History and Implementation of the Federally Funded Healthy Marriage and Relationship Education (HMRE) Grants

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Overview

The mission of the Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services (HHS) is to "...foster health and well-being by providing federal leadership, partnership and resources for the compassionate and effective delivery of human services."[1] To advance this mission, ACF administers a range of programs for families, including Healthy Marriage and Relationship Education (HMRE). HMRE programs are designed to teach youth and adult individuals—as well as unmarried, married, or co-parenting couples—how to communicate effectively, manage conflict, identify signs of an unhealthy relationship, and apply other skills for developing and maintaining healthy relationships.[a]

ACF has been steadily building an evidence base of best practices in implementing HMRE programming. Two ACF agencies contribute significantly to this effort: The Office of Family Assistance (OFA) provides oversight and monitoring of HMRE grants, while the Office of Planning, Research, and Evaluation (OPRE) manages research studies of these programs, including rigorous impact evaluations. In this brief, we draw from a mix of evaluation and descriptive studies that highlight implementation findings that inform the HMRE initiative to promote the well-being of children and families.

The purpose of the brief is to:

- Provide a brief overview of HMRE funding.
- Describe program implementation characteristics for three cohorts of HMRE grantees.
- Present implications of findings and lessons learned to support best practices in HMRE programming.

MAST CENTER RESEARCH

The Marriage Strengthening Research and Dissemination Center (MAST Center) conducts research on marriage and romantic relationships in the U.S. and healthy marriage and relationship education (HMRE) programs designed to strengthen these relationships. This research aims to identify critical research gaps, generate new knowledge, and help programs more effectively serve the individuals and families they work with. MAST Center research is concentrated in two areas:

- **Relationship Patterns & Trends.** Population-based research to better understand trends, predictors, dynamics, and outcomes of marriage and relationships in the United States.
- **Program Implementation & Evaluation.** Research that helps build knowledge about what works in HMRE programming, for whom, and in what context.

[a] see https://www.acf.hhs.gov/ofa/programs/healthy-marriage/healthy-marriage

MAST Marriage Strengthening Research & Dissemination Center

July 2021

Overview of findings

- HMRE programs can be implemented in various settings, including schools and community-based organizations.
- HMRE skills-building curricula can be implemented with diverse populations, including adult individuals, couples, and youth; racial and ethnic minorities; economically distressed families; co-parenting but nonresidential couples; and culturally and linguistically diverse populations.
- HMRE programs require intentional and multi-pronged approaches to recruitment.
- Additional programmatic elements beyond general skill-building may be necessary to meet participant needs. Partnerships and referral services are common strategies for meeting these needs.
- Youth are an important priority population for HMRE efforts. HMRE programs for youth differ from those for adults in order to accommodate developmental differences and age-specific content.
- Delivering HMRE services is complex and programs may need support. Federal grantees receive data-driven training and technical assistance to support performance.

History of HMRE Funding

Marriage and relationship education programs emerged in the late 1980s and early 1990s as a response to community, state, and federal interest in strengthening marriage and reducing divorce rates. Federal interest in strengthening families increased with the 1996 passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which instituted the Temporary Assistance for Needy Families (TANF) program and included the goals of supporting marriage and reducing nonmarital births. In 2002, ACF launched the Healthy Marriage Initiative and began funding HMRE programs (also referred to as marriage and relationship education or relationship education programs) across a range of funding streams to help couples increase their knowledge and develop skills to promote more stable, better-quality unions, and to teach youth the elements of healthy and unhealthy relationships. In 2006, Congress signed the Deficit Reduction Act, Public Law (DRA, P.L. 109-170), which provided a dedicated federal funding stream for HMRE programs.[2] In 2010, HMRE programming was reauthorized through the Claims Reduction Act (CRA, P.L. 111-291).[3] From 2006 to 2015, OFA awarded 230 HMRE grants to school- and community-based groups across the nation. These awards were allocated across three cohort funding cycles: 2006 to 2011, 2011 to 2015, and 2015 to 2020. Below, we describe characteristics of priority populations, goals, and priorities by grantee cohort.

Implementation Characteristics of Three HMRE Cohorts

Cohort 1: 2006-2011

In 2006, OFA awarded approximately $100 million dollars[b] to 125 grantees annually to support projects to strengthen existing marriages and to prepare unmarried couples and youth for successful, healthy relationships. (For a description of the specific activities supported by this funding see **Healthy Marriage and Relationship Education Activities: 2006 to 2011** text box.) All grantees were required to provide at least eight hours of skills training to teach individuals how to communicate effectively, resolve conflict peacefully, and increase commitment to marriage (as relevant). Priority populations included married, engaged, and cohabitating couples, as well as high school students. Priority was given to grantees targeting couples with low incomes, either married or unmarried, and expectant or new parents. Grantees funded under a specific part of the HMRE initiative that focused on broad-based community approaches (the Community Healthy Marriage Initiative) were awarded funds to bolster community-wide relationship-strengthening activities that included preventative interventions. These grants had to involve stakeholders

[b] Total funding amounts include grant funding for programming, as well as funding for a national resource center (the National Healthy Marriage Resource Center in 2006 and the National Resource Center for Healthy Marriage and Families in 2011 and 2015), research contracts, and other related activities.

from a range of sectors such as government, schools, faith-based organizations, businesses, and health care to coordinate resources and support buy-in and sustainability.[4] Finally, in recognition that not all marriages or relationships are healthy for adults or children, the healthy marriage legislation required that grantees consult with experts in domestic violence (DV) and child maltreatment.

Healthy Marriage and Relationship Education Activities: 2006 to 2011

Pursuant to Public Law 109-170 of the Deficit Reduction Act (DRA), grantees could offer eight types of services to encourage healthy relationships:

I. Public advertising campaigns on the value of marriage and the skills needed to increase marital stability and health

II. Education in high schools on the value of marriage, relationship skills, and budgeting

III. Marriage education, marriage skills, and relationship skills programs, which may include parenting skills, financial management, conflict resolution, and job and career advancement

IV. Premarital education and marriage skills training for engaged couples and for couples or individuals interested in marriage

V. Marriage enhancement and marriage skills training programs for married couples

VI. Divorce reduction programs that teach relationship skills

VII. Marriage mentoring programs that use married couples as role models and mentors in at-risk communities

VIII. Programs to reduce disincentives to marriage in means-tested aid programs if offered in conjunction with any of the other seven activities

A portion of the HMRE funding was used to support evaluation activities. Specifically, grantees were required to have an evaluation component, which included, at minimum, a plan for describing the services and activities provided and identifying project milestones and expected outcomes.[5] In addition, groups of grantees were selected to participate in various cross-site evaluations of these initiatives, including the Community Healthy Marriage Initiative (CHMI) Evaluation,[6] the Building Strong Families (BSF) Project,[7] and the Supporting Healthy Marriage (SHM) Evaluation.[8]

Cohort 2: 2011-2015

The second cohort of HMRE programs began in 2011. OFA awarded approximately $75 million annually to 60 HMRE grantees and other related activities.[b] Funding for this HMRE cohort was stipulated in the CRA, which dedicated resources for grantees to support nearly the same eight HMRE activities as addressed in the 2006-2011 cohort.[3] Priority populations continued to include families receiving TANF or other couples with low incomes, but also prioritized refugees and immigrants, as well as at-risk individuals such as those who had dropped out of school, noncustodial parents, individuals with disabilities, and veterans. In light of the complex struggles around relationship stability and economic insufficiency,[9,10] the HMRE grant scope was broadened to emphasize job and career advancement.[11]

Grantees were also encouraged to link participants to a comprehensive array of assistance through community partnerships, provide case managers to assess participants' needs, and create individualized service plans. DV protocols were required and grantees were expected to consult with DV experts on all aspects of program planning and implementation. In addition, grantees had to demonstrate that their proposed approaches to promoting healthy marriage were evidence-based or evidence-informed. Two individual grantees were selected to participate in a federal study designed to get a deeper understanding

of program implementation and impact (the Parents and Children Together Evaluation, or PACT). Although grant funds could not be used for independent program evaluations, grantees were expected to collect data for performance monitoring and quality improvement.

Cohort 3: 2015-2020

The third cohort of HMRE grantees began in 2015, when OFA awarded $75 million dollars annually to 45 HMRE grantees and other funded activities. Authorized by the 2010 CRA (P.L. 111-291), priority populations were similar to prior cohorts and focused on couples with low-incomes and individuals receiving government assistance. More emphasis was placed on noncustodial parents and youth, particularly those aging out of the foster care system or involved in the juvenile justice system. Grantees were encouraged to combine HMRE services with activities to support economic stability and mobility and more flexibility was allowed for integrating HMRE activities. This flexible approach differed from previous cohorts, where the eight HMRE activities were independent of each other and grantees were not able to combine activities to achieve program goals.[12]

OFA encouraged the 2015 cohort to develop comprehensive programming approaches which could include increased access to career-advancing education, career counseling, job training and placement, financial literacy, and soft skill development. Grantees were also expected to reduce barriers to enrollment and engagement by using case management and offering program supports such as transportation and child care. Grantees conducted intake assessments and helped participants set goals, create individual and couple development plans, and discuss steps for sustaining involvement in services after enrollment. Information from prior grantees indicated that many participants faced numerous stressors, including poverty, unemployment, psychological distress, and early and unexpected parenthood.[7] Exposure to chronic or severe stress has been shown to be related to poor health and social outcomes.[13] As such, OFA noted that the 2015 grantees should consider the potential influence of trauma on HMRE-related outcomes (e.g., relationship and parenting skills, workforce success) and provide services through a trauma-informed lens.[c] Program objectives also were broadened to emphasize parenting and co-parenting skills, successful youth transition to adulthood, and reduced recidivism.

To fulfill the continued requirement that grantees consult with DV experts, grantees were encouraged to establish plans for identifying and responding to DV, dating violence, and/or child maltreatment, including provisions for family safety and mandatory reporting (for suspected child abuse and neglect). Programmatic requirements also stressed the importance of carefully constructed recruiting plans that included targeted marketing and outreach, as well as plans for project sustainability.

Finally, there was a strong emphasis on performance monitoring and evaluation:

- All grantees were required to submit a plan for a local evaluation. The highest tier of funding was awarded to grantees who proposed a randomized controlled trial (RCT) or a high-quality quasi-experimental design (QED) for their local evaluation.
- All grantees were required to report on standardized performance measures using a management information system (Information, Family Outcomes, Reporting, and Management, or nFORM) that OFA made available to grantees to document and monitor implementation progress.

[c] Providing trauma-informed behavioral health care, mental health treatment, and substance abuse treatment were not allowable uses of funds, and grantees were encouraged to partner with public and community-based organizations to provide participants with access to these services.[12]

- Five grantees were selected to participate in the Strengthening Relationship Education and Marriage Services (STREAMS) evaluation to answer specific policy-relevant questions about integrating HMRE curricula into high school classes; combining relationship skills and economic stability training into workshops for young adults; identifying ways to support pregnant women with low incomes; and assessing the impact of texting on program attendance and completion.[14]

More details about this third cohort can be found in the 2015 Cohort of Healthy Marriage and Responsible Fatherhood Grantees Interim Report on Grantee Programs and Clients.[15]

Lessons Learned about HMRE Program Implementation

In the next section, we highlight select findings from research describing grantee implementation characteristics across the three cohorts. We also draw from the authors' experiences as technical assistance providers for the 2015 cohort of grantees. Data used to inform these findings were taken from several sources: federal evaluations, performance data entered into nFORM, grantee progress reports, workshop participation information, feedback from federal staff working with grantees, and training and technical assistance (TTA) records from Cohort 3.[d] We note qualitative themes that emerged through the synthesis of TTA interactions and materials when possible. Findings are grouped around key issues related to the implementation of the HMRE grants.

Implementation feasibility

- Implementation evaluations of select HMRE grantees showed that HMRE programs could be integrated into existing organizations serving adults and youth, including community-based agencies, high schools and universities, social services agencies, correctional facilities, substance abuse treatment centers, and DV shelters. Grantees that participated in the BSF and SHM federal evaluation delivered HMRE programs using three main approaches: (1) adding to pre-existing programming options for families, (2) integrating HMRE content into related services such as home visiting, or (3) establishing a new program.[16,17] These findings from the earliest evaluations were important for understanding HMRE programming because, prior to 2006, there was little research on implementation feasibility or the organizational structure of HMRE program delivery.
- Implementation challenges among the grantees who participated in the BSF evaluation varied depending on their organizational structure. Grantees who embedded HMRE into existing services faced competing missions, burdens on staff time, and the need to develop new policies and procedures. Multi-agency programs needed to coordinate various roles and reconcile how to use case managers or other staff to coordinate pre-existing services with HMRE workshops. Grantees establishing their HMRE program for the first time needed longer periods of time for planning, building partner networks, and staffing. Further, most grantees in this evaluation had worked primarily with mothers and children and had little experience with men or couples with low incomes.[18]
- Findings from federal cross-site evaluations showed the importance of having grantees work closely with curriculum developers when serving a new population or adapting a curriculum to better fit a new setting. For example, in the first cohort of HMRE grantees, many organizations participating in the BSF evaluation had no experience working directly with couples. Thus, to serve the key priority population of unmarried, expectant couples, program directors participated in extensive training, monitoring, and coaching by curriculum developers to ensure fidelity.[18] In the third cohort, some grantees in the STREAMS evaluation that served youth in schools worked closely with curriculum developers to adapt a briefer curriculum to fit the school schedule while retaining core components. These grantees also developed a detailed implementation plan for coordinating with schools and created an organizational structure to support implementation.[19]

[d] Training and technical assistance records were reviewed by OFA's technical assistance contractor, Public Strategies, to inform the lessons discussed in this brief.

Priority populations

- Since 2006, HMRE programs have reached diverse populations with interest in attending HMRE programs, ranging from unmarried, expectant parents (studied in BSF), to married couples with low incomes (in SHM), to single adults participating in the STREAMS evaluation. This broad interest in HMRE is relevant because HMRE was a new approach in social policy and the research literature was unclear about couples' desire for such services.[16,8]
- Approximately half of the 2011-2015 grantees served youth in schools or through community-based organizations. Most grantees planned to serve youth with particular family experiences, including those from households headed by a single parent or those with a parent struggling with addiction or with a history of criminal justice involvement. There were also programs aimed at pregnant and parenting teens, immigrant populations, and youth facing severe circumstances such as being homeless or a survivor of sexually assault.[20]

Recruitment, retention, and engagement

- Recruiting couples into HMRE programs was both challenging and affected by factors that varied across programs and settings. TTA systems were used in cohort 3 to identify common challenges, such as building and coordinating referral networks; hiring qualified staff for recruitment, facilitation, and administration; tailoring recruitment messages and content to specific populations; and executing data-driven recruitment processes. Evaluations suggested that recruitment techniques are site-specific and require periods of trial and error. For example, grantees in the BSF evaluation used marketing efforts that were helpful in increasing enrollment, including public service announcements, mass mailings, street outreach, and attendance at community events.[18]
- Expecting both members of a couple to commit and attend sessions together, despite barriers such as work or child care, presented additional challenges to recruitment and retention. Findings from the STREAMS project indicated that recruitment improved when programs broadened settings to find couples (e.g., malls, churches, health facilities), partnered with school counselors to identify families, or improved messaging to address benefits to couples.[21] OFA and its TTA partners have worked with grantees to enhance couple-friendly practices, recruitment messaging, curriculum fit, and delivery schedule.
- Grantees reported to TTA providers that recruitment is easier when HMRE programs are embedded within organizations that have existing infrastructures, especially easily accessible settings with large groups of individuals, such as schools or residential centers. To develop and maintain successful service delivery opportunities, grantees needed to focus on oversight and management of these partnerships.
- Findings from grantees participating in the BSF federal evaluation suggest that maintaining program engagement throughout the duration of programming was another major challenge. To address barriers to participation, programs offered child care, gas vouchers, classes outside of typical work hours, transportation, and incentives in the form of gift certificates or items of value.[22] Tracking this engagement is also important. Data systems (supported by TTA) were developed during cohort 3 to better track and improve client participation and completion.

- Recruiting and retaining lesbian, gay, and bisexual (LGB) populations (either individuals or LGB individuals in couple relationships) requires specific approaches. In a review of the 2015-2020 grantees serving this group, combined with recommendations from key stakeholders, researchers noted that to gain trust, grantees should work with local organizations that serve LGB individuals, distribute flyers and recruiting materials that picture images of same-sex couples, and revise intake approaches to ensure language inclusivity. To better retain LGB populations, programs may need adaptations to address these couples' unique challenges, including discrimination, legal needs, 'coming out,' stigma and stereotypes, harassment, and identity.[23]
- Culture, language, and acculturation level influenced strategies for recruitment and retention. Program staff from nine sites participating in the Hispanic Healthy Marriage Initiative (HHMI) used recruiting tactics such as going door-to-door, having graduates of the program and trusted leaders conduct recruitment, distributing marketing materials adapted for language and literacy, and basing programs in organizations with a long history in the community.[24] To increase retention, grantees incorporated Latinx values into programs. Cultural adaptations included involving the whole family, making personal connections, creating a respectful and safe space, and emphasizing the important socio-emotional contributions that fathers make to children's development. It was also important to address stressors that impacted the family such as immigration and racism/discrimination.[25]
- Recruitment and retention strategies for youth served in the 2011 and 2015 cohorts varied based on whether programs were conducted in schools or in community-based settings. Findings from the Youth Education and Relationship Services (YEARS) study showed that some school-based programs did not have to recruit because HMRE programming was offered during a required class; meanwhile, other grantees used flyers, community partners, referrals, and social media to recruit participants. Engagement strategies were fairly similar across school and community-based settings. Both used social media, encouraged a sense of belonging and ownership in the program, and emphasized welcoming and connecting with youth. Programs offered in non-school settings offered additional supports such as transportation and child care.[20]

Programmatic elements

- DV screening was a critical element of intake and programs found it necessary to monitor for signs of DV during program delivery.[16] Data from HMRE evaluations indicate that the prevalence of DV is high in couples who participate in HMRE programs.[26] Grantees utilized various approaches to addressing DV, including assessments, safe opportunities for disclosure, strict confidentiality policies, universal education, safety assessment and plans, private consultations, and referrals to community partners.[27] Findings from the Responding to Intimate Violence in Relationship Programs (RIViR) study indicated that shorter screening tools could be more accurate for teen dating violence disclosure than longer tools, and that questionnaire-style tools were more likely to elicit DV disclosure than universal education about teen dating violence; the latter is provided to all youth rather than asked directly through a formal assessment.[28,29]
- The SHM and BSF evaluations showed that many participants struggled economically and faced a host of challenges associated with poverty.[9,10] To meet the complex needs of families with low incomes, some programs participating in the BSF evaluation relied on case management that linked participants to educational and employment services, housing, mental health and substance abuse treatment, child care, and parenting education.[9] Over time, OFA has provided both guidance and flexibility on how grantees can use case management to enhance programming.
- Grantees used various approaches to promote economic stability and mobility services, including referrals. For instance, about one in five participants involved in the SHM evaluation received referrals for employment, education, or training services.[17] The two HMRE grantees followed in the PACT study delivered economic support services through individual meetings with a case manager or employment specialist, along with standalone workshops. The PACT evaluation indicated that although participation in HMRE workshops was high (95% and 78%), the standalone job and career workshops were much less popular (13% and 33%, respectively), even among participants with low incomes.[30,31] The STREAMS project is testing ways to increase uptake of economic services using integrated relationship enhancement, job readiness, and financial literacy training.[32]

- HMRE programs for youth differ somewhat from those for adults in order to accommodate developmental differences and age-specific content. Youth-focused programs use a range of technology-based approaches, including for recruitment, and apply active learning by which youth engage directly in the learning process rather than receiving information passively. In the YEARS study, Scott and colleagues[20] found that, in addition to relationship education, programs serving youth addressed teen pregnancy and parenting, dating violence, sexual risk avoidance, and general life skills. Some programs in the YEARS study also used technology to better engage youth by using cell phones during activities and viewing videos on YouTube.

Training and technical assistance

- TTA activities were informed and strengthened by the use of data systems developed during cohort 3. In response to a desire from ACF to better support program monitoring and improvement, the nFORM system was developed to monitor grantees' progress and performance.[33] However, data from nFORM were also important for informing TTA and training needs for individual grantees, as well as the larger cohort. OFA also commissioned the development of a system to track and house TTA requests and resources. Data from this system—referred to as the First-Line Access System for Training, Technical Assistance, Resources, and Communication, or FastTRAC—were used to identify implementation challenges such as partner oversight, staffing models, program designs, staff accountability, and recruitment and attendance monitoring and improvement.
- Understanding the diverse contexts and cultures of HMRE grant programs is critical to building trusted relationships necessary for TTA uptake. For instance, tribal grantees have unique circumstances related to sovereignty and self-determination that may necessitate special consultation processes, protection of human subjects procedures, and data confidentiality and ownership agreements. Additionally, many pre-existing evidence-based programs do not resonate with Native populations and thus require adaptations to incorporate culture, traditions, and worldviews.[34]

Conclusion

Findings from the implementation of HMRE programs from 2006 to 2020 reveal several important considerations about future service delivery:

- HMRE programs can be implemented in various settings such as schools and community-based organizations. Services can also be delivered through diverse organizational structures and there is no single prescribed approach. For example, HMRE services can be embedded within existing infrastructures or added to a coordinated network of services. HMRE providers could consider using local resource mapping and needs assessment methods to inform program delivery decisions.
- HMRE skills-building curricula can serve diverse populations. Across the three cohorts discussed in this brief, grantees served adult individuals, couples, and youth; racial and ethnic minorities; economically distressed families; co-parenting but nonresidential couples; and culturally and linguistically diverse populations. Further, OFA's priorities have changed over time in terms of priority populations, as summarized in a recently released fact sheet that describes OFA's funding priorities across the three cohorts.[35] Although there is a universal need for general relational skills, services will likely benefit from customized tailoring to context and culture to best serve participants with diverse characteristics and relationship experiences.
- Programs require intentional and multi-pronged approaches to recruitment. This could include engaging participants through targeted messaging, designating staff specifically for recruiting, developing organizational networks, working in congregant settings, using data-based tracking, increasing awareness through social media, and addressing potential barriers up front.
- Additional programmatic elements beyond general skill building were needed to meet participant needs. Programs engaged partners or referral networks to address needs that may interfere with healthy couple and family functioning, such as intimate partner violence or child abuse, under- or unemployment, housing instability, lack of child care, or substance abuse and mental health concerns.

- Youth are an important priority population for HMRE efforts. However, programs for youth must account for developmental differences that affect skill sets, unique stressors, curriculum content, and delivery mechanisms specific to adolescents and young adults.
- Delivering HMRE services is complex and grantees need support. TTA systems that tracked performance measures and organized trainings around obstacles identified by the data were an important component of the overall HMRE initiative.

OFA is continuing its commitment to supporting youth and adult individuals, couples, and families through a new cohort of HMRE grants awarded in September 2020. This five-year cohort will build on what we have learned about strengthening relationships, couples, and families. For a more detailed examination of the first three cohorts of HMRE grantees, see the brief, An Introduction to Program Design and Implementation Characteristics of Federally Funded Healthy Marriage and Relationship Education Grantees.

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Acknowledgments

The authors would like to thank the Steering Committee of the Marriage Strenghtening Research and Dissemination Center (MAST Center) and Heather Zaveri for their feedback on earlier drafts of this brief. The authors would also like to thank staff from the Office of Planning, Research, and Evaluation (OPRE) and Office of Family Assistance (OFA) who provided input on various drafts.

Editor: Brent Franklin

Designer: Catherine Nichols

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About the MAST Center

The Marriage Strengthening Research and Dissemination Center (MAST Center) conducts research on marriage and romantic relationships in the U.S. and healthy marriage and relationship education (HMRE) programs designed to strengthen these relationships. The MAST Center is made up of a team of national experts in marriage and relationship research and practice, led by Child Trends in partnership with Public Strategies and the National Center for Family and Marriage Research at Bowling Green State University.

The MAST Center is supported by grant #90PR0012 from the Office of Planning, Research, and Evaluation within the Administration for Children and Families in the U.S. Department of Health and Human Services. The MAST Center is solely responsible for the contents of this brief, which do not necessarily represent the official views of the Office of Planning, Research, and Evaluation, the Administration for Children and Families, or the U.S. Department of Health and Human Services.