THE SUPPORTING HEALTHY MARRIAGE EVALUATION

FINAL IMPLEMENTATION FINDINGS

OPRE Report 2012-12
August 2012

Supporting Healthy Marriage

Executive Summary

The Supporting Healthy Marriage Evaluation: Final Implementation Findings

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Overview

The Supporting Healthy Marriage (SHM) evaluation was launched in 2003 to test the effectiveness of a skills-based relationship education program designed to help low-income married couples strengthen their relationships and, in turn, support more stable and more nurturing home environments and more positive outcomes for children. The evaluation is led by MDRC, in collaboration with Abt Associates and other partners, and is sponsored by the Department of Health and Human Services.

The SHM evaluation includes a rigorous random assignment research design that compares outcomes for families who are offered SHM's services with outcomes for a similar group of families who are not offered SHM services but can access other services in the community. The evaluation also includes this implementation study documenting how eight local programs delivered SHM's services. The SHM program offers a voluntary, yearlong package of relationship and marriage education services for low-income married couples who have children or are expecting a child. The model has three complementary components: group workshops based on structured curricula; supplemental activities to build on workshop themes; and family support services to address participation barriers, connect families with needed resources, and reinforce curricular themes. This report presents final findings from the SHM implementation study, the characteristics of couples who enrolled, and their participation in the program.

Key Findings

- **Local programs implemented the SHM model in adherence with established guidelines.** Program designers and evaluators consider the implemented programs a fair field test of the SHM model. The core marriage education workshops were implemented consistently across program locations, but there was more variation in implementation of the other two program components.

- **Couples engaged in SHM services and continued participating over time.** Ninety-one percent of couples participated in at least one program service. On average, couples completed 27 hours of services across the three components, and those who initiated attendance remained engaged for approximately eight months.

- **Multiple strategies supported the implementation process.** Written curricula, protocols, and performance benchmarks established expectations for the content, frequency, and quality of SHM services. Technical assistance teams held programs accountable for working toward their goals, and they offered assistance to improve programs' performance over time.

- **Couples who enrolled are a diverse and relatively disadvantaged group.** Most couples who enrolled in SHM had low or modest income; many are Hispanic; and more than half reported thinking that their marriage was in trouble in the past year.

- **SHM services were implemented in diverse agency settings.** Host agencies include community-based organizations, private for-profit entities, a hospital, and a university. Within the broad parameters of the program model, these agencies played an important role in shaping implementation.

While this study was not designed to directly test how different implementation strategies affect program performance or participation rates, the experiences of the SHM programs indicate that multiple implementation strategies can be employed to address challenges that low-income families face in staying connected to long-term, voluntary programs. A companion report, *The Supporting Healthy Marriage Evaluation: Early Impacts on Low-Income Families,* shows that the program produced a pattern of small, positive effects on multiple aspects of couples' relationships.

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The Authors

Executive Summary

The Supporting Healthy Marriage (SHM) evaluation was launched in 2003 using a rigorous research design to test the effectiveness of one possible approach to improving outcomes for lower-income parents and children: strengthening marriages as a foundation for supporting stable, nurturing family environments and the well-being of parents and children.[1] The Department of Health and Human Services, Administration for Children and Families (ACF), sponsored the evaluation as part of its family-strengthening research agenda. The evaluation is led by MDRC in collaboration with Abt Associates, Child Trends, Optimal Solutions Group, and Public Strategies as well as academic experts Thomas Bradbury, Philip Cowan, and Carolyn Pape Cowan.

SHM is motivated by two strands of research. One growing body of research shows that parents and children tend to fare better on a range of outcomes when they live in low-conflict, two-parent families; parent-child relationships are more supportive and nurturing when parents experience less distress in their marriages; and children are less likely to live in poverty when they grow up in two-parent families. A different strand of research points to the potential effectiveness of preventive, skills-based relationship education curricula for improving the quality of marriages. To date, this research has focused primarily on middle-income couples. Collectively, these findings have motivated policymakers to test strategies that could improve relationship stability and quality for low-income parents and, thereby, improve outcomes for parents and their children.

This report from the SHM implementation study documents how eight local programs implemented this new model for services.[2] It presents final findings on the implementation and participation outcomes that the local programs achieved. Because SHM was a new model for services, examining the following questions was a central task of the implementation study:

- Could programs successfully implement the SHM model as intended?

[1]Throughout this report, the terms "low-income," "low-to-modest income," and "lower-income" are used to refer to couples with family incomes that are below 200 percent of the federal poverty level.

[2]The eight programs that were selected to participate in the SHM evaluation are located in Orlando, Florida; Wichita, Kansas; the Bronx, New York; Oklahoma City, Oklahoma; Bethlehem and Reading, Pennsylvania; El Paso and San Antonio, Texas; and Seattle and Shoreline, Washington. The Pennsylvania and Texas programs each offered services in two locations. In the implementation and impact analysis, these programs are each considered one site, and the research samples from both locations are combined. Variations in program implementation at each location are discussed throughout the report.

- To what extent would low-income married couples participate in this voluntary program during the 12-month period in which they were eligible to receive services?
- What supports would help encourage their participation?
- What service variations would develop in local programs as they implemented a structured model that allowed for some local innovation?
- What role could technical assistance and accountability mechanisms play in supporting performance goals for implementation and participation?

This report explores these questions and describes the characteristics of couples who enrolled in the SHM program and the program's operating costs. A companion report presents the impact results of SHM after 12 months of follow-up and shows that the program produced a consistent pattern of small, positive effects on multiple aspects of couples' relationships.[3]

The SHM Program Model

In eight locations across the United States, the SHM evaluation is testing a voluntary, yearlong program for low-income, married couples who, at study entry, had children or were expecting a child. The program included three complementary components described in Box ES.1. The program's central and most intensive component was a series of *relationship and marriage education workshops* offered for the first four to five months of enrollment in the program. Longer than most marriage education services and based on structured, research-based curricula previously used with middle-income couples, the workshops were designed to help couples enhance the quality of their relationships by teaching strategies for managing conflict, communicating effectively, increasing supportive behaviors, and building closeness and friendship. Workshops also wove in strategies for managing stressful circumstances commonly faced by lower-income families (such as job loss, financial stress, or housing instability), and they encouraged couples to build positive support networks in their communities. The eight local programs selected one of four curricula for their workshops.[4]

[3] JoAnn Hsueh, Desiree Principe Alderson, Erika Lundquist, Charles Michalopoulos, Daniel Gubits, David Fein, and Virginia Knox, *The Supporting Healthy Marriage Evaluation: Early Impacts on Low-Income Families;* OPRE Report 2012-11 (Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Office of Planning, Research and Evaluation, 2012).

[4] The local programs used one of four curricula adapted for use in SHM: Within Our Reach (WOR); For Our Family, For Our Future (FOF); Loving Couples, Loving Children (LCLC); and the Becoming Parents Program (BPP). Appendix G describes the four curricula.

Box ES.1

The SHM Program Model: Three Complementary Components

Relationship and marriage education workshops. The core SHM service, workshops were typically conducted with a range of 3 to 20 couples in a group setting in weekly sessions lasting 2 to 5 hours each. Longer than many marriage education services, SHM workshops typically lasted 6 to 15 weeks, for a total of 24 to 30 hours of curriculum.

Supplemental activities. These events built on and complemented the workshops, providing couples additional opportunities to learn and practice relationship skills and to build support networks with other married couples.

Family support services. Family support coordinators were the main link between couples and the program. They maintained contact over time, facilitated participation in the program by linking couples to needed community services, and worked in one-on-one settings to reinforce themes presented in the workshops.

Complementing the workshops was a second component, which consisted of *supplemental activities* — educational and social events that were intended to build on and reinforce lessons from the curricula. The third component, *family support services,* paired couples with a specialized staff member who maintained contact with them and facilitated their participation in the other two program components. Because programs sought to keep couples engaged in services for one year, family support staff helped to meet family resource needs by connecting participants with other needed services, which also helped address participation barriers and relationship stressors. Staff also reinforced the workshop themes and skills in their one-on-one meetings with couples.

Implementation of the SHM Program

The SHM model operated in diverse agency settings

The eight local programs that participated in this evaluation demonstrated that the SHM model can be implemented in a variety of contexts. Even as programs adhered to a common model, host agencies played an important role in shaping daily operations. The program settings can be divided into three groups:

- **Embedded within community-based multiservice organizations.** Programs in Pennsylvania, Shoreline, Texas, and Wichita operated within longstanding community-based organizations that had deep connections to low-income neighborhoods. In all four locations, SHM was embedded within

an array of services, and programs drew on agency resources as they developed recruitment and referral networks. To increase accessibility, all four programs delivered services in more than one location in their communities.

- **Located in large local institutions.** Programs in the Bronx and Orlando operated in hospital and university settings, respectively, which offered name recognition, connections to recruitment and referral partners, administrative support, and attractive, newly renovated office space. The agency setting heavily influenced hiring decisions: Orlando hired master's-degree students from the university's counseling and social work programs as family support coordinators, and the Bronx hired clinically trained psychologists as workshop facilitators.

- **Operated by stand-alone for-profit entities.** Programs in Oklahoma City and Seattle operated as for-profit organizations with marriage education as their sole or primary service.[5] Not embedded in larger social service settings, their stand-alone structure lent flexibility in shaping services according to their vision.

Each of the local SHM programs implemented the full model: multiple strategies supported implementation

ACF and the SHM research team sought to evaluate well-implemented tests of the SHM model, and final analysis presented in this report shows that the local programs operated the three SHM program components in adherence with guidelines. Though some programs achieved more robust services than others, designers and evaluators consider the implemented programs a fair field test of the SHM model. Multiple strategies, described below, supported the local programs throughout their implementation process.

- **Beginning with small-scale pilots before launching full-scale operations.** Local programs began offering SHM services in small-scale pilots that lasted from 1 month to 10 months. By the time full-scale operations and the formal impact evaluation began, the programs had worked through many early implementation challenges, and pilot tests likely contributed to higher levels of implementation quality during the early months of full operations. Still, it took time to reach a steady state of implementation for all three program components. Programs focused first on launching workshops and family support services to help ensure that couples participated. Supplemental ac-

[5] All services were provided at no cost to couples in all the SHM programs.

tivities began last, and programs offered a limited number of activities at first, with the goal of scaling up as more couples enrolled over time. Many programs did not begin offering a full calendar of supplemental activities until the second year of the evaluation.

- **Building support for couples' participation directly into the program model.** Several elements of the SHM model emphasized making services accessible and attractive to low-income married couples. For example, services were offered on weeknights and Saturdays to accommodate work schedules, and programs supported participation by offering reimbursements for transportation and child care costs as well as modest incentives. Perhaps most importantly, family support coordinators were responsible for maintaining contact with couples throughout the 12 months that they were eligible to receive services from the program. They followed up if a couple missed a workshop or activity, and they connected couples to community resources to address barriers to participation and the stressors that families faced. This combination of regular contact, follow-up, resources, participation supports, and modest incentives was a likely contributor to the engagement and participation rates that programs were able to achieve.

- **Providing written documents to guide service delivery.** Programs began implementation with two important resources: (1) written curricula and participant materials to guide relationship and marriage education workshops and (2) an SHM Toolkit outlining expectations for the content, frequency, and quality of SHM services.[6] These materials provided a starting point for developing job descriptions, training materials, and service delivery protocols, and they formed the basis for performance monitoring by technical assistance providers. The level of specificity varied for each of the three components in the SHM model, which may help explain variations in the consistency of content and engagement that programs were able to achieve across components. Marriage education workshops were the most structured, with written curricula and formal staff training. Family support became more structured over time as technical assistance focused on making the content and frequency of services more consistent. Programs were given very basic guidelines for supplemental activities and were allowed substantial latitude in developing this component, in hopes that activities would reflect local needs

[6]MDRC, *Supporting Healthy Marriage Toolkit: Resources for Program Operators from the Supporting Healthy Marriage Demonstration and Evaluation* (New York: MDRC, 2011). The SHM Toolkit is available online at http://www.mdrc.org/publications/593/full.pdf.

and interests. In a small number of programs, this flexibility yielded a creative and robust approach. Others faced more challenges in developing programming that attracted large numbers of couples, as evidenced by lower overall take-up rates for this service.

- **Placing a continuous focus on performance.** Because little similar work had been undertaken with low-income couples, there was no clear base from which to estimate the level of engagement and participation in SHM services that could be or should be expected. It was important, however, to establish benchmarks for engagement and participation so that program managers and the SHM research team could assess performance on a regular basis and could undertake corrective action in a timely manner, when needed. Local SHM programs operated under performance-based contracts,[7] and continued funding was contingent on achieving benchmarks for recruitment, participation, and quality of program implementation. Benchmarks were set at minimum levels that the SHM developers hoped the programs would be able to achieve.[8] As programs began demonstrating success in achieving the initial benchmarks, additional written implementation guidance was issued, urging them to set more ambitious goals. For example, one of the benchmarks for workshop participation required programs to engage couples in five workshops within six months of enrollment (roughly a third of the total curriculum hours offered). As programs began achieving this goal, they were asked to focus on helping couples complete as many curriculum hours as possible.

- **Offering ongoing technical assistance to support performance goals.** A team of technical assistance providers led by MDRC was closely involved in monitoring performance, holding programs accountable for achieving benchmarks and quality measures, and providing technical assistance to improve services. Technical assistance was delivered using multiple methods and was organized around a continuous process of trial, error, analysis, and retooling to develop effective strategies for meeting performance goals. Each program was assigned a technical assistance representative, or "site rep," who worked with staff as both a monitor and a one-on-one management

[7]Some programs also had funding from other sources, such as state funds or grants from the Office of Family Assistance.

[8]For more information on the performance benchmarks used in SHM, see Jennifer Miller Gaubert, Virginia Knox, Desiree Principe Alderson, Christopher Dalton, Kate Fletcher, and Meghan McCormick, *Early Lessons from the Implementation of a Relationship and Marriage Skills Program for Low-Income Married Couples* (New York: MDRC, 2010).

coach beginning in the pilot and lasting through the end of full operations. Site reps regularly reviewed data on program performance and took responsibility for holding routine telephone check-ins with program managers and staff to review the data and to generate ideas for improving performance in the coming month. In subsequent meetings, managers and site reps analyzed progress: strategies that appeared to be working were kept, and those that did not were thrown out or retooled, and new plans were drafted. In this way, staff were actively encouraged to experiment and were supported in their efforts to test different approaches until they found the ones that worked. Lastly, site reps also made periodic on-site visits to observe staff and to offer feedback on the content and quality of service delivery.

- **Developing a common, Web-based management information system (MIS).** A critically important tool in supporting day-to-day management and technical assistance efforts was a Web-based MIS that was customized for use by SHM programs.[9] The MIS was set up to collect data on couples' characteristics and service receipt. Customized reports allowed managers, staff, and technical assistance providers to assess programs' performance toward benchmarks in real time — for example, tracking weekly workshop attendance and identifying absent couples so that family support staff could place a call offering assistance to help them attend the following week — and to analyze programs' efforts to improve daily operations. The Web-based format facilitated frequent review of performance data, which was routinely discussed as part of staff and technical assistance meetings. Learning to use and maximize the capacities of the MIS was a process that lasted well into full operations. Each program had a part-time MIS coordinator whose role was to train staff, monitor data for accuracy, and run reports. In some locations, the MIS coordinator also played a key role in helping staff interpret results and create more sophisticated reports to make performance tracking easier.

[9]The Oklahoma City program used its own MIS and provided data to the SHM team for purposes of research and technical assistance.

Participation in the SHM Program

Couples participated an average of 27 hours across the three components, and those who initiated attendance remained engaged for about eight months

To understand the implementation of the new program model used in the SHM evaluation, two primary questions that the study sought to answer were whether low-income couples would be interested enough in this type of program to enroll and whether services would be attractive enough to keep them coming over time, despite the day-to-day challenges that often interfere with participation in voluntary programs. At the outset of implementation, SHM had little information about what level of participation one might expect in a program designed to be more intensive and longer-term than most existing marriage education services. One goal of the evaluation, then, was to find out what initial engagement and ongoing participation rates programs would be able to achieve in a model for long-term services that included multiple strategies for supporting participation.

In characterizing participation rates, this report relies primarily on data that SHM program staff recorded in the SHM management information system. In contrast, the SHM early impacts report presents program-control group differences in participation based on sample members' responses to the 12-month follow-up survey.[10] Therefore, the findings on program participation are not identical across the two reports.

A total of 6,298 couples enrolled in the SHM study.[11] Final data show that most couples did participate in all three components of the program. Among all couples who were enrolled in the program group,[12] 91 percent engaged in at least one SHM service within 12 months; 88 percent attended at least one meeting with their family support coordinator; 83 percent attended at least one workshop; and 66 percent attended at least one supplemental activity. Couples spent an average of 27 hours engaged in a combination of SHM services, including completing 17 hours of marriage education workshops. In addition, couples completed 6 hours of supplemental activities and 4 hours of in-person family support meetings.

Looking at the results among couples who ever initiated participation in any SHM activity (91 percent of the program group), participation rates are slightly higher. These

[10]See Hsueh et al. (2012).

[11]Half of the 6,298 couples who enrolled were randomly selected to participate in SHM services and are referred to as the "program group." The other half of the couples who enrolled were assigned to a control group and did not participate in SHM but could access other services in their communities.

[12]Average participation hours are calculated for all program group couples, including couples who attended zero hours of activities.

couples spent an average of 29 hours in SHM services and completed 18 hours of workshops. These couples completed roughly the same number of hours in supplemental activities (6 hours) and in-person family support meetings (5 hours). Once engaged, couples stayed connected to the program for an average of eight months, somewhat short of the model's goal of keeping couples engaged in services for a full year. Couples attended most services within the first six months after enrollment.

Comparing the workshop hours offered in a given location and the hours actually completed provides one gauge of whether couples experienced the program model as intended. As is often the case with programs consisting of multiple sessions, in all the locations, the typical couple attended fewer workshop hours than the total hours offered. Among all program group members, couples completed roughly 60 percent of the workshop hours offered. Among couples who ever initiated participation in SHM workshops, this number increases to 71 percent. These results fall roughly between what was achieved by two similar relationship education programs: Building Strong Families and Supporting Father Involvement.[13]

Couples who enrolled in SHM were a diverse and relatively disadvantaged group

A goal of the SHM evaluation was to test the model in programs that would serve a diverse range of couples. SHM programs succeeded in recruiting couples from a variety of backgrounds:

- **Most couples had low or modest income.** Though a majority of couples had at least one spouse who was employed at baseline, about 82 percent of couples had income below 200 percent of the federal poverty level, and 43 percent of couples had income below 100 percent of the poverty level. In roughly half of couples, both spouses had at least a high school diploma, and 16 percent of couples had at least one spouse with a four-year college degree.

[13]In the Building Strong Families program, which served unmarried couples who were expecting or had recently had a child, program group couples completed an average of 12 workshop hours, or 30 percent of curriculum hours offered. Couples who attended at least one workshop (55 percent of couples) completed an average of 21 workshop hours, representing 55 percent of curriculum hours offered. In the Supporting Father Involvement study, program group couples completed an average of 25 hours, or 79 percent of curriculum hours offered. Couples who attended at least one workshop (91 percent of couples) completed an average of 29 hours, representing 91 percent of curriculum hours offered (32 hours). See M. Robin Dion, Sarah A. Avellar, and Elizabeth Clary, *Implementation of Eight Programs to Strengthen Unmarried Parent Families* (Washington, DC: Mathematica Policy Research, 2010); and Philip A. Cowan, Carolyn Pape Cowan, Marsha Kline Pruett, Kyle Pruett, and Jessie J. Wong, "Promoting Fathers' Engagement with Children: Preventive Interventions for Low-Income Families," *Journal of Marriage and Family* 71, 3: 663-679 (2009). Data for Supporting Father Involvement were provided by Philip Cowan and Carolyn Pape Cowan.

- **Many enrollees are Hispanic.** Overall, 43 percent of couples who enrolled in the study are Hispanic; 21 percent of couples are both white; 11 percent are both black; and 25 percent are couples of another race/ethnicity or couples who differ in racial/ethnic background.[14] Slightly less than 50 percent of couples have at least one spouse who is an immigrant to the United States.

- **Enrollees were, on average, 31 years old and had two children.** About 30 percent of couples were expecting a child when they enrolled in SHM, and most couples had children under age 10 living in their home. Couples in the Oklahoma City and Seattle programs, which targeted their services to expectant parents, served couples who were slightly younger, on average.

- **Couples had been married an average of six years.** The average length of marriage at study entry ranged from three to four years in Seattle and Oklahoma City to nine years in Pennsylvania and Texas. More than a quarter of SHM families were stepfamilies.

- **Roughly 20 percent of enrollees reported experiencing psychological distress, and 20 percent reported facing substance abuse.** The percentage of couples who reported that at least one spouse faced psychological distress, such as symptoms of depression, ranged from 11 percent in Oklahoma City to more than 30 percent in Wichita. The percentage of couples facing substance abuse issues ranged from 12 percent in Orlando to 28 percent in the Bronx.

- **While most couples stated that they were happy with their marriages, more than half also reported thinking that their marriage was in trouble in the past year.** About three-quarters of husbands and wives reported at baseline that they were currently happy with their marriages, but a little more than half reported having thought during the past year that their marriage was in trouble.

When compared with low-income married couples in national samples, SHM couples are more likely to be Hispanic, to be younger, and to report being less happy in their marriages.

[14]The "other/multiracial" category includes couples who are of different race/ethnicity (70 percent), couples in which at least one spouse has more than one race/ethnicity (15 percent), couples in which both of these conditions are true (8 percent), and couples who both self-identified as only Asian, Pacific Islander, Native American, or Other (8 percent).

Participation levels varied somewhat for couples with different characteristics and in different locations

Local programs' rates of engaging couples in any SHM activity hovered fairly close to 90 percent. Programs varied more widely in the total hours of participation that they were able to achieve. The report explores the extent to which variation in participation is associated with differences in how local programs implemented the SHM model or with differences in couple characteristics.

Initial engagement. According to the analysis, couples' likelihood of initiating participation in any SHM services varied in different programs, even when adjusting for variation in couple characteristics. Rates of initial engagement by location ranged from a low of 83 percent in Pennsylvania's Bethlehem location to 96 percent in Shoreline. In comparison, rates of initial engagement for couples with different demographic, economic, and family characteristics fall within a relatively smaller range, from 87 percent to 94 percent. Only two characteristics — women's age and presence of a stepchild in the household — are significantly associated with initial engagement.

Hours of participation. As with initial engagement, program location is also associated with the average number of hours that couples participated in SHM services, even when adjusting for variation in couple characteristics. For example, couples in Oklahoma City and Texas's San Antonio location attended the most hours (33 on average), and couples in Pennsylvania's Bethlehem location attended the fewest hours (19). Oklahoma offered services from pregnancy through the child's first birthday, slightly longer than the 12 months for the other SHM programs, whereas Bethlehem operated a 9-month SHM program. For couples with different demographic, economic, and family characteristics, hours of SHM services completed range from 23 to 30. Characteristics that are significantly associated with hours of participation include race/ethnicity, husband's age, wife's age, education, and presence of a stepchild in the household.

Taken together, these analyses suggest that how local programs implemented SHM — not just differences in the characteristics of enrolled couples — appears to have influenced the extent to which couples engaged in SHM services and participated over time.

Summary

Each of the eight local SHM programs implemented the full SHM program model, and their experiences indicate that multiple implementation strategies can be employed to address challenges that low-income families face in staying connected to long-term voluntary programs. While the SHM study was not designed to directly test how different implementation strategies affect program performance or participation rates, three factors stand out as particularly rele-

vant. Family support services played an important role in encouraging couples' ongoing participation by maintaining contact with couples, addressing barriers to participation, and reinforcing themes presented in the workshops. Offering assistance with transportation and child care costs, as well as modest incentives, may have also encouraged couples' participation. Finally, programs were held accountable for working toward performance goals, and they received continuous technical assistance and support to help them meet those goals. Early impact results from the SHM project are presented in a companion report,[15] and future reports will examine longer-term impacts.

For further information, visit the SHM Web site: www.supportinghealthymarriage.org.

[15]Hsueh et al. (2012).