assessment, participants in the intervention group were 2.94 times less likely than participants in the comparison group were to recidivate (odds ratio = 0.34; $p < .05$).
Studies Measuring Outcome	Study 1, Study 2
Study Designs	Quasi-experimental
Quality of Research Rating	3.2 (0.0-4.0 scale)

Outcome 2: Relationship skills	
Description of Measures	This outcome was measured by a 71-item questionnaire that assessed varying relationship skills across nine scales: • Communication Skills (e.g., "I am able to express my true feelings to those whom I trust") • Conflict Resolution Skills (e.g., "Even when in a conflict with someone I trust, I can respectfully share my thoughts and feelings") • Intra-Personal Skills (e.g., "I am honest with myself about what I feel and need") • Emotional Awareness (e.g., "Those I trust can really understand my hurts and joys") • Emotional Expression (e.g., "I often let others know what I am feeling") • Inter-Personal Skills (e.g., "I'm open and honest with what I say to those I trust") • Relationship Management Skills (e.g., "I know I can count on some of the people in my life") • Relationship Satisfaction (e.g., "I am happy with how conflict is resolved in my relationships") • Relationship Commitment ("I trust my partner enough to stay with them") Using a score ranging from 1 (strongly disagree) to 5 (strongly agree), participants rated each item. Scale scores were calculated from the average scores of items in each scale, then all nine scale scores were averaged to create a relationship skills aggregate summary measure for all skills examined.
Key Findings	A study was conducted with men who received substance abuse treatment services during incarceration and who voluntarily participated in CLFCFP (intervention group) or in other programs typically offered to those being released from prison, such as residential reentry centers, training and job assistance, substance abuse treatment, and group-based substance abuse support (e.g., Alcoholics/Narcotics Anonymous) (comparison group). Most of the participants (78%) had been released from prison at the time of their study participation. All participants were assessed at pretest; at posttest, immediately following the end of the program; and at follow-up, from 3 to 6 months after the posttest assessment. From pretest to the follow-up assessment, participants in the intervention group had an improvement in the relationship skills aggregate summary measure

	relative to participants in the comparison group ($p < .01$). Specifically, participants who received CLFCFP had a large improvement from pre- to posttest and then a slight improvement from posttest to the follow-up assessment; those in the comparison group had relatively constant relationship skills from pretest to the follow-up assessment. The same pattern of results was found for all nine scales ($p < .01$ for each scale).
Studies Measuring Outcome	Study 2
Study Designs	Quasi-experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Outcome 3: Knowledge about sexually transmitted diseases	
Description of Measures	Knowledge about sexually transmitted diseases was assessed with 18 true/false items (e.g., "only people who look sick can spread the HIV/AIDS virus"). Each participant's score was determined as the percentage of correct responses, with higher scores indicating greater knowledge about sexually transmitted diseases.
Key Findings	A study was conducted with men and women who were recently released from prison and who received substance abuse treatment services during incarceration. Participants voluntarily participated in CLFCFP (intervention group) or in other programs typically offered to those being released from prison, such as residential reentry centers, training and job assistance, substance abuse treatment, and group-based substance abuse support (e.g., Alcoholics/Narcotics Anonymous) (comparison group). All participants were assessed at pretest; at posttest, immediately following the end of the program; and at follow-up, from 3 to 6 months after the posttest assessment. From pretest to the follow-up assessment, participants in the intervention group had a greater increase in knowledge about sexually transmitted diseases relative to participants in the comparison group ($p < .01$).
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.9 (0.0-4.0 scale)

Outcome 4: Intention to binge drink	
Description of Measures	Intention to binge drink was assessed with a single item: "In the next 6 months, how likely are you to drink five or more alcoholic drinks in one sitting?" Response options ranged from 1 (not at all likely) to 4 (very likely).
Key Findings	A study was conducted with men and women who were recently released from prison and who received substance abuse treatment services during incarceration. Participants voluntarily participated in CLFCFP (intervention group) or in other programs typically offered to those being released from prison, such as residential reentry centers, training and job assistance, substance abuse treatment, and group-based substance abuse support (e.g., Alcoholics/Narcotics Anonymous) (comparison group). All participants were assessed at pretest; at posttest, immediately following the end of the program; and at follow-up, from 3 to 6 months after the posttest assessment. From pretest through the follow-up assessment, intention to binge drink remained relatively constant for participants in the intervention group but increased for participants in the comparison group ($p < .05$).
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.9 (0.0-4.0 scale)

Outcome 5: Spirituality	
Description of Measures	Spirituality was assessed with three items: (1) "In general, how important are religious or spiritual

	beliefs in your day-to-day life?" (2) "When you have problems or difficulties with your school (education), work, family, friends, or personal life, how often do you seek spiritual guidance and support?" and (3) "How spiritual or religious would you say you are?" Each item used a different Likert-type response scale, and all items were transformed to a 1-4 response scale prior to calculating the mean rating.
Key Findings	A study was conducted with men and women who were recently released from prison and who received substance abuse treatment services during incarceration. Participants voluntarily participated in CLFCFP (intervention group) or in other programs typically offered to those being released from prison, such as residential reentry centers, training and job assistance, substance abuse treatment, and group-based substance abuse support (e.g., Alcoholics/Narcotics Anonymous) (comparison group). All participants were assessed at pretest; at posttest, immediately following the end of the program; and at follow-up, from 3 to 6 months after the posttest assessment. From pretest to the follow-up assessment, participants in the intervention group had an increase in spirituality, and those in the comparison group had a decrease ($p < .01$).
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	2.9 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	18-25 (Young adult) 26-55 (Adult) 55+ (Older adult)	77% Male 23% Female	53% Black or African American 45.8% Race/ethnicity unspecified 1.2% Hispanic or Latino
Study 2	18-25 (Young adult) 26-55 (Adult) 55+ (Older adult)	100% Male	57% White 37% Black or African American 3% Hispanic or Latino 2% Race/ethnicity unspecified 1% American Indian or Alaska Native

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Recidivism	3.1	3.1	3.5	3.0	3.0	3.5	**3.2**
2: Relationship skills	2.5	2.5	3.5	3.0	3.0	3.5	**3.0**
3: Knowledge about sexually transmitted diseases	2.3	2.3	3.5	3.0	3.0	3.5	**2.9**
4: Intention to binge drink	2.3	2.3	3.5	3.0	3.0	3.5	**2.9**

5: Spirituality	2.3	2.3	3.5	3.0	3.0	3.5	**2.9**

Study Strengths

The psychometric properties of all outcome measures ranged from fair to good. The measure used to assess relationship skills was adapted from a validated measure to more closely align with the principles and content of the intervention. Fidelity was addressed in several ways, yielding high rates of adherence; for example, implementers received training in the delivery of the intervention, and activity logs were kept for each session to determine whether the content was delivered as intended. Statistical techniques were used to address attrition. Statistical analyses used current conventions and were appropriate for the data and study questions.

Study Weaknesses

Intention to binge drink was measured by only one item. Cronbach's alpha values were low for three of the nine scales of the validated measure used to assess relationship skills, and it is unclear how this measure was adapted to meet the needs of the diverse sample. Although the measures have face validity, no data were provided to support other forms of validity. The study did not use randomization to conditions, raising some concerns about confounding variables. Although statistical approaches controlled for confounding variables, the approaches had limitations.

Readiness for Dissemination

Review Date: January 2013

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Council on Prevention and Education: Substances, Inc. (2005). Creating Lasting Family Connections. Developing Positive Parental Influences: High, drunk or state of mind? [DVD]. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2005). Creating Lasting Family Connections. Developing Positive Parental Influences: Problem drinking or alcoholism [DVD]. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2005). Creating Lasting Family Connections. Developing Positive Parental Influences: The intoxication curve [DVD]. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2005). Creating Lasting Family Connections. Getting Real: Adult role play [DVD]. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2005). Creating Lasting Family Connections. It takes two to know you! [DVD]. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2007). Creating Lasting Family Connections. Developing Positive Parental Influences manual. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2007). Creating Lasting Family Connections. Developing Positive Parental Influences notebook. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2007). Creating Lasting Family Connections. Getting Real manual. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2007). Creating Lasting Family Connections. Getting Real notebook. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2007). Creating Lasting Family Connections. Raising Resilient Youth manual. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2007). Creating Lasting Family Connections. Raising Resilient Youth notebook. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections. ABC 3(D) Approach to HIV, Hepatitis and Other Sexually Transmitted Diseases Prevention notebook. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections. ABC 3(D) Approach to HIV, Hepatitis and Other Sexually Transmitted Diseases Prevention trainer manual. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections Fatherhood Program: Family Reintegration. Adaptation guidebook. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections Fatherhood Program: Family Reintegration. Case management services and optional joint intervention meeting (JIM) guide. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections Fatherhood Program: Family Reintegration. Implementation training guide, fidelity package, national training and certification system. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections Fatherhood Program: Family Reintegration. Master training certification training materials. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections Fatherhood Program: Family Reintegration. Retrospective survey kit. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections Fatherhood Program: Family Reintegration. Survey kit for outcome evaluation. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections: Secrets to successful facilitation. Louisville, KY: Resilient Futures Network.

Program Web site, http://www.copes.org/explore-fatherhood.php

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
4.0	4.0	4.0	**4.0**

Dissemination Strengths

The implementation and training materials are organized and easy to follow. A preimplementation assessment tool is available to help organizations determine their readiness to implement the program. The facilitation guide provides information on the roles and characteristics of a successful group facilitator as well as several suggested scripts, and the adaptation guidebook provides additional implementation support, if needed. Training is required and can be tailored to the needs of the adopting organization. The materials for the master training option include session-by-session instructions, preparation guidelines, goals, objectives, and notes for each program module. Quality assurance is addressed in the comprehensive fidelity package and the outcome evaluation kit. The quality assurance instruments are designed to be used throughout the implementation process, and materials allow trainers and management to assess fidelity during the implementation process.

Dissemination Weaknesses

No weaknesses were identified by reviewers.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Developing Positive Parental Influences training kit (includes trainer manual, poster set, and set of 25 participant notebooks)	$250 each	Yes
Raising Resilient Youth training kit (includes trainer manual, poster set, and set of 25 participant notebooks)	$250 each	Yes

Getting Real training kit (includes trainer manual, poster set, and set of 25 participant notebooks)	$250 each	Yes
The ABC 3(D) Approach to HIV, Hepatitis and Other Sexually Transmitted Diseases Prevention training kit (includes trainer manual and set of 25 participant notebooks)	$150 each	No
Participant notebooks (set of 25), available for each of the 4 modules	$99.95 per set for each module	No
Trainer manuals, available for each of the 4 modules	$75 per manual for each module	No
Adaptation guidebook	$99 each	No
Secrets to Successful Facilitation	$75 each	No
Program package (includes a trainer manual for each of the four modules, a set of 25 participant notebooks for each of the 4 modules, a poster set for the 3 standard modules, adaptation guidebook, case management services and optional joint intervention meeting guide, Secrets to Successful Facilitation, fidelity package, survey kit for outcome evaluation, retrospective survey kit, carrying case for posters, and carrying case for manuals and notebooks)	$1,125 per package	No
It Takes Two To Know You! [DVD]	$100 each	No
Getting Real: Adult Role Play [DVD] (with trainer's notes)	$114 each	No
Developing Positive Parental Influences: The Intoxication Curve [DVD]	$114 each	No
Developing Positive Parental Influences: High, Drunk or State of Mind? [DVD]	$114 each	No
Developing Positive Parental Influences: Problem Drinking or Alcoholism [DVD]	$114 each	No
8-day, off-site implementation training for up to 18 participants in Louisville, Kentucky (includes national training and certification system materials, implementation training guide, program fidelity package, and up to 10 hours of implementation consultation by phone)	$950 per participant (maximum of 18 participants)	Yes (one implementation training option is required)
6- to 8-day, on-site implementation training for up to 18 participants (includes national training and certification system materials, implementation training guide, program fidelity package, and up to 10 hours of implementation consultation by phone)	$800-$1,500 per day for up to 18 participants, depending on the trainers, plus travel expenses for 2 trainers	Yes (one implementation training option is required)
8-day, off-site master training in Louisville, KY (includes master trainer certification training materials)	$3,500 per participant (maximum of 12 participants)	No
Case management services and optional joint intervention meeting guide	$30 each	No
Additional phone consultation	$65 per hour	No
On-site consultation	$520 per day, plus travel expenses	No
Survey kit for outcome evaluation	$149 each	No
Additional outcome evaluation survey booklets (set of 25)	$69.99 per set	No
Retrospective survey kit	$99 each	Yes

Replications

No replications were identified by the developer.

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.copes.org/explore-fatherhood.php**
- **http://www.myresilientfuturesnetwork.com**

Creating Lasting Family Connections Marriage Enhancement Program (CLFCMEP)

The Creating Lasting Family Connections Marriage Enhancement Program (CLFCMEP) is a community-based effort designed for couples in which one or both partners have been physically and/or emotionally distanced because of separation due to incarceration, military service, substance abuse, or other circumstances. The principal goal of CLFCMEP is to build and/or strengthen partners' relationship skills by providing structure and the opportunity for participants to develop greater capacity in the areas of communication, conflict resolution, emotional awareness, commitment, and trust.

Two certified trainers implement the module-based program with a group of 4-15 couples through one of the following implementation options: (1) an 8- to 10-session format (with 2-hour sessions), (2) a 2- to 3-day weekend retreat format, or (3) an 18- to 20-session format (with 2-hour sessions) that includes all modules. The program is delivered through a combination of instructional and interactive formats, and trainers encourage partners to discuss ideas and practice skills with each other and with other couples both during and between sessions. CLFCMEP consists of up to three stand-alone interactive training modules:

- Marriage Enhancement. This module consists of 12 marriage-focused, guided exercises that are designed to strengthen marriage through the learning of open, nondefensive communication skills. These skills include the partners' development of a shared vision, understanding of positive and negative traits, understanding of personal needs and the needs of his or her partner, active listening, expectations, compassion, romance, and fair fighting.
- Getting Real. This module is designed to enhance marital relationships through clear and honest communication and the setting of boundaries, and it uses guided role-playing in which partners learn to identify the effects of verbal and nonverbal communications in their relationship.
- Developing Positive Parental Influences. This module is intended for participants who are interested in positively influencing youth. Participants are expected to develop a greater awareness of facts and feelings about chemical use, abuse, and dependency; to review effective approaches to prevention; and to develop a practical understanding of intervention, referral procedures, and treatment options. This module includes an examination of personal and group feelings and attitudes toward alcohol and drug issues, as well as an in-depth look at the dynamics of chemical dependency and its impact on marriages and families.

Case management is a critical component of CLFCMEP, and program implementers are strongly encouraged to have an understanding of how to assess the needs of participants and link participants to additional support services in the community. In addition, before delivering the program, trainers must become certified through a 3-day implementation training.

In the study reviewed for this summary, CLFCMEP was delivered through both a 10-session format and a weekend retreat format. The program was provided to husbands who had been recently released from prison and/or substance abuse treatment and their wives. The husbands were felony offenders, and many of them had drug- or alcohol-related convictions.

Creating Lasting Family Connections programs have been developed for use with other targeted populations. The Creating Lasting Family Connections/Creating Lasting Connections program has been designed for use with families of high-risk youth, and the Creating Lasting Family Connections Fatherhood Program has been designed for use with fathers, men who are in fatherlike roles, and men who plan to be fathers; these programs have been reviewed separately by NREPP.

Descriptive Information

Areas of Interest	Mental health promotion
Outcomes	**Review Date: January 2013** 1: Relationship skills
Outcome Categories	Family/relationships
Ages	18-25 (Young adult) 26-55 (Adult) 55+ (Older adult)
Genders	Male

	Female
Races/Ethnicities	Black or African American Hispanic or Latino White
Settings	Outpatient Correctional Other community settings
Geographic Locations	Urban Suburban Rural and/or frontier
Implementation History	CLFCMEP was first implemented in 2006 in a federally funded and evaluated project: the Jefferson County Healthy Marriage Initiative in Louisville, Kentucky. Since 2006, the initiative has served approximately 300 couples.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: No Evaluated in comparative effectiveness research studies: No
Adaptations	No population- or culture-specific adaptations of the intervention were identified by the developer.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Selective Indicated

Quality of Research

Review Date: January 2013

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Pacific Institute for Research and Evaluation. (2011, June). Addendum to Jefferson County Healthy Marriage Initiative: Final evaluation report.

Pacific Institute for Research and Evaluation & McGuire & Associates. (2011, May). Jefferson County Healthy Marriage Initiative: Final evaluation report.

Supplementary Materials

McGuire & Associates. (2011, September). Jefferson County Healthy Marriage Initiative: COPES, Inc. Semi-annual evaluation report: Year 5. Healthy Marriage Initiative Grant.

Shamblen, S. R., Arnold, B. B., McKiernan, P., Collins, D. A., & Strader, T. N. (2012). Applying the Creating Lasting Family Connections Marriage Enhancement Program to marriages affected by prison reentry. Family Process. Advance online publication. doi:10.1111/famp.12003

Outcomes

Outcome 1: Relationship skills	
Description of Measures	This outcome was measured by a 71-item questionnaire that assessed various relationship skills across nine scales: • Communication Skills (e.g., "I am able to express my true feelings to those whom I trust") • Conflict Resolution Skills (e.g., "Even when in a conflict with someone I trust, I can respectfully share my thoughts and feelings") • Intra-Personal Skills (e.g., "I am honest with myself about what I feel and need") • Emotional Awareness (e.g., "Those I trust can really understand my hurts and joys") • Emotional Expression (e.g., "I often let others know what I am feeling") • Inter-Personal Skills (e.g., "I'm open and honest with what I say to those I trust")

	• Relationship Management Skills (e.g., "I know I can count on some of the people in my life") • Relationship Satisfaction (e.g., "I am happy with how conflict is resolved in my relationships") • Relationship Commitment ("I trust my partner enough to stay with them") Using a score ranging from 1 (strongly disagree) to 5 (strongly agree), participants rated each item. Scale scores were calculated from the average scores of items in each scale, then all nine scale scores were averaged to create a relationship skills aggregate summary measure for all skills examined.
Key Findings	A study was conducted with husbands who had been recently released from prison and/or substance abuse treatment and their wives. Data from the couples, who participated in CLFCMEP together, were collected at pretest; at posttest, immediately following the end of the program; and at follow-up, 3-6 months after the posttest assessment. Husbands who received CLFCMEP were compared with a convenience sample of husbands who had been recently released from prison but who participated in other programs typically offered to prisoners upon release; these programs included contact with parole staff and aftercare programming, such as residential reentry centers, training and job assistance, substance abuse treatment, and group-based substance abuse support (e.g., Alcoholics/Narcotics Anonymous). Data were not collected from the wives of the husbands in the comparison group. Findings from pretest to the follow-up assessment included the following: • Husbands who received CLFCMEP had an improvement in the relationship skills aggregate summary measure relative to husbands in the comparison group ($p < .01$). Specifically, husbands who received CLFCMEP had a large improvement from pre- to posttest and then a slight improvement from posttest to the follow-up assessment; husbands in the comparison group had relatively constant relationship skills from pretest to the follow-up assessment. The same pattern of results was found for eight of the nine scales ($p < .01$ for each of the eight scales); there was no significant between-group difference in scores for the Relationship Commitment scale. • Wives who participated with their husbands in CLFCMEP had an improvement in the relationship skills aggregate summary measure ($p < .01$) and in all nine scales ($p < .01$ for each scale). Like their husbands, the wives had a large improvement from pre- to posttest and then a slight improvement from posttest to the follow-up assessment for the summary measure and each scale.
Studies Measuring Outcome	Study 1
Study Designs	Quasi-experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	18-25 (Young adult) 26-55 (Adult) 55+ (Older adult)	64.1% Male 35.9% Female	51% Black or African American 46% White 3% Hispanic or Latino

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Relationship skills	2.5	2.5	3.5	3.0	3.0	3.5	**3.0**

Study Strengths

The measure used to assess relationship skills was adapted from a validated measure to more closely align with the principles and content of the intervention. The study considered multiple aspects of fidelity, including the requirement of certification for implementers and the completion of session activity logs by workshop leaders, which demonstrated that all required activities were implemented in the sampled sessions. There were no significant differences in attrition between intervention and comparison groups. Where attrition was identified as being related to key variables, appropriate statistical corrections were used. Analyses were appropriate for the data and study questions posed.

Study Weaknesses

Cronbach's alpha values were low for three of the nine scales. It is unclear how the validated measure was adapted to meet the needs of the diverse sample. Although the Heckman two-step procedure offers a means of correcting for nonrandomly selected samples and helps address issues of selectivity, it does not eliminate all issues and weaknesses related to a quasi-experimental design. It is unclear how the husbands' use of typically offered services impacted the findings.

Readiness for Dissemination

Review Date: January 2013

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections Marriage Enhancement Program: Implementation training guide, program fidelity package, and national training and certification system. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections Marriage Enhancement Program: Master training certification training materials. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections Marriage Enhancement Program: Participant notebook. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections Marriage Enhancement Program: Retrospective survey kit. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections Marriage Enhancement Program: Survey kit for outcome evaluation. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections Marriage Enhancement Program: Trainer manual. Louisville, KY: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (2012). Creating Lasting Family Connections: Secrets to successful facilitation. Louisville, KY: Resilient Futures Network.

Program Web site, http://www.copes.org/explore-marriage.php

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating

4.0	4.0	4.0	**4.0**

Dissemination Strengths

The implementation and training materials are comprehensive, well organized, and easy to follow. A preimplementation assessment tool is available to help organizations determine their readiness to implement the program. The facilitation guide provides information on the roles and characteristics of a successful group facilitator as well as several suggested scripts. The training, which is required and can be tailored to the needs of the adopting organization, includes opportunities for practice and role-play. The materials for the optional master training include session-by-session instructions, preparation guidelines, goals, objectives, and notes for each program module. Ample materials for quality assurance are provided in the program fidelity package and the survey kit for outcome evaluation. The quality assurance instruments are designed to be used throughout the implementation process so that "course corrections" can be made as needed.

Dissemination Weaknesses

No weaknesses were identified by reviewers.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Participant notebooks (set of 24)	$99.95 per set	Yes
Trainer manual	$75 each	Yes
Secrets to Successful Facilitation	$75 each	No
Program package (includes trainer manual, set of 24 participant notebooks, program fidelity package, survey kit for outcome evaluation, retrospective survey kit, and carrying case for materials)	$472.95 each	No
3-day, off-site implementation training in Louisville, KY (includes national training and certification system materials, implementation training guide, program fidelity package, and up to 10 hours of implementation consultation by phone)	$650 per participant (maximum of 18 participants)	Yes (one implementation training option is required)
3-day, on-site implementation training (includes national training and certification system materials, implementation training guide, program fidelity package, and up to 10 hours of implementation consultation by phone)	$2,400-$4,500 for up to 18 participants, depending on the trainers, plus travel expenses for 2 trainers	Yes (one implementation training option is required)
5-day, off-site master training in Louisville, KY (includes training materials)	$2,500 per participant (maximum of 12 participants)	No
Additional phone consultation	$65 per hour	No
On-site consultation	$520 per day, plus travel expenses	No
Survey kit for outcome evaluation	$149 each	No
Participant outcome evaluation survey booklets (set of 24)	$69.99 per set	No
Retrospective survey kit	$99 each	Yes

Replications

No replications were identified by the developer.

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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.copes.org/explore-marriage.php**
- **http://www.myresilientfuturesnetwork.com**

Creating Lasting Family Connections (CLFC)/Creating Lasting Connections (CLC)

Creating Lasting Family Connections (CLFC), the currently available version of Creating Lasting Connections (CLC), is a family-focused program that aims to build the resiliency of youth aged 9 to 17 years and reduce the frequency of their alcohol and other drug (AOD) use. CLFC is designed to be implemented through a community system, such as churches, schools, recreation centers, and court-referred settings. The six modules of the CLFC curriculum, administered to parents/guardians and youth in 18-20 weekly training sessions, focus on imparting knowledge and understanding about the use of alcohol and other drugs, including tobacco; improving communication and conflict resolution skills; building coping mechanisms to resist negative social influences; encouraging the use of community services when personal or family problems arise; engendering self-knowledge, personal responsibility, and respect for others; and delaying the onset and reducing the frequency of AOD use among participating youth. The program supports problem identification and referrals to other community services for participants when necessary. Manuals for trainers, notebooks for participants, and other materials are available, but the program is intended to be modified with each implementation to reflect the needs of the participants and the skill level of the trainers.

Creating Lasting Connections was an experimental program implemented and evaluated in church and school communities with the families of high-risk 11- to 14-year-old youth. CLC served as the basis for CLFC, which is now in use.

CLFC programs have been developed for use with other targeted populations. The Creating Lasting Family Connections Fatherhood Program has been designed for use with fathers, men who are in fatherlike roles, and men who plan to be fathers, and the Creating Lasting Family Connections Marriage Enhancement Program has been designed for use with couples; these programs have been reviewed separately by NREPP.

Descriptive Information

Areas of Interest	Substance abuse prevention
Outcomes	**Review Date: June 2007** 1: Use of community services 2: Parent knowledge and beliefs about AOD 3: Onset of youth AOD use 4: Frequency of youth AOD use
Outcome Categories	Alcohol Drugs Family/relationships Tobacco
Ages	6-12 (Childhood) 13-17 (Adolescent) 26-55 (Adult)
Genders	Male Female
Races/Ethnicities	Data were not reported/available.
Settings	School Other community settings
Geographic Locations	Urban Suburban Rural and/or frontier

Implementation History	According to the developer, since the publication and distribution of the CLFC curriculum, the program has been implemented by professionals and volunteers in hundreds of cities in almost all 50 States, Puerto Rico, and the U.S. Virgin Islands (St. Thomas and St. Croix). CLFC also has been used in Canada, Ghana, Indonesia, Mexico, Netherlands Antilles (St. Maarten), Spain, and United Arab Emirates. It is estimated that tens of thousands of individuals have participated in the CLFC intervention.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: No Evaluated in comparative effectiveness research studies: No
Adaptations	CLFC materials are produced in English and Spanish. In addition, one component of CLFC, the community advocate team (CAT), ensures that the intervention is adapted by each community implementing it. According to program developers, this group (formerly known as the church advocate team) assists with "building a two -way bridge of understanding and acceptance between the participant population and the facilitator(s)" by teaching the program facilitators about local cultural issues. The cultural input provided by the CAT informs appropriate adaptations to the program.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the developer.
IOM Prevention Categories	Universal Selective Indicated

Quality of Research

Review Date: June 2007

Documents Reviewed

The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Johnson, K., Berbaum, M., Bryant, D., & Bucholtz, G. (1995). Evaluation of Creating Lasting Connections: A program to prevent alcohol and other drug abuse among high risk youth. Final evaluation report. Louisville, KY: Urban Research Institute.

Johnson, K., Bryant, D. D., Collins, D. A., Noe, T. D., Strader, T. N., & Berbaum, M. (1998). Preventing and reducing alcohol and other drug use among high-risk youths by increasing family resilience. Social Work, 43(4), 297-308. PubMed

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Supplementary Materials

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Outcomes

Outcome 1: Use of community services	
Description of Measures	Parents and youth were asked a series of questions about (1) their use of community services when personal or family problems arose, (2) the action they took based on those contacts with community services, and (3) the perceived helpfulness of those actions.
Key Findings	One year after the initiation of CLC, compared with individuals who did not receive the intervention, CLC participants reported that they used more community services when personal or family problems arose ($p = .001$ for youth), they took more action based on those contacts with community services ($p = .05$ for parents, $p = .001$ for youth), and they found those actions to be

	more helpful (p = .04 for parents, p = .001 for youth).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Outcome 2: Parent knowledge and beliefs about AOD	
Description of Measures	Parents were asked a series of questions about their AOD knowledge and beliefs.
Key Findings	One year after the initiation of CLC, compared with parents who did not receive the intervention, parents who participated in CLC reported gains in knowledge about AOD and enhanced beliefs against using these substances (p < .001).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	3.0 (0.0-4.0 scale)

Outcome 3: Onset of youth AOD use	
Description of Measures	Youth were asked the age at which they first used tobacco, alcohol, marijuana, cocaine or crack, inhalants, and other drugs.
Key Findings	The program produced positive moderating effects on the onset of AOD use among youth when family-level and youth-level resiliency factors targeted by the program also improved. The onset of AOD use was delayed among youth who participated in CLC for 1 year, relative to youth in the comparison group, as parents reported increased AOD knowledge and beliefs consistent with program content (p = .03 for alcohol, p = .04 for AOD) and youth reported decreased conflict with their parents (p = .01 for alcohol, p = .05 for AOD).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	2.9 (0.0-4.0 scale)

Outcome 4: Frequency of youth AOD use	
Description of Measures	Youth were asked how frequently they used tobacco, alcohol, marijuana, cocaine or crack, inhalants, and other drugs in the past 3 and 12 months. Response options ranged from 0 (never) to 4 (more than once per day).
Key Findings	The CLC program produced positive moderating effects on the frequency of AOD use at 3- and 12-month intervals among youth when family-level and youth-level resiliency factors targeted by the program also improved. In terms of family-level factors, the frequency of alcohol use in the previous 3 months among youth who received CLC was reduced, relative to youth in the comparison group, as parents reported a decrease in their likelihood of punishing youth AOD use (p = .05); a decrease in family pathology (p = .03); and using more community services when a personal or family problem arose (p = .05), taking more action based on those contacts with community services (p = .04), and finding that those actions proved to be more helpful (p = .03). The program also produced a reduction in the frequency of alcohol and other drug use in the previous 12 months as family pathology decreased (p < .001 and p < .01, respectively). In terms of youth-level factors, the frequency of alcohol use in the previous 3 and 12 months among youth who received CLC was reduced, relative to youth in the comparison group, as youth reported an increase in being honest about their AOD use (p < .001 and p < .01, respectively), parents reported an increase in youth bonding with their father (p = .02 and p = .05, respectively), and youth reported a decrease in rejecting conventional values (p = .02 and p = .03, respectively).

	A reduction in the frequency of other drug use was related to an increase in youth being honest about their AOD use ($p < .001$) and schoolwork ($p = .02$) and an increase in parent-reported bonding between the youth and father ($p = .03$).
Studies Measuring Outcome	Study 1
Study Designs	Experimental
Quality of Research Rating	2.9 (0.0-4.0 scale)

Study Populations

The following populations were identified in the studies reviewed for Quality of Research.

Study	Age	Gender	Race/Ethnicity
Study 1	6-12 (Childhood) 13-17 (Adolescent) 26-55 (Adult)	57.5% Female 42.5% Male	Data not reported/available

Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see Quality of Research.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Use of community services	3.8	3.3	2.5	3.0	2.5	3.0	**3.0**
2: Parent knowledge and beliefs about AOD	3.8	3.3	2.5	3.0	2.5	3.0	**3.0**
3: Onset of youth AOD use	3.5	3.0	2.5	3.0	2.5	3.0	**2.9**
4: Frequency of youth AOD use	3.5	3.0	2.5	3.0	2.5	3.0	**2.9**

Study Strengths

The research team used items from well-known, well-developed measures with acceptable psychometric properties, including reliability, cultural relevance, and construct validity. Implementation fidelity was monitored in a systematic fashion using process measures for trainer behavior, content of the class, and setting of the class. Members of the church advocate team, who recruited families and participated in project implementation, received extensive training to perform their role. Attrition and some potentially confounding variables were taken into account in the analyses.

Study Weaknesses

One third of the participating families were lost to attrition. The control group was not matched to the intervention group for attention. Church advocate team members were encouraged to adapt elements of the program and recruitment strategy, but it is unclear how such modifications were tracked. There were a few issues that might be confounds in explaining the results, such as the involvement of participating families in other AOD programs and the participation of church advocate team members and their families in the intervention. Because the sample size was small, power may have been an issue in some of the analyses.

Readiness for Dissemination

Review Date: June 2007

Materials Reviewed

The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Council on Prevention and Education: Substances, Inc. (Producer). (2005). Creating Lasting Family Connections. Developing positive parental influences: The intoxication curve [Motion picture]. United States: Resilient Futures Network.

Council on Prevention and Education: Substances, Inc. (Producer). (2005). Creating Lasting Family Connections. Getting real: "Adult role play" (with trainer's notes) [Motion picture]. United States: Resilient Futures Network.

Creating Lasting Family Connections: Implementation Training

Creating Lasting Family Connections: Implementation Training Packet

Creating Lasting Family Connections: Information Packet

Creating Lasting Family Connections: Master Trainer's Binder

Data collection and other instruments:

- CLFC Fidelity Instrument
- CLFC Readiness Assessment and Scoring Key
- Facilitator interview report
- Suggested questions for facilitator interviews

Handouts:

- CLFC Order Information
- CLFC Prevention Specialist Job Description
- CLFC Trainer Characteristics
- CLFC Training, Technical Assistance, and Certification Information

Johnson, K., Young, L., & Collins, D. (2004). The Creating Lasting Family Connections program: Evaluation kit. Louisville, KY: Resilient Futures Network.

Program Web site, http://www.copes.org

Strader, T., Collins, D., & Noe, T. (2000). Building healthy individuals, families, and communities: Creating Lasting Connections. New York: Kluwer Academic/Plenum.

Strader, T., & Noe, T. (1998). Creating Lasting Family Connections: Developing independence and responsibility manual. Louisville, KY: Council on Prevention and Education: Substances.

Strader, T., & Noe, T. (1998). Creating Lasting Family Connections: Developing independence and responsibility notebook. Louisville, KY: Council on Prevention and Education: Substances.

Strader, T., & Noe, T. (1998). Creating Lasting Family Connections: Developing a positive response manual. Louisville, KY: Council on Prevention and Education: Substances.

Strader, T., & Noe, T. (1998). Creating Lasting Family Connections: Developing a positive response notebook. Louisville, KY: Council on Prevention and Education: Substances.

Strader, T., & Noe, T. (1998). Creating Lasting Family Connections: Developing positive parental influences manual. Louisville, KY: Council on Prevention and Education: Substances.

Strader, T., & Noe, T. (1998). Creating Lasting Family Connections: Developing positive parental influences notebook. Louisville, KY: Council on Prevention and Education: Substances.

Strader, T., & Noe, T. (1998). Creating Lasting Family Connections: Raising resilient youth manual. Louisville, KY: Council on Prevention and Education: Substances.

Strader, T., & Noe, T. (1998). Creating Lasting Family Connections: Raising resilient youth notebook. Louisville, KY: Council on Prevention and Education: Substances.

Strader, T., Noe, T., & Crawford Mann, W. (1998). Creating Lasting Family Connections: Getting real manual. Louisville, KY: Council on Prevention and Education: Substances.

Strader, T., Noe, T., & Crawford Mann, W. (1998). Creating Lasting Family Connections: Getting real notebook. Louisville, KY: Council on Prevention and Education: Substances.

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the intervention's Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
3.9	3.6	3.7	**3.7**

Dissemination Strengths

Implementation materials are clear and comprehensive. The core resources needed for implementation are clearly specified. The program developers provide optional training and technical assistance for various levels of expertise. Tools for outcome and implementation fidelity, a logic model, and technical assistance on evaluation are available to support quality assurance.

Dissemination Weaknesses

Guidance for implementation is provided in many different documents and sources, making it somewhat difficult for the reader to get an overall picture of program implementation. Though training is optional, the complexity of the readiness and community mobilization component of the program may make training necessary. Limited information is provided on common implementation problems and solutions. Materials do not specify how and when to use the fidelity tool.

Costs

The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

Item Description	Cost	Required by Developer
Curriculum material	$1,125	Yes
Individual CLFC training module kits	$250 each	No
Replacement manuals	$50 each	No
Replacement participant notebook sets	$99.95 for 25	No
Standard evaluation kit with one each of Youth and Parent Survey, Construct Definitions, and Psychometric Properties	$300 each	No
Additional Youth Survey Booklets set	$49.99 for 25	No
Additional Adult Survey Booklets set	$49.99 for 25	No
Retrospective Survey Kit	$300 each	No
CLFC Program Training Assessment Survey	$150 each	No
5-DVD set	$499 each	No
Getting Real: It Takes Two To Know You DVD	$100 each	No
Getting Real: Role Plays with Adults (with trainer's notes) DVD	$114 each	No
The Intoxication Curve DVD	$114 each	No

High, Drunk, or State of Mind DVD	$114 each	No
Problem Drinking or Alcoholism DVD	$114 each	No
5-day CLFC Implementation Training at COPES, Inc., in Louisville, KY (includes technical assistance for 1 year)	$500-$750 per person depending on the number attending	No
On-site CLFC Implementation Training (includes technical assistance for 1 year)	$5,000-$7,500	No
Additional on-site technical assistance	$300-$1,250 per day plus travel expenses	No
Fidelity instrument	Free	No

Replications

No replications were identified by the developer.

Contact Information

To learn more about implementation, contact:
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Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):

- **http://www.copes.org**
- **http://myresilientfuturesnetwork.com**

Chuck Burklow
Sterling Yard, Inc.

Section 4:

Studies:

CLFC: *Reducing Recidivism With Community-Based Family Strengthening Model*; Criminal Justice Policy Review; 24(1)94-122, 2013

CLFCFP: *Applying the Creating Lasting Family Connection Marriage Enhancement Program to Marriages Affected by Prison Reentry*; Family Process; 52:477-498, 2013

Criminal Justice Policy Review
24(1) 94–122

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Creating Lasting Family Connections: Reducing Recidivism With Community-Based Family Strengthening Model

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Abstract

There is increasing evidence of the effectiveness of continued care after reentry for those who have participated in prison-based substance abuse treatment. This article presents results from analyses of program and comparison group data from two community-based programs that implemented a culturally adapted version of the Creating Lasting Family Connections (CLFC) curriculum. Both programs sought to strengthen individuals (and their families) recently reentering the community after incarceration. Results suggested that the first program had effects on increasing HIV knowledge and spirituality, while reducing intentions to binge drink and recidivism. The second program similarly showed effects on recidivism, and participants also showed an increase in nine separate relationship skills. The policy implications of the results are discussed.

Keywords

recidivism, reentry, substance abuse, family strengthening, relationship skills

Over three decades, the United States has expended excessive amounts of resources and time building prisons as a primary means for handling drug offenders. As the costs for this approach have increased without the expected decrease in criminal offenses,

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found to be effective with populations of adolescents with a substance use disorder (Dennis et al., 2004; Waldron, Slesnick, Brody, Turner, & Peterson, 2001), and those with co-occurring substance use and other mental health disorders (Kaminer, Burleson, & Goldberger, 2002).

Because of prison overcrowding and the expense of incarceration, many states have aggressively developed early release initiatives and established policies to reduce recidivism (Anglin, Brown, Dembo, & Leukefeld, 2009). Research on treatment of substance abusing criminal offenders and outcomes supports the need for effective treatment approaches. This research further identified the importance of policy revision related to the successful diversion from prison and effective postrelease strategies for inmates exiting prison to ensure continued treatment at reentry (Jolley & Kerbs, 2010). Taxman (2009) provides further support in testimony before the Congressional Subcommittee on Commerce, Justice, Science, and Related Agencies, where it was concluded, "the community component is critical to sustained results"(p. 3).

To this end, many states initiated a policy shift from a punishment focus to balancing punishment and treatment (Taxman, 2008). The Second Chance Act of 2005 acknowledged that the 600,000 inmates exiting prison each year need access to resources and opportunities that allow and encourage positive participation in society to reduce recidivism and increase public safety (Pogorzelski et al., 2005). Kentucky Governor Steve Beshear (March 4, 2011) signed into law revisions to the penal code with the goal of reducing recidivism to help lower the cost of incarceration through the combination of diversion programs, substance abuse treatment, and early release programs that enhance community supervision and collaboration with community service providers. This legislation identified the need to address excessive recidivism that peaked at 44% in 2003 and stood at 40% in 2007 (Pew Center, 2011). According to the Pew Center report (2011), recidivism in Kentucky is described as prisoners returning within 3 years.

Description of the Intervention

In 2000, The Kentucky Department of Corrections (KDOC) began addressing the recidivism problem by increasing the availability of substance treatment programs: six prison programs (increased from four programs) and 18 regional jail programs (increased from two programs; Staton-Tindall et al., 2009). During the same period, the Kentucky Department of Corrections increased collaboration with community-based treatment and prevention organizations to expand support of reentry populations with the goals of reducing recidivism and increasing community protection. In particular, the KDOC sought to find partners that offered community-based programming designed to advance aftercare services using evidence-based approaches identified as effective in addressing deficits in multiple domains (e.g., psychiatric, employment, and family problems; Huebner & Cobbina, 2007). This search resulted in the KDOC developing a partnership with the Council on Prevention and Education: Substances, Inc. (COPES, Inc.).

Miller, Smith, & Tonigan, 2000; Meyers, Smith, & Lash, 2005) and in treatment that teach behavioral skills to reduce enabling and support the addict in recovery (McCrady, 1989; McCrady, Epstein, & Hirsch, 1996; Meyers et al, 2000; Miller, Meyers, & Tonigan, 1999; Rotunda & O'Farrell, 1998; Stanton, 2004; Stanton & Heath, 2005; Stanton & Shadish, 1997; Staton-Tindall, McNees, Walker, & Leukefeld, 2007; Velleman, 2006; Yoshioka, Thomas, & Ager, 1992) significantly reduce substance abuse across the following year.

Furthermore, best practices call for the use of a combination of family systems and functional analysis for assessment provided with cognitive and behavioral methods to initiate change in family members and/or the substance abuser (e.g., Kelley & Fals-Stewart, 2002; McCrady, Epstein, & Hirsch, 1999; Nelson & Sullivan, 2007; O'Farrell et al., 1996a, 1996b; O'Farrell & Fals-Stewart, 2000; Powers, Vedel, & Emmelkamp, 2008). Studies of substance abuse treatment identify positive outcomes following CBT interventions, coping skills training, identification and elimination of cognitive distortions, and development of refusal skills (Marlatt & Donovan, 2005; Monti, Abrams, Kadden, & Cooney, 1989). Other studies note the role of relapse prevention and development of self-control skills (Marlatt, Parks, & Witkiewitz, 2002). In addition, assessment scales, functional analyses, and feedback are ideally suited as group methods, and cognitive and behavioral skills training are currently delivered as primary interventions across a variety of inpatient and outpatient settings (Dennis, Foss, & Scott, 2007).

Finally, the CLFC program is based on Risk and Resiliency Theory with an emphasis on strengthening resiliency factors for individuals, their families, and their communities (Strader, Collins, & Noe, 2000). Much research has been devoted to factors that may account for successful outcomes for individuals who face high risks (Garmezy, 1985; Hawkins, Catalano, & Miller, 1992). Risk factors can include early and persistent problems such as substance use, delinquent/criminal behavior, association with peers that model problem behavior, and poor family relationships. Braverman (1999, 2001) has noted that there is a great deal of overlap between research on resiliency and research on substance abuse prevention. The resilience literature tends to take a broader view, focusing not just on substance abuse, but on the larger issues of adjustment and adaptation. Resnick (2000) has also noted that the resiliency paradigm, which emphasizes strengths, resources, and assets as opposed to the "restatement of pathology" that has characterized much of the research on communities of color, resonates with and often finds acceptance among minority constituents.

The CLFC modules, "Developing Positive Parental Influences," "Raising Resilient Youth," "Getting Real," and "The ABC 3D Approach to HIV Prevention," represent a delivery method that includes elements of each of the aforementioned approaches. A brief description of each module is outlined below:

- "Developing Positive Parental Influences" is a training that promotes a deep awareness of personal thoughts, feelings, attitudes, beliefs, and experiences along the continuum of chemical use, abuse, and dependency. This module

can avoid drug use, abuse and prison recidivism even when multiple and severe risk factors are present. Because these two projects served minority adult ex-offenders who had received substance abuse treatment while incarcerated, the program focused on relapse and prison recidivism prevention and broadly enhancing other strengths and positive resiliency factors.

A key factor in our theoretical approach to effective treatment and prevention is human "connectedness." Research on adolescents identifies family connectedness as one of the most important factors for psychological well-being and positive outcomes (Blum & Reinhardt, 1997; Doll & Lyon, 1998; Field, Diego, & Sanders, 2001). Similarly, social support systems represent an important variable in treatment compliance and outcomes for men (Booth et al., 1992). Other studies (Knight & Simpson, 1996) found that improved personal relationships during treatment improved outcomes, such as reduced drug use and greater program compliance.

Connectedness means feeling emotionally close, cared about, and listened to in one's family, with significant others outside of our family, and with others in the broader community. Furthermore, when "connected," one is able to express personal thoughts and feelings, and to discover that one's self and one's family are rooted in—and connected to—a community of "others" in significant and meaningful ways. Feeling or perceiving one's self to be connected (to self, family, and community) appears to create a protective shield of resiliency and strength to resist problem behaviors. The CLFC model proposes that connectedness is a critical protective and healing force in human beings—young or old, rich or poor, male or female. Deep, healthy human connections build strong protective shields (or immunity) to prevent harm and provide both nurturing and healing support, even when challenges penetrate this shield. From this reference came the title, "The Connect-Immunity Project." For a complete review of the underlying beliefs embedded in the CLFC intervention, please see *Building Healthy Individuals, Families, and Communities: Creating Lasting Connections* (Strader et al., 2000, p. 124).

Another key component of the CLFC intervention included comprehensive, compassionate, and culturally sensitive case management services to participants. Case managers provided caring support, advice, and referral to other services in the community to address a wide range of barriers to recovery and reentry, and to promote retention (i.e., job search skills, child care issues, transportation, etc). Case management services were offered to the individual and their family during the initial assessment, prior to and during the program, and for up to a year after enrollment into the program.

Prior to implementing the CLFC intervention, COPES, Inc. conducted a comprehensive, year-long community needs assessment to discover gaps in services, built organizational and community capacity by developing a coalition of community agencies to equip the community to fill service gaps discovered during the needs assessment process, initiated strategic planning for the program based on findings of the needs assessment process with our program partner agencies, and included input from

comparison (78%) group and in their mid-30s (intervention: 34.68 and comparison: 37.13). About half of the participants were African American (53% in both groups) and very small proportions were Hispanic (intervention: .44% and comparison: 2%). The participants were predominately of low socioeconomic status, as about one quarter were independently housed (intervention: 23% and comparison: 27%), about one half were employed (intervention: 51% and comparison: 53%), and the majority of participants had an income at or under US$30,000 (intervention: 80% and comparison: 82%). The majority of participants had either a high school diploma or a GED (intervention: 82% and comparison: 81%). The majority of participants reported that they had a heterosexual sexual orientation (95% in both groups).

Selectivity biases. Two alternative explanations for putative study findings are that (a) intervention effects could be due to nonrandom assignment of individuals to the intervention and comparison groups (i.e., a quasi-experimental design) and (b) intervention effects could be due to participants who are likely to exhibit negative outcomes being more likely to drop out of the study, especially in the intervention group. Both of these potential sources of selectivity biases were addressed using a Heckman two-step procedure (Heckman, 1976, 1979). This approach involves regressing either (a) intervention group or (b) attrition status on participant background characteristics in the first step using a probit regression model. The second step involves producing predicted scores, where these scores are transformed to an inverse Mill's ratio (IMR), and the IMR is included in all inferential analyses. These methods are not subject to the same biases that characterize propensity methods.

Prior to performing the first step probit models, missing background characteristic data were imputed using the Expectation Maximization (EM) algorithm in SPSS 18.0. EM employs maximum-likelihood estimation to ensure consistency between the variance-covariance matrix derived from the observed data and the imputed data (Dempster, Laird, & Rubin, 1977). All background characteristics mentioned in the participants section were used as predictors and outcomes in the EM model. As the amount of missing data were minimal (less than 5% for any variable) and due to the necessity of eliminating any case with any missing background characteristic, we felt that imputation posed fewer inferential risks than eliminating entire cases.

Our first probit model examined selectivity biases due to assignment to the intervention or comparison group. There was no evidence to suggest that any of the background characteristics predicted intervention group assignment ($ps > .05$) and the overall model did not predict intervention group assignment, $\chi^2(335) = 345.29, p = .34$. As there was no evidence of bias due to assignment to the intervention or comparison group, we did not create an IMR representing this source of selectivity bias.

Our second probit model examined selectivity biases due to attrition. Of the 345 participants, 70% completed all three waves of the study, 2% completed waves one and two of the study, and 28% completed only wave one of the study. Our model suggested that individuals without a high school education or GED were more likely to drop out of the study, $z = -2.26$, $p = .02$; however, the overall model did not predict attrition, $\chi^2(335) = 341.20$, $p = .40$. As we did have one significant predictor of

Table 1. Psychometrics for Outcome Measures

	No. of Items	Range	Alpha Time 1
No. of days cigarettes used (in past 30)	1	0-30	n/a
No. of days other tobacco used (in past 30)	1	0-30	n/a
No. of days alcohol used (in past 30)	1	0-30	n/a
No. of days drunk (in past 30)	1	0-30	n/a
No. of days marijuana used (in past 30)	1	0-30	n/a
No. of days other illegal drugs used (in past 30)	1	0-30	n/a
Perceived great risk of substance use	3	1-4	.72
No. of types of unprotected sex acts (last time)[a]	3	0-3	.69
No. of types of risky sexual behaviors (past 3 months)[a]	5	0-5	.34
Perceived risk of risky sexual behavior	6	1-4	.82
Knowledge	18	0-100	.78
Future high likelihood of safe sex	1	1-5	n/a
Future intentions to binge drink	1	1-4	n/a
Future intentions to use illegal drugs	1	1-4	n/a
Sexual self-efficacy	6	1-4	.90
Family cohesion	6	1-4	.86
Social support[a]	4	0-4	.80
Spirituality	3	1-4	.85
Recidivism Time 2	1	0-1	n/a
Recidivism Time 3	1	0-1	n/a

a. These scales more reflect a count of occurrences, so we would not necessarily expect these scales to follow traditional psychometric theory and have a high alpha (see Bollen & Lennox, 1991).

Substance use was measured with six items inquiring about substance use in the past 30 days, where participants indicated the number of days they had used the substance or engaged in the behavior in the past 30 days. Specifically, participants were asked about cigarette use, other tobacco use (e.g., smokeless tobacco), alcohol use, drunkenness, marijuana use, and other illegal drug use.

Perceived great risk of substance use ($\alpha = .72$) was measured with three items assessing the degree to with which participants thought people would risk harming themselves if they engaged in a moderate level of cigarette, alcohol, and marijuana use. Participants responded to items using a 1 (*no risk*) to 4 (*great risk*) scale.

Number of types of risky sexual behaviors was assessed with five items inquiring about whether a risky sexual behavior (e.g., Have you ever had unprotected sex with someone whom you knew was, or suspected of being, an injected drug user?) had occurred in the past 3 months. A count of yes responses was taken for these items. *Number of types of unprotected sex acts* was measured with three items where participants indicated if they had unprotected oral, vaginal, or anal sex the last time they engaged in sexual activities. A count of yes responses was taken for these items. Using barrier methods becomes less important with a single and consistent sex partner, especially if the goal is to reduce the likelihood of sexually transmitted diseases. As such,

directly from the Department of Corrections for each participant, and these data were not collected using the questionnaire.

Analysis. Our primary analysis of interest is concerned with examining whether (a) the changes in the intervention group between waves one and three were more positive than the changes in the comparison group between waves one and three, and (b) whether changes in the intervention group were predicted by intervention dosage. Thus this design reflects a quasi-experimental or correlational research design.

HLM was used to deal with multiple observations being nested within each participant (i.e., multiple wave repeated observations) for nearly all analyses for Question 1. Although simpler general linear models can be used to handle these data, HLM performed in this manner confers the benefits of being able to use all of the data, regardless of whether a participant has all three repeated observations (cf. Raudenbush & Bryk, 2002). This method is more consistent with an intent-to-treat approach. All models were posed as random intercept models, which assume that variability may arise among individuals due to nesting. More specifically, at Level 1 (i.e., the repeated observation level), all outcomes were seen as being predicted by orthogonally coded linear (–1, 0, 1) and quadratic (1, –2, 1) time contrasts:

$$\text{Outcome} = \pi_0 + \pi_1(\text{Linear}) + \pi_2(\text{Quadratic})$$

At Level 2 (i.e., the individual level), the Level 1 intercept was seen as being predicted by a coded contrast (–1 vs. 1) representing the intervention group and our correction for selectivity biases due to attrition:

$$\pi_0 = \beta_{00} + \beta_{01}(\text{Intervention}) + \beta_{02}(\text{Inverse Mill's Ratio}) + r_0$$

The remaining Level 2 equations represented the cross-level interactions between time and intervention group:

$$\pi_1 = \beta_{10} + \beta_{11}(\text{Intervention})$$

$$\pi_2 = \beta_{20} + \beta_{21}(\text{Intervention})$$

This approach was used to examine antisocial outcomes; however, our criminal outcome, recidivism, was examined using a simple, multiple logistic regression model. These models regressed recidivism status at Times 2 and 3 in separate analyses on intervention status and our correction for selectivity biases. All models were run using SPSS 18.0.

Results. In the interest of brevity, only statistically significant findings are graphed and discussed in the prose of the report. Our analysis of intervention effects suggested that there were some antisocial outcome intervention effects for knowledge, future intentions to binge drink, and spirituality, as well as intervention effects on recidivism (i.e., criminal behavior) at wave three. The cell means/percentages for these effects

Table 3. Intervention Effect Unstandardized Regression Coefficients, Effect Sizes, and Statistical Significance

	Intercept	Attrition Selectivity Correction	Linear Change	Quadratic (U-Shaped) Change	Intervention	Intervention X Linear	Intervention X Quadratic
No. of days cigarettes used (in past 30)	19.87 (.63)**	−1.04 (−.07)	−1.56 (−.16)**	−.26 (−.05)	−.75 (−.06)	.26 (.03)	.38 (.07)
No. of days other tobacco used (in past 30)	8.09 (.38)**	−.87 (−.07)	.17 (.02)	−.26 (−.05)	.29 (.03)	−.80 (−.08)+	.00 (.00)
No. of days alcohol used (in past 30)	.75 (.20)**	−.05 (−.02)	.31 (.09)*	.06 (.03)	−.09 (−.04)	−.15 (−.05)	−.11 (−.06)
No. of days drunk (in past 30)	.42 (.09)*	−.02 (−.01)	.10 (.03)	.03 (.02)	−.04 (−.01)	.00 (.00)	−.12 (−.06)+
No. of days marijuana used (in past 30)	.56 (.17)*	−.04 (−.02)	.13 (.04)	.18 (.10)*	−.18 (−.10)	−.25 (−.08)+	−.09 (−.05)
No. of days other illegal drugs used (in past 30)	.48 (.15)*	−.06 (−.03)	.15 (.06)	.02 (.01)	.00 (.00)	−.15 (−.05)	−.04 (−.03)
Perceived great risk of substance use	3.32 (.94)**	.01 (.01)	.07 (.11)*	−.01 (−.04)	.08 (.12)*	.01 (.02)	.00 (−.01)
No. of types of unprotected sex acts (last time)	1.42 (.59)**	.00 (.00)	−.03 (−.03)	−.01 (−.01)	.06 (.06)	.04 (.05)	.01 (.01)
No. of types of risky sexual behaviors (past 3 months)	.32 (.36)**	.00 (.00)	−.03 (−.05)	−.01 (−.03)	.00 (.00)	−.01 (−.02)	.00 (−.01)
Perceived risk of risky sexual behavior	3.47 (.96)**	−.01 (−.01)	−.01 (−.03)	−.01 (−.04)	.00 (.00)	.02 (.05)	−.01 (−.03)
Knowledge	59.96 (.85)**	1.02 (.04)	3.18 (.22)**	−1.38 (−.17)**	2.63 (.13)*	2.16 (.15)**	−.51 (−.06)
Future high likelihood of safe sex	3.30 (.86)**	.06 (.04)	.08 (.07)	.00 (−.01)	−.05 (−.05)	.02 (.02)	−.01 (−.02)
Future intentions to binge drink	1.20 (.83)**	.00 (.00)	.05 (.08)+	.01 (.02)	−.02 (−.04)	−.05 (−.09)*	−.01 (−.03)
Future intentions to use illegal drugs	1.20 (.82)**	−.02 (−.04)	.06 (.11)*	.01 (.03)	−.02 (−.04)	−.04 (−.07)+	−.01 (−.03)
Sexual self–efficacy	3.00 (.86)**	−.03 (−.02)	.04 (.05)	−.04 (−.10)*	.02 (.02)	−.03 (−.03)	−.01 (−.03)
Family cohesion	3.92 (.96)**	.00 (.00)	−.02 (−.04)	.00 (.00)	−.09 (−.14)*	.04 (.07)+	−.02 (−.06)
Social support	3.75 (.94)**	.00 (.00)	−.03 (−.05)	.00 (−.01)	.02 (.02)	.05 (.07)	−.01 (−.03)
Spirituality	3.03 (.92)**	.03 (.04)	−.02 (−.04)	.01 (.03)	.04 (.05)	.05 (.13)**	.00 (.00)

Note: Unstandardized regression coefficients listed first, and in parentheses *t*-values with accompanying degrees of freedom were transformed to an effect size *r*, using the formula presented in Cohen (1988).
+$p < .01$. *$p < .05$. **$p < .01$.

program attempts to foster in participants. Study 2 was designed explicitly to address this limitation.

Study 2

Method

Participants. The participants for the present study were 500 male individuals who voluntarily participated in the CLFC program (i.e., intervention group) or one of the

Table 5. Psychometrics for Outcome Measures

	No. of Items	Range	Alpha Time 1
Communication skills	8	1-5	.78
Conflict resolution skills	6	1-5	.52
Intrapersonal skills	9	1-5	.66
Emotional awareness	9	1-5	.78
Emotional expression	9	1-5	.85
Interpersonal skills	8	1-5	.80
Relationship management skills	8	1-5	.59
Relationship satisfaction	7	1-5	.89
Relationship commitment	7	1-5	.77
Recidivism Time 2	1	0-1	n/a
Recidivism Time 3	1	0-1	n/a

characteristics predicted attrition ($ps > .05$) and the overall model did not predict attrition, $\chi^2(489) = 498.37$, $p = .38$. As there was no evidence of bias due to attrition, we did not create an IMR representing this source of selectivity bias.

Procedure. The procedures were identical in all respects to the procedures reported for Study 1.

Measures

Questionnaire. Clients completed a questionnaire at each of the three waves of the study that included 71 items inquiring about various relationship skills using a 1 (*strongly disagree*) to 5 (*strongly agree*) scale. Some of the relationship skill items, developed by McGuire and Associates for this project, were adapted from scales by Olson and colleagues (Barnes & Olson, 2003; Olson, 2006; Olson, Fournier, & Druckman, 1986; Olson & Schaefer, 2000) to more closely align with the content and principles of CLFC. Nine facets of relationship skills were assumed to be measured by these items. We examined whether all items purported to measure an underlying construct were measuring the same underlying construct by calculating Cronbach's alpha at time one for each scale. Scale scores were calculated by taking the average of responses to items comprising each scale. The psychometric properties of these measures appear in Table 5. The nine scales measured in the data with example item content were as follows.

- Communication Skills ($\alpha = .78$, n items = 8). Example item: I am able to express my true feelings to those whom I trust.
- Conflict Resolution Skills ($\alpha = .52$, n items = 6). Example item: Even when in a conflict with someone I trust, I can respectfully share my thoughts and feelings.
- Intrapersonal Skills ($\alpha = .66$, n items = 9). Example item: I am honest with myself about what I feel and need.

Table 6. Unadjusted Study Cell Means and Percentages for Outcomes

	Intervention			Comparison		
	Time 1	Time 2	Time 3	Time 1	Time 2	Time 3
N	387	303	302	113	100	87
Communication skills	3.87	4.33	4.36	4.06	4.12	4.03
Conflict resolution skills	2.98	3.21	3.34	3.14	3.12	3.12
Intrapersonal skills	3.13	3.52	3.58	3.19	3.30	3.21
Emotional awareness	3.42	3.94	4.02	3.54	3.70	3.61
Emotional expression	3.59	4.21	4.26	3.73	3.87	3.86
Interpersonal skills	3.58	4.10	4.14	3.73	3.79	3.78
Relationship management skills	3.65	3.98	4.02	3.75	3.72	3.72
Relationship satisfaction	3.53	4.11	4.20	3.68	3.82	3.80
Relationship commitment	4.12	4.49	4.48	4.21	4.27	4.25
Relationship skills (avg. of 9 prior skills)	3.54	3.99	4.05	3.67	3.75	3.71
Recidivism Time 2 (%)	13.97	—	—	14.86	—	—
Recidivism Time 3 (%)	5.08	—	—	13.51	—	—

At Level 2 (i.e., the individual level), the Level 1 intercept was seen as being predicted by a coded contrast (–1 vs. 1) representing the intervention group:

$$\pi_0 = \beta_{00} + \beta_{01}(\text{Intervention}) + r_0$$

The remaining Level 2 equations represented the cross-level interactions between time and intervention group:

$$\pi_1 = \beta_{10} + \beta_{11}(\text{Intervention})$$

$$\pi_2 = \beta_{20} + \beta_{21}(\text{Intervention})$$

This approach was used to examine relationship skills; however, recidivism was examined using a simple, multiple logistic regression model. These logistic regression models regressed recidivism status at Times 2 and 3 in separate analyses on intervention status. All models were run using SPSS 18.0.

Results

Relationship Skills. We first examined the pattern of means for relationship skills by condition and wave, which appears in Table 6. As can be seen in the table, the pattern of changes in means by condition for most scales is similar. The contrast of changes in the intervention and comparison groups appears in Table 7. Statistically significant effects of particular interest appear in the columns 5 and 6 (i.e., Intervention X Linear

Table 8. Intervention Recidivism Effect Unstandardized Regression Coefficients, Odds Ratios, and Statistical Significance

	Intercept	Intervention
Recidivism Time 2	−1.75 (.17)**	−.07 (.93)
Recidivism Time 3	−1.86 (.16)**	−1.07 (.34)*

Note: Unstandardized coefficients come first and odds ratios appear in parentheses.
+$p < .10$. *$p < .05$. **$p < .01$.

Conclusion

The outcomes of this research indicate substantial improvements in all areas of investigation through producing gains in relationship skills, reductions in substance use, and recidivism. Like other studies, these two studies indicate that building meaningful relationships with offenders and implementing evidence-based interventions increases strengths and reduces risk behavior. These results reflect the findings in other studies that demonstrate the importance of the therapeutic alliance. Substance abuse treatment compliance and retention studies have identified that program attributes that increase engagement in treatment improve treatment outcomes (Barber et al., 2001; De-Weert-Van, Schippers, DeJong, &Schrijvers, 2001; Simpson, 2004; Simpson, Joe, & Rowan-Szal, 2001). Consistent with findings from Corrigan and Bogner (2007), individuals who stay in treatment longer are not only more likely to achieve sobriety but also to develop new behavior and sources of reinforcement that serve to maintain sobriety.

Furthermore, studies on success in treatment identify the positive role of motivation and engagement. Studies indicate that clients with high motivation are more likely than those with low motivation to become actively involved in treatment, to complete the prescribed course of treatment, and to have better outcomes following treatment (Huebner & Cobbina, 2007). It is notable that an adjunctive component to the CLFC program, referred to as the Joint Intervention Meeting (JIM), provides a combination of characteristics of the therapeutic alliance (e.g., the meeting is designed to connect with the client) and aligned with methods to increase and sustain client motivation (the meeting focuses on what is important to the client; Knight, Hiller, Broome, & Simpson, 2000). The utilization of this approach influenced retention and completion, meriting further study.

Why Does CLFC Work With This Population?

The results clearly indicate positive outcomes for participants in the CLFC program. Examination of the CLFC program identified a variety of mediators associated with success described in the substance abuse treatment literature. CLFC contains and delivers interventions that increase coping skills and motivation to change, improve self regulation, and encourage the creation of a social support network. This support network promotes prosocial behaviors and provides ongoing accountability. Notably,

In summary, the Creating Lasting Family Connections (CLFC) program is a combination of strong therapeutic alliance coupled with the implementation of a unique blend of evidence-based practices in an intervention delivered with fidelity and reinforced over time. This process, previously described as "connect-immunity," empowers individuals to first recognize and accept their personal and family responsibility, and to ultimately develop a deeper recognition of both what they contribute to and receive from the larger community. This represents a true model of what has been previously described as placing importance on the individual's well-being as a means of achieving community safety. As a result of this programming, many participants remained in the community and the community remained safe.

These combined positive outcomes endorse the importance of continued implementation and expansion of community-based agencies delivering evidence-based interventions to reentry populations. The outcomes also strongly endorse the consideration of the following recommendations:

1. Consider evidence-based family strengthening programming with reentry populations to reduce recidivism.
2. Examine the mechanism of action within evidence-based practices to increase understanding of how they work with reentry populations.
3. Increase movement toward the policy of connecting reentry populations with community-based organizations trained in evidence-based approaches and cultural awareness with reentry populations, as these two studies show this approach produces positive results.
4. Recognize the importance of programming of significant scope and duration in producing lasting change.
5. Look at cost-effective methods to provide long-term support for reentry populations, and consider the use of technologies such as web-based and cell phone applications to increase opportunities for low-cost and longer term reentry support services.
6. Recognize and endorse the role of interagency collaboration to ensure a unified approach and consistency in programming provided for reentry populations.

The clear limitation of these studies is that firm conclusions are precluded by both (a) the results being based on a quasi-experimental design and (b) a lack of explication of the underlying mechanisms by which the positive outcomes are produced by the program. The former concern is less troublesome, as the reported studies were not based on a purely convenience sample of participants. Also, the robust nature of our findings, especially for recidivism, helps foster faith that the program, as opposed to selectivity biases, produced the observed results. Furthermore, explicit statistical controls were included in our models for such biases. The latter, while it does not impugn the positive program effects on outcomes, underscores the need for future research to explore the *causal* mechanisms by which the CLFC program works. On balance, these

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Bios

Patrick McKiernan is trained in the treatment of addictions has a PhD in Psychology with thirty years experience working in the counseling field. Throughout his career he has developed and directed addiction treatment programs for criminal offenders, veterans, and adolescents. His interest includes developing transitional housing, employment and training, and use of technologies to improve addition treatment outcomes.

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FAMILY PROCESS

Applying the Creating Lasting Family Connections Marriage Enhancement Program to Marriages Affected by Prison Reentry

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Divorce proportions are currently high in the US and they are even higher among those who are incarcerated with substance abuse problems. Although much research has examined marital interventions, only two studies have examined marital interventions with prison populations. There is some empirical evidence that incarcerated couples benefit from traditional marital therapy (O'Farrell and Fals-Stewart, 1999, Addictions: A comprehensive guidebook, New York, Oxford University Press). An adaptation of the evidence-based Creating Lasting Family Connections program was implemented with 144 married couples, where one spouse was incarcerated, in a southern state with particularly high divorce and incarceration proportions. Results suggested that married men exposed to the program had larger improvements in some relationship skills relative to a convenience sample of men not so exposed. Both husbands and wives exposed to the program exhibited similar and significant increases in relationship skills. The results were comparable to a Prevention and Relationship Enhancement Program adaptation for inmates. The implications of the findings for prevention practitioners are discussed.

Keywords: Prison Populations; Marriage; Prevention

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Recent estimates suggest that 85% of the U.S. population will marry; however, 40–50% of all marriages will end in divorce (Popenoe & Whitehead, 2010). These high rates of marital dissolution are significantly higher in the U.S. South, where this study was conducted (Elliot & Simmons, 2011). Marital dissolution is higher in populations with stressful life situations, such as incarceration or separation from a spouse (Massoglia, Remster, & King, 2011). Dissolution is also more likely among those who have previously

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Improving Marital Skills in High-Risk Populations

A review of the literature uncovered only two prevention efforts to improve the marriages of inmates returning to the community. Accordino and Guerney (1998) implemented the Relationship Enhancement Program (REP) with Jewish prisoners and their wives. The REP (Accordino & Guerney, 1998) consists of two sessions, each lasting 8 hours. The prevention material focuses on developing the following skills: empathic, expressive, discussion/negation, problem/conflict resolution, self-change, other-change, facilitation (i.e., continuing the use of learned skills), generalization (i.e., how to use developed skills outside of the marriage), and maintenance (i.e., maintaining skills learned). Unfortunately, the authors did not report any data on changes in relationship outcomes and processes as a result of the program (Accordino & Guerney, 1998).

The Prevention and Relationship Enhancement Program (PREP; Markman, Stanley, & Blumberg, 2010) developed by Howard Markman and his colleagues was adapted (PREP: PREP Inside and Out-Marriage Education for Inmates) for implementation with inmate populations (Einhorn et al., 2008). Curriculum adaptations included additional communication skills training, modeling how to complete homework assignments, capturing inmates' attention quickly, and providing examples, videos, and movies that are specific to inmates' lives and current situations (Einhorn et al., 2008). This program consists of six weekly sessions lasting 2 hours per session delivered by prison staff and chaplains. The topical content of the program focuses on problem-solving skills, ground rules for relationships, unrealistic expectations, protection of friendship, and negative communication patterns. The study reported involved an intervention group only design, where the intervention occurred while individuals were still incarcerated. Attrition was particularly high in this study between pretest and posttest prior to reentry, as data from only 57% of the original sample of 448 participants were available for analysis. The study reported improved outcomes and relationship processes for all variables examined: satisfaction, commitment, confidence, communication skills, friendship, negative interaction, and loneliness (Einhorn et al., 2008). These studies suggest the need for a program that (1) can be implemented with inmates upon reentry to reduce program attrition, which (2) offers the added benefit of these skills being taught more proximal to when the learned skills can be enacted.

Creating Lasting Family Connections (CLFC) Marriage Enhancement Program

The Council on Prevention and Education: Substances (COPES), Inc., developed a collaborative, community-based effort to strengthen the marriages of individuals and their spouses recently reentering the community after incarceration. The project was designed specifically to (1) increase the likelihood of marital stability and (2) promote marriage and relationship skills with this high-risk population. This program is an adaptation of the Creating Lasting Family Connections program (Strader, Collins, & Noe, 2000; Strader, & Noe, 1998a,b,c,d; Strader, Noe, & Crawford-Mann, 1998), which is listed on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices. The adapted version is called the Creating Lasting Family Connections Marriage Enhancement Program (CLFCMEP).

The substantive topics addressed in program sessions include marriage enrichment, effective communication, refusal and conflict resolution skills, using positive parenting techniques, and encouraging responsible and healthy attitudes and behaviors regarding substance abuse. This approach was specifically designed to cultivate an atmosphere of inclusion, respect, and cultural sensitivity for a high-risk audience traditionally considered resistant and difficult to recruit and retain in a program of significant scope and duration.

thorough review of the theoretical framework underlying the CLFC model appears elsewhere (see Strader et al., 2000).

The CLFC model is a good fit to reentry marital relationships, because it focuses on positive relational changes for the entire family system, which will enhance and support the reentry process for the offender. Conversely, in the absence of such support for both the family and offender, the offender will likely revert to his/her prior antisocial behavior (Slaght, 1999). Furthermore, when the reentering inmate recognizes that the community is invested in their future, he or she often has the potential for positive, long-term change.

Overview

Toward these ends, data were collected from prison residents recently released. Participants in the CLFCMEP program participated with their spouses. Participants completed surveys containing study measures prior to program implementation, immediately after program implementation, and 3 months after program implementation. A convenience sample of reentry husbands similar to the male program participants also completed the same surveys at the same time intervals. This represents nonrandom assignment to condition, making this a quasi-experimental design. As such, this analysis should only be considered a preliminary approximation to what would be found in a randomized controlled trial. On the basis of the CLFC fostering a sense of connectedness in family relationships, we predicted that (1) CLFCMEP husbands would exhibit improved relationship skills (i.e., communication skills, conflict resolution skills, intrapersonal skills, emotional awareness, emotional expression, inter-personal skills, relationship management skills, relationship satisfaction, and relationship commitment) relative to our comparison sample and (2) both husbands and wives participating in the CLFCMEP program would exhibit an increase in relationship skills. The CLFCMEP program (typically 10 once-a-week sessions) was implemented in two formats with one specifically designed to be more amenable to completion by high-risk participants (i.e., an intensive weekend retreat format). The latter is more amenable to completion, as reentry populations often have competing pressures to get a job, see their parole officer, and attend Alcoholics/Narcotics Anonymous meetings. We predicted that (3) we would not find any evidence of differences in the outcomes experienced by those participating in either program format.

METHOD

Participants

The participants for this study were 250 married individuals who voluntarily participated in the COPES, Inc., Jefferson County Healthy Marriage Initiative (i.e., intervention group) or one of the programs typically offered for those being released from prison (i.e., the comparison group). All participants were recruited through local social services organizations or the Kentucky Department of Corrections. Data were collected from intervention group participants between October 2007 and February 2011 and data were collected from the comparison group between February 2008 and January 2011. Of the 250 individuals, 230 participated in the intervention condition and 20 participated in the comparison condition. As can be seen in Table 1, the individuals were in their mid-thirties ($M = 33.72$) and predominantly African American (57%) or Caucasian (40%) with very few Hispanics (3%) being represented in the sample. Close to half lived with their spouse at the time of the study (45%), which is lower than might be expected for married couples. This is due to participants fulfilling requirements of their parole (e.g., living in a halfway house). Examining the background characteristics of these individuals, the majority of the

Selectivity Biases

Two alternative explanations for putative study findings are that (1) intervention effects could be due to nonrandom assignment of individuals to the intervention and comparison groups (i.e., a quasi-experimental design), and (2) effects could be due to participants who are likely to exhibit negative outcomes being more likely to drop out of the study, especially among those exposed to CLFCMEP. With respect to the latter, attrition from the study was relatively low and all participants who completed the posttest survey completed the program. Of the 115 husbands participating in the intervention group, 95 (or 83%) completed the intervention and posttest survey and 93 (or 81%) completed the follow-up survey. Of the 20 husbands participating in the comparison group, 19 (or 95%) completed the posttest survey and 18 (or 90%) completed the follow-up survey. Both of these potential sources of selectivity biases were addressed using a Heckman two-step procedure (Heckman, 1976, 1979). This approach involves regressing either (1) intervention group or (2) attrition status on participant background characteristics in the first step using a probit regression model. Intervention status was also included as a predictor when examining attrition as the dependent measure. The second step involves producing predicted scores, where these scores are transformed to an inverse Mill's ratio (IMR), and the IMR is included as a predictor in all inferential analyses.

Prior to performing the first step probit models, missing background characteristic data were imputed using the Expectation Maximization algorithm (Dempster, Laird, & Rubin, 1977), as implemented in PASW 18.0. Due to the necessity of eliminating any case with any missing background characteristic, we felt that imputation posed fewer inferential risks than eliminating entire cases, as less than 4% of observations were missing for any variable. It is important to note that data imputation was not used for our dependent measures of interest. Our selectivity bias analyses were conducted separately for the two sample subsets, where we examined attrition and assignment biases in the intervention versus comparison sample subset and only attrition biases in the couples sample subset.

Examining selectivity biases in the intervention comparison sample subset, there was evidence to suggest that participants in the comparison group were likely to be slightly older, $z = -2.35$, $p = .02$; however, the overall model did not significantly predict assignment to condition, $\chi^2(126) = 127.58$, $p = .44$. There were no significant predictors of attrition for this sample subset, and the overall model was not significant, $\chi^2(125) = 133.58$, $p = .28$. Examining selectivity biases due to attrition in our couple sample subset, Hispanic participants, $z = 2.08$, $p = .04$, and those who lived with their partner, $z = 2.18$, $p = .03$, were more likely to drop out of the study; however, the overall model did not predict attrition, $\chi^2(602) = 636.44$, $p = .16$. On the basis of these results, we created an IMR representing biases due to assignment for the intervention comparison sample subset and an IMR representing biases due to attrition in the couple sample subset.

Measures

Questionnaire

Clients completed a questionnaire at each of the three waves of the study that included 71 items inquiring about various relationship skills using a 1 (strongly disagree) to 5 (strongly agree) Likert scale. Some of the relationship skill items, developed by McGuire and Associates, were adapted from scales by Olson and colleagues (Barnes & Olson, 2003; Olson, 2006; Olson, Fournier, & Druckman, 1986; Olson & Schaefer, 2000) to more closely align with the content and principles of CLFC. Scale scores were calculated by taking the average of responses to items comprising each scale. The nine scales measured in the data with example item content were as follows:

doubled in size (2.6 times larger: Pew Center on the States, 2009, 2010). These problems are compounded by 38% of these inmates being drug offenders, as substance abuse problems are often associated with marital distress (Whishman, 1999). A large proportion of this population in the Jefferson County metropolitan area (where the city of Louisville is located) indicates that they are married or that they were previously married (and currently divorced) after release from prison (39%; Allen, Nicholson, Kruzich, & Hardison, 2005).

Due to the large number of married inmates reentering the local community and our mandate to serve a large proportion of this population, a comparison group was not readily available; however, another initiative with a comparison group of reentry men was being conducted within the same time frame. These men only participated in other programs typically required upon prison release (i.e., treatment as usual). The services to which these comparison men were exposed depended on their needs, but the services typically received by this population are exposure to parole staff (i.e., officers and social service staff) and after-care programming, such as residential reentry centers, training and job assistance, substance abuse treatment, and group-based substance abuse support (e.g., Alcoholics/Narcotics Anonymous). Although this comparison group serves as a sample of convenience, it does allow us to conduct a more meaningful and rigorous analysis of the data.

Participants in both groups were recruited through the use of brochures in locations that would be seen by reentry populations and referrals (e.g., friends or family aware of the program). The brochures recruiting intervention participants highlighted that the program was a relationship skills training/education for couples, where one couple member was recently released from prison. The brochures recruiting the comparison group focused on relationship skills training/education for fathers. The 20 married fathers examined as a comparison group in this study were those who were randomly assigned to the comparison group for the purposes of another study (McKiernan, Shamblen, Collins, Strader, & Kokoski, in press).

The CLFCMEP was offered in a weekend retreat format (two 8-hour sessions) or a 10-session format (2 hours per session) to which participants were assigned nonrandomly, based on their availability. Although this does introduce variability into the intervention being administered, this was necessary to accommodate the schedules of the target population. Twelve guided exercises were employed to strengthen marriage through learning open, nondefensive communication skills. The specific topical content and lessons of the CLFCMEP intervention were as follows: (1) job descriptions of parents and children in families; (2) a shared vision for a happy marriage; (3) roles in a marriage and raising children based on family experiences; (4) expressing and validating emotions and discuss differing beliefs; (6) learning to appreciate a partner's strengths and weaknesses; (6) how your past family experiences may impact your current relationships; (7) how to listen and respond to your partner; (8) recognizing defenses in relationships; (9) recognizing your and your partner's needs; (10) listening and validation skills; (11) practicing skills and conflict management; and (12) rediscovering romance. These skills are gained through the couple developing a shared vision, understanding positive and negative traits, personal and others' past wounds and needs, active listening, expectations, compassion, romance, and learning to "fight fairly" by employing conflict resolution skills including mutual validation and respect. The group setting allowed for couples to learn from others by sharing hope and practice skills in a safe environment. Two trainers (typically one male and one female) led all sessions. All trainers were certified prevention specialists and certified in CLFC (the latter certification requires completion of a 5-day, 40-hour training).

The survey used to collect data for this report was administered to all participants at pretest (i.e., prior to any intervention activities), posttest, and 3-month follow-up. Pretest

In our models examining change only for intervention group couples (hypothesis 2), at level one (i.e., the repeated observation level), all outcomes were seen as being predicted by orthogonally coded linear (−1, 0, 1) and quadratic contrasts (1, −2, 1; i.e., "u"-shaped) time contrasts for husbands and wives separately:

$$\text{Outcome} = \pi_0(\text{Husband Constant}) + \pi_1(\text{Wife Constant}) + \pi_2(\text{Husband Linear}) + \pi_3(\text{Wife Linear}) + \pi_4(\text{Husband Quadratic}) + \pi_5(\text{Wife Quadratic})$$

At level two (i.e., the individual level), the level one intercepts were seen as being predicted by our correction for selectivity due to attrition and our estimates of random variability:

$$\pi_0 = \beta_{00} + \beta_{01}(\text{Selection IMR}) + r_0$$

$$\pi_0 = \beta_{10} + \beta_{11}(\text{Selection IMR}) + r_1$$

The remainder of the level two equations simply represented an intercept with no predictors:

$$\pi = \beta$$

We also performed a series of models that were nearly identical to the prior model; however, we also explored whether attending the weekend retreat implementation moderated intervention effects (hypothesis 3). More specifically, at level two, we included a predictor for husbands and wives representing whether they attended the weekend retreat (−1 = attended 10 week sessions [$n_{couples}$ = 93] or 1 = attended weekend retreat [$n_{couples}$ = 51]):

$$\pi_0 = \beta_{00} + \beta_{01}(\text{Selection IMR}) + \beta_{02}(\text{retreat}) + r_0$$

$$\pi_1 = \beta_{10} + \beta_{11}(\text{Selection IMR}) + \beta_{12}(\text{retreat}) + r_1$$

We also entered the cross-level interactions for husband and wife linear and quadratic effects, which represent whether there were differential changes over time for husbands and wives who attended the 10-week sessions or the weekend retreat:

$$\pi_2 = \beta_{20} + \beta_{21}(\text{retreat})$$

$$\pi_3 = \beta_{30} + \beta_{31}(\text{retreat})$$

$$\pi_4 = \beta_{40} + \beta_{41}(\text{retreat})$$

$$\pi_5 = \beta_{50} + \beta_{51}(\text{retreat})$$

All models were run using SPSS 18.0.

RESULTS

Changes in Relationship Skills for Men Exposed and Not Exposed to the Intervention

Hypothesis one predicted that we would see more positive relationship skill change for husbands in the intervention group relative to husbands in the comparison group. We first examined the pattern of means for relationship skills by condition and wave, which appears in Table 2. As can be seen in the table, the pattern of changes in means by condition for most scales is similar. The contrast of changes in the intervention and comparison groups appears in Table 3. Statistically significant effects of particular interest appear in

TABLE 3

Intervention Effect Unstandardized Regression Coefficients, Effect Sizes, and Statistical Significance

	Intercept	Linear Change	Quadratic (U-shaped) Change	Intervention	Intervention × Linear	Intervention × Quadratic	Random Intercept Effect (ICC)
Communication skills	4.01 (.99)**	.05 (.10)	−.04 (−.12)+	.00 (.00)	.08 (.15)*	.01 (.02)	.18 (.53)**
Conflict resolution skills	3.04 (.98)**	.07 (.13)*	−.01 (−.02)	.11 (.16)+	.08 (.16)*	.00 (−.02)	.20 (.58)**
Intra-personal skills	3.28 (.98)**	.04 (.09)	−.03 (−.11)+	.07 (.11)	.04 (.10)	.00 (.00)	.16 (.60)**
Emotional awareness	3.57 (.98)**	.08 (.15)*	−.03 (−.11)+	.01 (.02)	.06 (.12)+	.01 (.03)	.19 (.57)**
Emotional expression	3.78 (.99)**	.10 (.18)**	−.01 (−.03)	.05 (.08)	.06 (.10)	−.01 (−.04)	.16 (.49)**
Inter-personal skills	3.71 (.98)**	.08 (.14)*	−.02 (−.06)	.04 (.06)	.08 (.13)*	−.02 (−.06)	.17 (.49)**
Relationship management skills	3.69 (.99)**	.05 (.09)	−.01 (−.03)	.08 (.15)+	.04 (.08)	−.02 (−.08)	.11 (.47)**
Relationship satisfaction	3.66 (.97)**	.16 (.22)**	−.03 (−.08)	.11 (.13)	.03 (.05)	−.04 (−.09)	.30 (.53)**
Relationship commitment	4.29 (.99)**	.01 (.02)	.01 (.05)	.04 (.07)	.02 (.05)	−.04 (−.14)*	.10 (.39)**
Relationship skills (avg. of 9 prior skills)	3.67 (.99)**	.07 (.18)**	−.02 (−.08)	.06 (.11)	.06 (.14)*	−.01 (−.06)	.12 (.60)**

Note. Unstandardized regression coefficients listed first, and in parentheses *t*-values with accompanying degrees of freedom were transformed to an effect size *r*, using the formula presented in Cohen (1988).

+$p < .10$.

*$p < .05$.

**$p < .01$.

TABLE 5

Couple Change Effect Unstandardized Regression Coefficients, Effect Sizes, and Statistical Significance

	Wives				Husbands				Random effects (ICC)	
	Intercept	Linear Change	Quadratic (U-shaped) Change	Attrition Correction (IMR)	Intercept	Linear Change	Quadratic (U-shaped) Change	Attrition Correction (IMR)	Wife Intercept	Husband Intercept
Communication skills	3.46 (.57)**	.17 (.29)**	−.05 (−.16)**	.25 (.10)	4.63 (.71)**	.14 (.24)**	−.03 (−.10)*	−.34 (−.13)	.24 (.42)**	.19 (.33)**
Conflict resolution skills	3.29 (.59)**	.16 (.27)**	−.02 (−.07)	−.02 (−.01)	3.48 (.59)**	.15 (.27)**	−.01 (−.04)	−.18 (−.07)	.18 (.37)**	.20 (.42)**
Intra-personal skills	2.78 (.55)**	.09 (.19)**	−.02 (−.08)	.31 (.15)	3.47 (.63)**	.09 (.19)**	−.03 (−.11)*	−.07 (−.03)	.18 (.37)**	.17 (.35)**
Emotional awareness	2.90 (.52)**	.15 (.27)**	−.01 (−.05)	.35 (.15)	3.90 (.65)**	.14 (.26)**	−.02 (−.08)	−.17 (−.07)	.23 (.40)**	.19 (.33)**
Emotional expression	3.24 (.55)**	.18 (.31)**	−.05 (−.14)**	.31 (.13)	4.24 (.70)**	.16 (.28)**	−.02 (−.07)	−.22 (−.09)	.23 (.42)**	.16 (.29)**
Inter-personal skills	2.89 (.52)**	.18 (.30)**	−.03 (−.10)+	.44 (.18)*	4.23 (.69)**	.16 (.27)**	−.04 (−.13)*	−.26 (−.11)	.20 (.41)**	.17 (.35)**
Relationship management skills	3.25 (.61)**	.11 (.22)**	−.04 (−.14)**	.29 (.14)	4.43 (.77)**	.08 (.18)**	−.03 (−.11)*	−.36 (−.18)+	.18 (.34)**	.11 (.21)**
Relationship satisfaction	2.40 (.34)**	.23 (.32)**	−.07 (−.18)**	.63 (.19)*	5.30 (.69)**	.20 (.27)**	−.07 (−.17)**	−.84 (−.27)**	.44 (.53)**	.27 (.32)**
Relationship commitment	3.88 (.67)**	.05 (.09)+	−.01 (−.03)	.24 (.11)	4.77 (.79)**	.04 (.07)	−.03 (−.09)+	−.24 (−.12)	.18 (.50)**	.11 (.31)**
Relationship skills (avg. of 9 prior skills)	3.11 (.64)**	.14 (.36)**	−.03 (−.16)**	.32 (.17)+	4.27 (.77)**	.13 (.33)**	−.03 (−.15)**	−.30 (−.15)	.15 (.35)**	.12 (.28)**

Note. Unstandardized regression coefficients listed first, and in parentheses *t*-values with accompanying degrees of freedom were transformed to an effect size *r*, using the formula presented in Cohen (1988).

+$p < .10$.

*$p < .05$.

**$p < .01$.

TABLE 7

Couple Change Effect Unstandardized Regression Coefficients, Effect Sizes, and Statistical Significance by Retreat Attendance

	Intercept	Linear Change	Quadratic (U-shaped) Change	Weekend Retreat	Retreat × Linear	Retreat × Quadratic	Attrition Correction (IMR)	Random Intercept Effect (ICC)
Wives								
Communication skills	3.48 (.57)**	.17 (.28)**	−.05 (−.15)**	.01 (.03)	−.02 (−.04)	.02 (.06)	.24 (.10)	.25 (.42)**
Conflict resolution skills	3.28 (.59)**	.17 (.28)**	−.02 (−.06)	.01 (.01)	.04 (.07)	.02 (.07)	−.01 (−.01)	.18 (.37)**
Intra-personal skills	2.79 (.55)**	.08 (.18)**	−.02 (−.06)	.04 (.09)	−.01 (−.02)	.02 (.08)	.30 (.15)	.18 (.37)**
Emotional awareness	2.93 (.52)**	.14 (.26)**	−.01 (−.02)	.04 (.08)	−.04 (−.07)	.04 (.12)*	.34 (.14)	.23 (.40)**
Emotional expression	3.26 (.55)**	.18 (.30)**	−.04 (−.12)*	.03 (.05)	−.02 (−.03)	.03 (.11)*	.30 (.12)	.23 (.42)**
Inter-personal skills	2.90 (.52)**	.18 (.29)**	−.03 (−.10)+	.01 (.03)	−.02 (−.03)	.00 (−.01)	.44 (.18)*	.20 (.41)**
Relationship management skills	3.26 (.61)**	.10 (.21)**	−.04 (−.14)**	.04 (.08)	−.01 (−.02)	.00 (.01)	.30 (.14)	.18 (.34)**
Relationship satisfaction	2.40 (.34)**	.24 (.31)**	−.07 (−.17)**	.03 (.04)	.01 (.02)	.01 (.03)	.63 (.19)*	.45 (.53)**
Relationship commitment	3.88 (.67)**	.05 (.09)+	−.01 (−.04)	.05 (.10)	.00 (−.01)	−.01 (−.02)	.25 (.12)	.18 (.50)**
Relationship skills (avg. of 9 prior skills)	3.12 (.64)**	.14 (.36)**	−.03 (−.14)**	.03 (.07)	−.01 (−.01)	.02 (.07)	.32 (.17)+	.15 (.55)**
Husbands								
Communication skills	4.60 (.70)**	.14 (.24)**	−.03 (−.10)+	−.02 (−.04)	.00 (.00)	.01 (.02)	−.32 (−.13)	.19 (.33)**
Conflict resolution skills	3.52 (.59)**	.16 (.28)**	−.01 (−.04)	.03 (.06)	.05 (.09)+	.00 (−.01)	−.20 (−.08)	.20 (.42)**
Intra-personal skills	3.40 (.63)**	.09 (.20)**	−.03 (−.11)*	−.05 (−.10)	.02 (.04)	.00 (.00)	−.04 (−.02)	.17 (.35)**
Emotional awareness	3.88 (.64)**	.14 (.26)**	−.02 (−.07)	−.02 (−.04)	−.02 (−.04)	.01 (.05)	−.16 (−.06)	.19 (.34)**
Emotional expression	4.22 (.69)**	.16 (.28)**	−.02 (−.07)	−.01 (−.03)	−.01 (−.01)	.01 (.02)	−.21 (−.09)	.16 (.29)**
Inter-personal skills	4.18 (.68)**	.16 (.26)**	−.04 (−.12)*	−.04 (−.09)	−.02 (−.04)	.00 (.01)	−.24 (−.10)	.17 (.35)**
Relationship management skills	4.42 (.77)**	.08 (.17)**	−.03 (−.11)*	−.01 (−.02)	.00 (−.01)	.00 (.01)	−.36 (−.18)+	.11 (.21)**
Relationship satisfaction	5.37 (.69)**	.20 (.27)**	−.07 (−.17)**	.05 (.09)	.01 (.02)	.00 (.01)	−.87 (−.28)**	.27 (.32)**
Relationship commitment	4.77 (.79)**	.03 (.07)	−.02 (−.08)+	−.01 (−.01)	−.01 (−.02)	.01 (.04)	−.24 (−.12)	.11 (.31)**
Relationship skills (avg. of 9 prior skills)	4.26 (.77)**	.13 (.33)**	−.03 (−.14)**	−.01 (−.02)	.00 (.00)	.01 (.03)	−.29 (−.15)	.12 (.45)**

Note. Unstandardized regression coefficients listed first, and in parentheses *t*-values with accompanying degrees of freedom were transformed to an effect size *r*, using the formula presented in Cohen (1988).

$^{\dagger}p < .10$.

$^{*}p < .05$.

$^{**}p < .01$.

discussed previously is that the latter programs were implemented while the participants were still incarcerated, whereas the CLFCMEP was implemented after participants were released from prison. Both implementation modes have their unique benefits and challenges. Implementing programs in the prisons confers the benefit of dosage being high for program implementation; however, as was observed in the *PREP Inside and Out* (Einhorn et al., 2008) implementation, attrition was extremely high due to transfers to different facilities and releases and there is likely less control over who is chosen as the trainers for the program (e.g., prison staff and chaplains were used as trainers).

Implementing programs after release, like the CLFCMEP, presents the challenges of keeping dosage high and obtaining data from participants to assess their long-term outcomes; however, it offers the benefits of lower study attrition and skills being taught more proximally to when learned skills can be enacted. We feel these challenges were dealt with effectively in the CLFCMEP, as 77% of the initial participants were exposed to the intervention (i.e., at least 16 hours of the program) and we obtained data from 76% of participants at 3-month follow-up, respectively. These challenges were dealt with effectively through attempts to make the program maximally convenient (e.g., offering a weekend retreat format) for this difficult to reach population with multiple demands for their time and by the use of highly skilled trainers.

The necessary data were not reported to compare the results of our program to the REP (Accordino & Guerney, 1998); however, we can assess the degree to with which our program is comparable to *PREP Inside and Out* (Einhorn et al., 2008). Both programs targeted a very similar set of outcomes and the curricula attempt to impart similar skill sets, despite the PREP (Markman, Stanley et al., 2010) having a more inter-personal communication theoretical focus and the CLFCMEP having a focus on connectedness to the community and family. The CLFCMEP and *PREP Inside and Out* (Einhorn et al., 2008) were both found to improve relationship satisfaction, commitment, communication, conflict resolution, and friendship/emotional expression. The only differences in outcomes between the two programs were likely a function of the measures used in each study, where the CLFCMEP also found improvements in intra-personal skills and the *PREP Inside and Out* (Einhorn et al., 2008) also found decreases in loneliness. Nevertheless, as a major goal of the CLFCMEP is to foster a sense of inclusion and community connectedness, we suspect that feelings of loneliness would have improved if they were measured.

One benefit of the CLFCMEP and the CLFC model more generally is that there is a focus on the broader social context of families, as opposed to only marriages. Future research must determine whether there is a positive impact on children as a result of parent participation in CLFCMEP. We suspect there may be, as there is an abundance of research supporting the idea that when parents are not in high-conflict relationships, children often perform better socially and emotionally (e.g., Amato & Booth, 1997; Cowan, Cowan, Pruett, Pruett, & Wong, 2009; Cummings & Davies, 2002; Katz & Gottman, 1993). The couples who participated in CLFCMEP were provided with the opportunity to reduce conflict in their relationship, increase their commitment to one another, and reestablish (or establish for the first time) trust with one another. This likely creates an environment for their children to feel safer and more secure. In addition, benefits are conferred upon the nonreentry partner through participation in the program.

The findings reported here come from correlational research with an extremely small comparison group, so they must be interpreted with caution. More specifically, differences between husbands exposed to CLFC and a similar sample of men not so exposed may be an artifact of the comparison group representing a nonrandomly assigned convenience sample, which was small in size. Firm conclusions about the effects of CLFCMEP on marital outcomes await further replications with a randomized controlled trial. Nevertheless, it should be noted that similar findings emerged when using the CLFC intervention

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Section 5:

Awards

Creating Lasting Family Connections
An Award-Winning Program

COPES programs have received numerous national awards for excellence. Below is a chronological listing.

- In 2013 the Creating Lasting Family Connections Marriage Enhancement program was **listed on the National Registry of Evidence-Based Programs and Practices (NREPP).**
- In 2013 the Creating Lasting Family Connections Fatherhood Program: Family Reintegration was **listed on the National Registry of Evidence-Based Programs and Practices (NREPP).**
- In 2010 the Creating Lasting Family Connections Program was recognized as an **unprecedented fourth time** recipient of the **Exemplary Program Award** from the **National Prevention Network** (NPN) and the National Association of State Alcohol/Drug Abuse Directors (NASADAD) **(1995, 1999, 2000 and 2010).**
- In 2010 the Creating Lasting Family Connections program was again listed as a **Model Program** by the **National Dropout Prevention Center/Network** sponsored by Clemson University.
- In 2009 the Creating Lasting Family Connections program was identified as a **Promising Fatherhood Program** in the Administration for Children and Families' Responsible Fatherhood Initiative.
- In 2007 the Creating Lasting Family Connections program was **listed on the National Registry of Evidence-Based Programs and Practices (NREPP).**
- In 2006 the Creating Lasting Family Connections program was **reconfirmed** as an **effective substance abuse and violence prevention curriculum** by the **Office of Juvenile Justice and Delinquency Prevention.**
- In 2002, Creating Lasting Family Connections was chosen as a **Model Program** by **Substance Abuse and Mental Health Services Administration,** U.S. Department of Health & Human Services.
- In 2001, COPES and the Creating Lasting Family Connections program received a **Special Recognition Award** from the **Executive Office of the President's Office of National Drug Control Policy.**
- In 2001, Creating Lasting Family Connections received the U.S. Department of Education's **Certificate of Recognition** as a **Promising Program for Safe, Disciplined and Drug-Free Schools.**
- In 2001, Creating Lasting Family Connections was **featured as an Exemplary Program** by Health Canada's Preventing Substance Use Problems Among Young People: A Compendium of Best Practices.
- The Creating Lasting Family Connections program was **featured as a Model Family Program** in the **Office of Juvenile Justice and Delinquency Prevention** and the **Substance Abuse and Mental Health Services** Administration's Strengthening America's Family publication on substance abuse and delinquency prevention in 2000.
- In 1997, COPES Model program, Creating Lasting Family Connections, was **chosen as one of only eight programs nationwide** for the **Center for Substance Abuse Prevention's model program dissemination project.**
- The Creating Lasting Connections program was also **featured in the Center for Substance Abuse Prevention's "Prevention Works" video** in 1996.
- Also in 1996, the Creating Lasting Connections program was **selected to join the International Youth Foundation's YouthNet,** an international effort to replicate highly successful programs as demonstrated by research. Only the most rigorously evaluated and effective programs in the world are selected to receive this honor.