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Engaging At-Risk Fathers in Home Visiting Services: Effects on Program Retention and Father Involvement

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Abstract
Healthy Families New York (HFNY) is an evidence-based home visiting program for expectant and new parents in socioeconomically disadvantaged families at elevated risk for child maltreatment and other adverse outcomes. HFNY makes concerted efforts to promote a father-inclusive culture and increase engagement of fathers in all aspects of home visiting. This study describes fathers' participation in HFNY and examines how fathers' participation relates to program retention and to father–child coresidency and father involvement. Program data were extracted from HFNY's data management system. Program participation was measured by whether the father ever participated in a home visit. The sample includes 3341 families enrolled from January 1, 2013 to June 30, 2015. Program retention, father's co-residency and father involvement were measured at the child's 6 months follow-up. Logistic regression was used to calculate odds ratios. Results showed that when fathers participated in home visiting, families were more than four times as likely to be retained in the program. Additionally, fathers who were engaged were more likely to live at home with the child and to remain emotionally involved at 6 months. The data support the advancement of policy and practice to encourage participation of fathers in high-risk families in home visiting services.

Keywords Home visiting · Father involvement · At risk families · Program retention · Parenting intervention

Fathers make critical contributions to the development and well-being of children (Jones, 2004; Lamb, 2010; Rostad, Self-Brown, Boyd, Osborne, & Patterson, 2017). Parenting interventions delivered in the home are empirically supported strategies for promoting healthy child development and positive parenting skills (Avellar & Supplee, 2013; Panter-Brick et al., 2014; Peacock, Konrad, Watson, Nickel, & Muhajarine, 2013; The Pew Center on the States, 2010). However, home visiting programs have predominantly focused on involving mothers and children, and until relatively recently, underemphasized fathers as program targets (Guterman, Bellamy, & Banman, 2018; Sandstrom et al., 2015; Sar, Antle, Bledsoe, Barbee, & Van Zyl, 2010). There is limited evidence on whether bringing fathers into home visiting programs increases father involvement or improves children's outcomes, but "preliminary research, including qualitative and quantitative data, indicates that may be the case" (Sandstrom et al., 2015, p. 4). Thus, an increased focus on fathers may offer an important opportunity for enhancing or augmenting current home visiting services (Guterman et al., 2018).

The current study examines fathers' participation in the Healthy Families New York (HFNY) home visiting program (DuMont et al., 2008; Kirkland, 2013; Lee et al., 2009), a Healthy Families America accredited home visiting program established in 1995. The program serves families at elevated risk for adverse child and family outcomes, and like other home visiting interventions, has increased efforts to involve fathers. Utilizing existing HFNY administrative data, the study aims to describe fathers' participation in HFNY; examine how fathers' participation is correlated with program retention; and assess the relationship between father participation and two areas of family functioning: fathers' emotional involvement and co-residency with the child.

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Father Involvement on Child Well-Being

The evidence base demonstrates that positive father involvement is incontrovertibly important in promoting child well-being and development (Bronte-Tinkew, Carrano, Horowitz, & Kinukawa, 2008; Cabrera, Fagan, Wight, & Schadler, 2011; Jones, 2004; Lamb, 2010; Panter-Brick et al., 2014). Father involvement has been conceptualized in multiple ways, and the concept has evolved over time. Key constructs include father–child engagement, availability, responsibility and emotional attachment (Lamb, 2010).

Positive paternal involvement with children affects multiple domains of children's lives starting at young ages (Hawkins, Lovejoy, Holmes, Blanchard, & Fawcett, 2008). For example, father involvement in reading activities has been found to promote improved language development and improved cognitive outcomes (Tamis-Lemonda, Shannon, Cabrera, & Lamb, 2004; Varghese & Wachen, 2016), and is linked with improved child social competence (Pettit, Dodge, & Brown, 1988). A systematic review of longitudinal studies linked father involvement with enhanced cognitive development, reduced levels of externalizing problems in boys, and reduced emotional problems in girls (Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008).

A key aspect of father's involvement with children is accessibility to the child, which has been conceptualized in terms of father's residential status (Robbers, 2009). Evidence emerging from the Fragile Families studies of high-risk, predominantly unmarried, and low-income parents suggests that early involvement of fathers is predictive of continued family and father–child contact and improved child outcomes even in highly stressed families (Choi & Jackson, 2011; Fagan & Lee, 2012). Several studies have shown that fathers have a strong indirect effect on child well-being through their relationship with the child's mother (Cabrera et al., 2011; Guterman & Lee, 2005; Rosenberg & Wilcox, 2006). The quality of the parents' relationship or communication increases the quality and level of involvement of fathers in their children's lives (Carlson, McLananhan, & Brooks-Gunn, 2008) and father involvement leads to continued cohabitation (McClain, 2011). A biological father's exit from the child's residence is associated with decreases in the father's coparenting and increases in maternal parenting stress (Martin, Ryan, Riina, & Brooks-Gunn, 2017; Osborne, Berger, & Magnuson, 2012).

Evidence from the Fragile Families study suggests that early development is a sensitive period for engagement of both parents with young infants. The transition to parenthood may be a fruitful time for father engagement, and particularly critical for unmarried, low-income fathers who are particularly likely to disengage with children over time (Cabrera et al., 2011; Ferguson & Gates, 2015; Martin et al., 2017; Osborne et al., 2012). Father support, involvement, and the quality of the mother–father relationships tend to decline quite quickly in high-risk families across the first couple of years following childbirth (Hofferth & Goldscheider, 2010; Martin et al., 2017; McClain, 2011).

It is important to note, however, that there are mixed findings about the extent to which fatherhood is a 'package deal' whereby a father's relationship attenuates when his relationship with the biological mother ends (Tach, Mincy, & Edin, 2010). For example, non-resident black fathers are more likely than white and Hispanic fathers to remain involved with their children after relationship dissolution (Mincy & Pouncy, 2007), and changes in a non-residential father's involvement following a mother's relationship transition have been found to be greater than after fathers' relationship transition (Tach et al., 2010).

Father presence and involvement can also present risks to children. Importantly, fathers may play a direct role in the maltreatment of children (Guterman & Lee, 2005; Sedlak et al., 2010) In addition, antisocial and violent behavior by fathers is associated with more negative parenting practices by mothers (Holmberg & Olds, 2015) and can negatively impact child development and family well-being (Holmberg & Olds, 2015; Sar et al., 2010). Working with fathers to address parenting risks and prevent maltreatment is clearly critical (Scourfield, 2014). On balance, research suggests that fathers should be viewed as a resource for improved family functioning even in challenged families such as those targeted in home visiting programs.

Father Involvement in Home Visiting Programs

Home visitation minimizes many barriers to parental participation in intervention services to vulnerable families with young children by bringing services directly to those who may find it difficult to otherwise access programs (Peacock et al., 2013). Among the evidence-based home visiting models that have been evaluated rather rigorously are the Nurse Family Partnership (NFP) and Healthy Families America (HFA). The NFP involves an extensive program of intensive pre-and post-natal visitation by nurses to first-time mothers designed to improve early maternal and child health and improve developmental outcomes (Nurse Family Partnership, 2010). A number of randomized controlled trials have indicated improvements in parental care and improved child development (Olds, 2002, 2006). Other home visiting programs, including HFA, utilize a less resource-intensive model of paraprofessional visitors to target similar objectives

and also yield improvements in the development and health of children (Avellar & Supplee, 2013; Peacock et al., 2013).

Based on the growing evidence base supporting these and related home visiting programs, the Patient Protection and Affordable Care Act established the Maternal, Infant and Early Childhood Home Visiting Program, which provides money to states for home visiting models that serve pregnant and at-risk women and children from birth to age 5 (Avellar & Supplee, 2013). Federal funding prioritizes evidence-based home visiting models that demonstrate outcomes in maternal and child health domains (Sama-Miller et al., 2016) and utilize performance indicators primarily developed for mothers and children (US DHHS, 2016). This focus means that mothers are usually the primary enrollee, and information on the role of father participation in home visiting programs has remained a relative gap in home visiting research (Azzi-Lessing, 2011; Panter-Brick et al., 2014; Stahlschmidt, Threlfall, Seay, Lewis, & Kohn, 2013).

The existing data on father participation in home visiting provides a mixed picture. The randomized trial evaluation of Hawaii's Healthy Start Home Visiting program (Duggan et al., 2004) reported father participation rates of 50% overall. Attendance may be sporadic and inconsistent however (Guterman, 2012; Guterman et al., 2018). A study of the Nurse Family Partnership model reported a median attendance rate of 2.25 visits with fathers from pregnancy through age one (Holmberg & Olds, 2015), similar to the average of 2.4 sessions attended by fathers in the first year in the Hawaii Healthy Start Program (Duggan et al., 2004). A study of Early Head Start found that demonstration programs focused on engaging fathers were successful in increasing fathers' program attendance (Raikes & Bellotti, 2006): 48% of fathers in these programs attended at least three times a month versus only 24% in typical programs. Guterman and colleagues specifically designed an enhancement to fully engage fathers in a home visiting program where trained home visitors provided services directly to fathers. In a small pilot study of preliminary intervention implementation and impact, all fathers in the intervention condition (n = 12) completed the intervention and follow up, whereas only 8 of those in the comparison condition did so (Guterman et al., 2018).

While efforts to engage fathers appear to be effective at increasing their participation in home visiting programs, evaluations of the impact of this participation have been limited and findings have been mixed. There is some evidence that father participation in interventions might lead to families deriving broader benefits from the program. Promisingly, early pilot data from the Dads Matter father enhancement to home visiting services indicates that positive trends were found in the intervention group on several indicators including father's involvement with the child, maltreatment indicators such as father's behavior towards the child, and fathers' verbalizations towards the child (Guterman et al., 2018). Similar trends are emerging in the larger RCT (Guterman, Bellamy, Banman, & Morales-Mirguem, 2015). Engaging fathers in a home visiting program has shown measurable effects on the couple's relationship quality, and both parents' reported stress (Guterman et al., 2018).

However, Duggan et al. (2004) found that participation in the Hawaii program had no overall impact on fathers' involvement in parenting activities or in sharing responsibility for the child's well-being. More problematically, Duggan found that fathers who participated less included those who worked, drank heavily, and were more violent. This literature prompts questions about whether father participation in such cases is helpful, particularly given mothers' reports that violence did not decrease following program participation. It is unknown whether home visitation can reduce the risk associated with fathers' negative behaviors, either when directly or indirectly targeted.

There is also qualitative evidence from fathers and professionals about the benefits of participation in parenting interventions. In a qualitative study of five home visiting programs from the Urban Institute (Gearing, Peters, Sandstrom, & Heller, 2015; Sandstrom et al., 2015), fathers reported that benefits included improved knowledge of child development and parenting skills, better communication and relationships with infants and partners, and increased knowledge of ways to manage anger and stress. Some unemployed fathers also reported benefits connected to employment resources. Professionals interviewed in these studies also felt that gains were made, even given fathers' highly vulnerable and challenged profiles. In another qualitative study of engaged fathers, Ferguson and Gates (2015) interviewed 24 young fathers involved in the NFP intervention about their needs and perception of services. Findings suggested that fathers in this study who attended the intervention improved their skills and comfort with parenting. They also conveyed that they were appreciative of the help they received to better understand their partner and their couple relationship. Little is known about specific barriers to participation, although a wide range of issues are discussed including logistical and family relationship challenges, as well as distrust and lack of connection with program content (Holmberg & Olds, 2015; Sandstrom et al., 2015).

In summary, there is evidence that father participation in home visiting can be enhanced using different approaches across different programs, There is some consensus that up to one-half of fathers participate to some extent in home visiting when this is a program focus. Those who do participate may be different types of fathers from those who do not participate, even within low-income and vulnerable families: they are likely to be married or cohabiting with the baby's mother and low on risk factors such as antisocial behavior and aggression (Duggan et al., 2004; Holmberg

& Olds, 2015). Although father participation in home visiting is increasing, more information is needed regarding fathers in home visiting programs in order to strengthen the potential impact of preventive home visiting on family and child outcomes. This study intends to address this gap in the literature and build further evidence on father involvement by addressing four exploratory questions:

1. To what extent do fathers participate in HFNY?
2. How does father participation in HFNY correlate with family program retention?
3. How does father participation in HFNY correlate with paternal co-residence with the mother and child?
4. How does father participation in HFNY correlate with father's emotional involvement with the child?

Healthy Families New York and the Fatherhood Initiative

Healthy Families New York is a Healthy Families America accredited home visiting program established in 1995, and currently operating in 38 programs statewide. New York State Office of Children and Family Services (NYS OCFS) oversees these community-based programs and is the primary funding source. HFNY is a strengths-based, intensive program designed to improve the health and well-being of infants and children through home-based services that begin prenatally and can last until the child enrolls in Head Start or enters kindergarten (DuMont et al., 2008; Kirkland, 2013; Lee et al., 2009). The program emphasizes a relational development approach to promote parent–child attachment; foster optimal child and family health, development, and safety; enhance family self-sufficiency; and prevent child abuse and neglect (Healthy Families New York, 2017). By design, the program model employs trained paraprofessionals who come from the community and are culturally competent and familiar with resources and challenges specific to the community.

Expectant parents with an infant under 3 months of age who live in targeted communities that have high rates of teen pregnancy, infant mortality, welfare receipt, and late or no prenatal care are referred to the program through a network of health and human service providers. Assessment workers meet with families to complete the Kempe Family Stress Inventory (Kempe & Kempe, 1976; Korfmacher, 2000) for each parent and any partner that may be living in the home to determine the family's eligibility. Eligibility for HFNY is limited to families with a score greater than 25, indicating a high risk for child maltreatment or other adverse outcomes. The majority of referred families are eligible for the program, and 67% of eligible families enroll. Families who enroll in services are then matched with a Family Support Worker (FSW) who provides ongoing information and support. FSWs are highly trained staff who generally live in the target community and share the same cultural backgrounds as participating families. Home visits are offered biweekly during pregnancy, increase to once a week after the baby is born, and then decrease over time as the family's functioning improves.

FSWs use various evidence-based curricula to promote parent–child attachment, foster safe and nurturing home environments, and encourage positive parenting practices. They educate families on child development and parenting, help families access community resources and services, connect families with medical providers, assess children for developmental delays, and work with parents to address family challenges such as substance abuse, intimate partner violence, and maternal depression.

Historically, the main focus of the HFNY program had been on mothers as primary care providers and their infants; very little information was available on fathers in participating families. Yet data from 2006 indicated that 45% of HFNY families had biological fathers living in the home when the mother was assessed for program eligibility. The realization that more fathers were potentially available to participate than initially recognized, together with increasing research on the importance of fathers, stimulated the development of the HFNY Fatherhood Initiative in 2007. The goals of the initiative were to promote the development of a father-inclusive culture and enhance father engagement and participation in services. Through this initiative, HFNY encouraged fathers to participate in every level of service, from initial outreach to continuous home visits.

When the Fatherhood Initiative was launched, a menu of program strategies were developed to support father participation, including the use of staff to serve as specialized father advocates or father support specialists, and the implementation of fatherhood groups within program sites. Explorations of admininstrative program data following the implementation of this initiative revealed that the program was not adequately capturing fathers' participation in services. Data collection procedures were therefore revised in 2013 to obtain more detailed information on father involvement.

Since the early days of the Fatherhood Initiative, father participation in home visits has increased modestly but steadily (from 13% of visits in 2006, prior to the start of the initiative, to 17% in 2015). The program has moved away from the specific focus of the Fatherhood Initiative, and rather, fatherhood activities have become incorporated into regular home visiting activities as part of a broader shift towards a more father-inclusive culture that values and encourages fathers' involvement. Strategies include tandem home visits, where two home visitors work with the mother and father separately; one-on-one sessions where the home visitor works with the father and child; fathers' groups where

the home visitor provides information on parenting skills, child development, or other topics of interest to fathers; and home visits providing parenting education and referrals for services to both the mother and father together. While there is no required fatherhood curriculum across sites, some choose to supplement the standard Healthy Families America curriculum with 24/7 Dads (Lewin-Bizan, 2015), Boyz 2 Dads (for teen fathers) (Kiselica, 2008), or InsideOut Dads (for incarcerated fathers) (Block et al., 2014). HFNY also has a standardized domestic violence protocol which is implemented consistently across program sites, and which assists home visitors in navigating cases in which a father or other figure may present a danger of violence to mother or child.

Methods

Study Data and Sample

This research is a collaboration between NYS OCFS, which implements the program and collects data, and research staff at the University at Albany. Data were analyzed from the centralized HFNY Management Information System (MIS) that contains comprehensive information on families from each HFNY site, including screening data, the parent risk assessment, family characteristics, the frequency and content of home visits, the nature and outcome of service referrals, and progress toward program objectives. All HFNY program enrollees sign the informed consent for data collection and evaluation which has been approved by the Institutional Review Board of the University at Albany.

Participants for the current study are drawn from 5386 families who were enrolled in the program from January 1, 2013, to June 30, 2015. Because 6-month retention was one of the outcomes of interest, the study sample was limited to families where the child would have reached 6 months of age by the end of 2015. After removing families where the child would not have turned 6 months old by the end of 2015 (n = 292), the primary caregiver was not the biological mother (n = 107), or the child or the primary caregiver died before the child was 6 months old (n = 15), 4972 families remained in the sample. Information on the biological father was available for 67% of these families (3341 families). Father information was not available for the remainder for a range of reasons, including unknown whereabouts or mother declining to provide information. Families where father information is not available are similar in many respects to families where information is available but the father is not in the home. The most striking difference is that families without father information available are more likely than other families to be headed by a black mother and less likely to be headed by a white mother. The 3341 families with biological father information available constitute the study sample.

The number of families in the final sample from each program site ranges from 37 to 233, with an average of 90 families from each program. Approximately half of the sample came from the 12 largest program sites. Program sites varied in location and demographics, but all served high-risk populations.

Measurement

Measures come from the assessment interview (family risk), the intake interview (demographics, family characteristics), the home visit logs (who is present, topics addressed), and the follow-up interviews scheduled when infants are 6 months of age. Measures used in the analysis are summarized in Table 1 and described below.

Family Characteristics

Parent information is gathered during the intake interview completed by the home visitor when the family enrolls in services. The mother is the main source for these variables. At the interview, if the biological father is not present, mothers are asked if the biological father lives at home. Family characteristics and demographic variables include father's employment status, mother's race and ethnicity, nativity status, each parent's marital status, and whether the family enrolled in HFNY before or after the child's birth. Another characteristic available in the data, albeit a much more

Table 1 Characteristics of HFNY families at intake and by father's residency

	All N = 3341	Co-resident n = 2280	Non-resident n = 1061
Family characteristics			
Both parents are married	19%	26%	5%
Mother born in U.S	74%	70%	84%
Mother is white	42%	44%	37%
Mother is black	21%	16%	32%
Mother is Hispanic	30%	33%	23%
Mother is other race	8%	8%	9%
Mother is under age 20	20%	15%	29%
Father is employed	55%	63%	39%
Risk factors and program engagement			
Mother's KFSI[a] score (mean)	40.1	39.1	42.1
Intake was before child's birth	46%	46%	47%
Father participated any home visit	65%	74%	48%

[a]Kempe Family Stress Inventory (Korfmacher, 2000)

subjective one, is the father's emotional involvement with the child. At intake and subsequent follow-ups, the home visitor records the father's involvement with the child as emotional, financial, both, or neither. This assessment is based largely on the mother's perception rather than on objective indicators, and so must be interpreted with caution. These family characteristics are controlled in the multivariate analyses presented here because they may have a bearing on father participation in home visiting, retention of families in home visiting, and the likelihood that the father lives with the family.

Family Risk

The Kempe Family Stress Inventory (KFSI) is a 10-item index that assesses risk for parenting difficulties based upon a thorough psychosocial screening interview focused on parental history and experiences. The scale covers a variety of domains, including psychiatric history; criminal and substance abuse history; childhood history of care; emotional functioning; attitudes towards and perception of child; discipline of child; and level of stress in the parent's life. The scale has been used in Healthy Families America studies to predict parents' future risk of maltreating their children as well as other family functioning outcomes (Korfmacher, 2000). This KFSI yields a score that describes the level of risks present in families' lives at the start of the study. Although little reliability information is available, construct validity has been demonstrated with the KFSI. A score is calculated for each parent and any partner that may be living in the home. If a parent or partner is not present at the time of the assessment, the person with whom the assessment is being conducted is asked to provide the information for the individual or individuals who are not there. Because father participation in the KFSI was variable and mother-reported father information could be incomplete or biased, only maternal KFSI scores are used in this analysis.

Program Participation

The most basic measure of engagement is whether a father ever participated in a home visit, from the intake appointment up to the 6-month follow-up. The participation of family members, including fathers, at each home visit is noted in the home visit log. Researchers also computed the percentage of overall home visits to the family in which the father participated. Given the wide range of the total number of home visits per family, as well as the large number of families that only had a single home visit, the percentage of home visits was unevenly distributed; whether the father had ever participated in a home visit was a more stable measure. Given these considerations, this study utilizes the dichotomous visit-or-no-visit participation measure as the main independent variable in the analyses that follow.

Program Retention

As participation in the HFNY program is voluntary and fairly intensive, the attrition of families before meeting their program goals is an ongoing challenge. While there are a number of ways to measure family retention (e.g., length of time receiving home visits, length of time enrolled in program), one of the most straightforward ways to assess this factor is based on whether the family participated in the 6-month follow-up. Follow-up visit timing is based on the child's date of birth, not on the date of intake. In this analysis, retention refers to whether or not the family was retained at the 6-month post-birth interview.

Fathers' Co-residence

As indicated, the home visitor asks at intake and at each follow-up whether the biological father is present in the home. In this analysis, we focus on whether the father is present in the home at the 6-month follow-up. The analysis is broken down by whether the father was present in the home at intake, which allows us to determine if the father has remained in the home, moved into the home, moved out of the home, or never lived in the home.

Fathers' Emotional Involvement

At intake and the 6-month follow-up, the home visitor records the mother's subjective perception of father's emotional involvement with the child. The question is not standardized, and the home visitors use their own wording to solicit this information. In this analysis, we look at whether fathers were recorded as being emotionally involved at the 6-month follow-up. Initial levels of reported father emotional involvement are also gathered during the assessment.

Analysis Plan

Data were extracted from the HFNY MIS and were analyzed using SPSS Version 21 software. We used descriptive statistics to check data quality; then used Chi square tests and one-way analyses of variance to examine differences in key variables of interest between fathers by co-residence and by program participation. Given the shortcomings of correlational data, we included socio-demographic variables as well as father's program participation, emotional involvement with child, and co-residence at intake in binary logistic regression models. All statistical tests were two-tailed, using an α of 0.05.

Results

Table 1 describes the characteristics of all families in the study, and by father's residence at the time of enrollment. Among these families, 68% reported the father living in the home at intake; 19% were families in which parents were married. Fifty-four percent of the families enrolled in HFNY before the child was born. Families in the sample were racially and ethnically diverse: the mother identified as non-Hispanic white in 42% of families, non-Hispanic black in 21% of families, and Hispanic/Latina in 30% of families.

Father Participation in Home Visits

The first question addressed is the extent to which fathers participate in HFNY. Once enrolled, 65% of fathers in families participated in at least one home visit within the first 6 months of the child's life (see Table 1). Those that did participate attended on average 22% of all visits to the family. Not surprisingly, participation was linked to whether the father lived with the mother and child: 72% of fathers who lived in the child's home participated in at least one visit, compared to 46% of those residing outside the child's home. Further, 68% of fathers who are reported as emotionally involved with their child at intake participated in at least one visit, compared to 31% of those who are not emotionally involved.

Effects of Father Participation on Program Retention

The next question investigated is whether father participation in home visits is associated with program retention. Overall, 62% of the sample completed the 6-month follow-up. The bivariate analysis indicates that 72% of families where the father participated in at least one home visit were retained at the 6-month follow-up, compared to only 45% of families where the father did not participate in any home visits.

Table 2 shows the results of a logistic regression model predicting family retention in the HFNY program for a minimum of 6 months after the target child's birth, as measured by completion of the 6-month follow-up. Families where fathers participated in at least one home visit were more than four times as likely to be retained as families where the father did not participate in any home visits (OR = 4.038), controlling for the father's presence in the home and emotional involvement with the family. Somewhat counterintuitively, when father's program participation was controlled, the father living in the home and being emotionally involved with the child at intake were both associated with a *lower* likelihood of family retention at the 6 months follow-up (OR = 0.824 and 0.694, respectively). Prenatal enrollment was associated with a higher likelihood of retention (OR = 2.030). Additional factors associated with an increased likelihood of family retention included older maternal age in years (OR = 1.043) and the mother being foreign-born (OR = 1.321). Families were less likely to be retained as maternal risk score increased (OR = 0.990).

Effects of Father Participation on Father Co-residence and Emotional Involvement with the Child

Lastly, we examined whether father participation in home visiting services was associated with father's co-residence and his reported emotional involvement with the child. Overall, 59% of the families in the sample retained at the 6-month follow-up visit (n = 2050) had biological fathers living with the child at both intake and 6 months, while 22% of the families had biological fathers who did not live with the child at either point. Eleven percent of fathers departed from the

Table 2 Predicting program retention in HFNY at 6 months follow-up

N = 3341	Exp (B)	95% CI
Mother is born outside the U.S. (1 = yes, 0 = no)	1.321*	1.045–1.670
Mother's age at Intake (in years)	1.043***	1.029–1.057
Mother's KFSI scores	0.990**	0.985–0.996
Mother's race[a]		
Non-Hispanic black	1.040	0.843–1.285
Hispanic/Latina	1.022	0.812–1.285
Other	0.884	0.656–1.192
Intake was before child's birth (1 = yes, 0 = no)	2,030	1.744–2.364
Father lives in home (1 = yes, 0 = no)	0.824*	0.685–0.990
Father is emotionally involved at Intake (1 = yes, 0 = no)	0.694**	0.539–0.892
Father has participated in ≥ 1 home visit (1 = yes, 0 = no)	4.038***	3.399–4.797

*p < .05; **p < .01; ***p < .001

[a]Referent: Non-Hispanic white

household between intake and 6 months, and 7% of fathers joined the household during this period.

Table 3 shows the likelihood of fathers residing with their child at 6 months. Odds ratios are presented separately for fathers residing with their child at intake (n = 1445) and for fathers not residing with their child at intake (n = 605). Among fathers residing in the family home at intake, those who participated in at least one home visit were nearly three times as likely to remain in the home when the child was 6 months old (OR = 2.963), controlling for other family characteristics. Additionally, the father was more likely to remain in the home in families where the mother was foreign-born or older (OR = 1.966 and 1.046, respectively), and less likely to remain in the home in families were the mother was non-Hispanic and black (OR = 0.392), or where the maternal risk score on the KFSI was higher (OR = 0.983).

Among fathers not residing in the family home at intake, the effects of participating in home visiting were even more notable. Fathers who participated in at least one home visit were more than five times as likely to have moved into the family home than their peers who did not participate in any home visits (OR = 5.440). As in the previous model, maternal nativity and age were also associated with the likelihood of the father joining the home (OR = 2.055 and 1.036, respectively). Furthermore, fathers were more likely to join the family home if the family enrolled in the HFNY program before the birth of the child (OR = 1.708) and if the father was emotionally involved with the child or pregnancy at intake (OR = 2.328).

Table 4 shows the results of a logistic regression model predicting fathers' emotional involvement with the child at 6 months of age among fathers who were emotionally involved at intake (n = 1814). The majority of fathers were emotionally involved at both points in time. A small number of fathers were involved at intake but became uninvolved by 6 months. Controlling for father's co-residence and other predictors, fathers who participated in at least one home visit were just over three times more likely than those who did not participate in a home visit to remain emotionally involved at 6 months (OR = 3.297).

Fathers who lived in the home were two and a half times as likely to remain involved until the child was 6-month-old. Both maternal age and risk scores are significant predictors

Table 4 Predicting father's emotional involvement with child at 6 months

N = 1814[a]	Exp (B)	95% CI
Mother is born in U.S.	1.071	0.633–1.814
Mother's age at intake (in years)	1.047**	1.015–1.079
Mother's KFSI scores	0.983**	0.971–0.996
Mother's race[b]		
Non-Hispanic black	0.908	0.589–1.400
Hispanic/Latina	1.413	0.840–2.376
Other	0.963	0.514–1.802
Intake was before child's birth	0.893	0.631–1.263
Father lives in home at intake	2.510***	1.752–3.596
Father has participated in 1 or more home visit	3.297***	2.291–4.743

**p < .01; ***p < .001

[a]Limited to only those who were emotionally involved at intake. Since the majority of fathers (89%) were emotionally involved at Intake, the sample for emotionally uninvolved fathers at Intake and who stayed for 6 months was too small for analysis. The model became unstable

[b]Referent: Non-Hispanic white

Table 3 Predicting father's co-residence at 6 months

	Co-resident at intake		Not resident at intake	
	n = 1445		n = 605	
	Exp (B)	95% CI	Exp (B)	95% CI
Mother is born outside U.S.	1.966**	1.249–3.094	2.055*	1.092–3.866
Mother's age at intake (in years)	1.046***	1.018–1.075	1.036*	1.002–1.072
Mother's KFSI scores	0.983**	0.972–0.994	0.995	0.977–1.012
Mother's race[a]				
Non-Hispanic black	0.392***	0.265–0.581	0.603	0.360–1.010
Hispanic/Latina	0.970	0.618–1.524	1.122	0.617–2.040
Other	0.719	0.400-1.291	0.789	0.359–1.734
Intake was before child's birth	0.924	0.683–1.251	1.708*	1.078–2.707
Father is emotionally involved at intake	–[b]	–[b]	2.328**	1.347–4.024
Father participated in 1 or more home visit	2.963***	2.048–4.288	5.440***	3.153–9.384

*p < .05,; **p < .01,; ***p < .001

[a]Referent: Non-Hispanic white

[b]Since nearly all families with a co-resident father (96%) reported that he was emotionally involved, it was not included in the model

in expected directions (OR = 1.047 and 0.983, respectively). Similar to what was observed in the co-residency model, fathers were almost 5% more likely to stay involved with every additional year of maternal age.

Discussion and Implications

Engaging fathers in prevention programs such as home visiting has emerged as an important area for program enhancement, although research is still in early stages. In the study sample, the proportion of fathers who participated in at least one visit reached 64%, but their rate of attendance remained low, at 22%. While these rates are comparable to other home visiting programs (Duggan et al., 2004; Holmberg & Olds, 2015; Smith et al., 2012), we encourage caution in interpreting father participation findings given the lack of "consistent operational definitions and methods for studying father participation" (Holmberg & Olds, 2015, p. 131).

One of the benefits of engaging fathers may be improved program retention. Families with involved fathers were more likely to be retained at 6 months. Though a causal relationship cannot be concluded from these data, the temporal order is appropriate in that the measure of father participation precedes the 6-month follow-up. These findings offer further evidence toward fathers' potential positive influence on mother's involvement and commitment to a parenting intervention and to co-parenting (Cowan et al., 2009; Guterman et al., 2018).

Interestingly, the study results also suggest that families with a co-resident father or a family where mothers report more father emotional involvement exit the program earlier than their counterparts, controlling for father participation and maternal stressors. This may be because the mothers of children whose fathers are more present have lower emotional and instrumental support needs, which is found in prior research to be associated with program attrition (Navaie-Waliser et al., 2000).

Additional findings in this study address the impact of father participation on father presence and involvement. Fathers who participated in home visiting were more likely than non-participants to be in the home at the 6-month follow up even if they were not there initially. Additionally, partners who live at home at follow up were more likely to be viewed by mothers as emotionally involved. Home visiting potentially provides an important opportunity for distressed couples to get assistance with conflicted relationships and communication at an early and critical stage of their relationship (Sar et al., 2010). These findings may lend weight to the recommendation to expand home visitation services to more explicitly target strengthened family relationships and co-parenting, given the declines in father support following childbirth noted earlier (e.g., Hofferth & Goldscheider, 2010) and some evidence that bolstering father–child involvement in a parenting program is less successful as children age (Robbers, 2009).

An important caveat raised by the study of Hawaii HFA by Duggan and colleagues (2004) is that promoting the involvement of a subset of resident fathers who are violent and substance-abusing is potentially counterproductive for mothers and children. Concern about such fathers creates service system and worker barriers to engaging fathers. Home visitors may hold negative perceptions about fathers, especially when family violence or drug abuse is present or suspected (Rosenberg & Wilcox, 2006; Zanoni, Warburton, Bussey, & McMaugh, 2014). These points are important for future work, but the current study's data cannot further illuminate this issue.

A number of limitations of this study should be noted. One significant limitation is that the results are correlational, and we cannot determine if the improved program retention is connected with the effects of visitors and sites, types of fathers, or the effects of the home visitation intervention itself. In particular, there was a good deal of variation between the program sites in terms of size, location, demographics, and available resources. Holmberg and Olds (2015) found that the influence of specific nurse visitors and specific site approaches strongly influenced engagement, and no doubt program outcomes as well, thus underlining the importance of taking a further look at these factors. We also have no direct knowledge of the parents' relationships with one another and no information directly from the father. A healthy, positive relationship between the mother and father prior to program enrollment could be a driver of both father participation in home visiting and the focal variables of family program retention and father co-residence. Finally, it should be noted that home visits typically took place during the day on weekdays. Therefore, paternal employment could interfere with the ability of a father to participate in home visits. This would be expected to weaken current results, however, because the presumably more socioeconomically stable fathers would be disproportionately represented among those not participating in home visiting, but paternal socioeconomic stability is usually associated with a greater likelihood of the father living in the home.

There are also clearly measurement weaknesses in this study, which are a function of using secondary data originally gathered for the purpose of program administration and not research. Primary information on the family and the visit is recorded by the home visitor, and the consistency and validity of particular observations across and within site visitors is not known, leading to unknown sources of bias in the study measures. For example the measure of father emotional involvement is gathered by the home visitor and may be based on different information depending on the visitor and site. It should be noted, however, that supervision

and quality assurance checks occur regularly. Furthermore, administrative databases—despite their limitations—are an invaluable source of knowledge about hard-to-reach, large populations followed over time in the community.

Implications for Practice and Policy

Despite varied strategies used to promote father engagement, diverse HFNY programs are able to increase the participation of fathers, and this progress invites further understanding of the processes through which father participation is strengthened. Strategies used in prior studies range from systematic outreach to fathers, changing the timing of visits, employing fatherhood coordinators, tailoring activities to meet fathers' preferences, and advocating for their specific needs (Holmberg & Olds, 2015; Sandstrom et al., 2015). HFNY sites in the current study used a variety of different strategies that included hiring male workers, changing visit times to accommodate fathers, and training workers to include fathers in home visiting. However, specific strategies used were not tracked. The identification of best-practice strategies for engaging fathers in home visiting is clearly an area that calls for more research.

Using specific modules to involve and target fathers is another promising practice strategy. One approach being evaluated is a father engagement training module, Dads Matter, which complements standard home visiting strategies and is designed to fit across different home visiting models and types of home visitors (Guterman, 2012; Guterman et al., 2018). Various components are included that focus on issues such as communication, managing stress, and anger. The intervention is associated with positive outcomes in father and family functioning in pilot work and a more extensive randomized clinical trial is underway. Evaluating the impact of specific father-engagement strategies that could be compared across sites would also add important knowledge. Thus, if it can be discerned what strategies are particularly successful in keeping fathers involved, this aspect of home visiting can be specifically enhanced, because early levels of father involvement are more likely to endure (McAllister & Burgess, 2012).

Some program barriers to father participation may be policy-related. There continue to be structural barriers to father engagement even with specific tested enhancements to increase father involvement. For example, one recent study of a program enhancement to improve father involvement in home visitation including HFA examined program administrator perspectives (McMillin, 2016). Respondents saw father involvement initiatives as important but expressed reservations about the impact on staffing and resources for the overall program. Such concerns are realistic especially given that federal funding supports use of federally approved home visiting models that traditionally target mothers and measure their outcomes (Sama-Miller et al., 2016; U.S. DHHS, 2016).

Another potentially fruitful area for future inquiry is in the domain of child maltreatment. HFNY and other home visiting programs are primary prevention programs developed specifically to reduce rates of child maltreatment in high-risk families. More research is needed on whether father participation in home visiting might be associated with reduced rates of father-perpetrated maltreatment, and whether it may affect the likelihood of maternal maltreatment (by potentially enhancing the support available to the mother). Current evidence on maltreatment outcomes is unclear and there is concern that the inherent surveillance in home visited families might lead to a 'surveillance bias' that increases chances of a maltreatment report (Green, Sanders, & Tarte, 2017). Since suspected and confirmed cases of child abuse and neglect are tracked by the administrators of the HFNY statewide program, these records might be used in a future analysis of fatherhood in home visiting.

Conclusion

In summary, this study adds to the research suggesting that focused efforts to encourage father participation in home visiting are associated with increases in father participation, although there are many potential strategies programs can employ and it is not clear which are most effective and how barriers can be overcome. Specific father involvement models are being developed which appear promising. Theoretically, increased father participation and involvement in home visiting presents an important opportunity for enhancing or augmenting child and family welfare. Paternal participation may be linked to longer program participation by families and an increased likelihood of the father residing with and being involved with the family. Home visiting appears to be a promising approach for reaching fathers in high-risk families and is worth further study in terms of longer-term outcomes.

Compliance with Ethical Standards

Conflict of interest All authors declare that there is no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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