SUPPORTING STATEMENT
FOR OMB CLEARANCE

PART B

DHHS/ACF
SUPPORTING HEALTHY MARRIAGE (SHM)
PROJECT EVALUATION

LOW-INCOME MARRIED COUPLES DATA COLLECTION ACTIVITIES –
12-MONTH FOLLOW-UP DATA COLLECTION

November 26, 2007

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B. COLLECTION OF INFORMATION USING STATISTICAL METHODS

B1. Sampling for 12-month survey sample

The 12-month survey sample will be fielded with approximately 800 respondents in each site, divided equally between the program and control groups. Our goal is to achieve an 80 percent response rate, resulting in completed surveys for approximately 640 men and 640 women in each site. Because the low-income married population is so heterogeneous, the universe of respondents for the survey will include individuals who differ by age, race, income, level of marital distress, and a host of other factors.

The evaluation literature often discusses the appropriateness of the sample size for a study by focusing on the smallest program impacts that are likely to be detected with a specified level of confidence, assuming a sample of a given size and characteristics. These are usually called the program's "minimum detectable effects" (MDEs). Analysis of MDEs is also referred to as "power analysis," as it estimates the study's power to measure the effects it was designed to find.

Exhibit B1.1 shows the minimum detectable effects (MDEs) that can be achieved with different sample sizes using the survey data. Because the literature on marriage education often expresses results in effect sizes (that is, in terms of the number of standard deviations of the outcome), the first column shows minimum detectable effect sizes. The remaining columns show the expected MDEs for several key outcomes — marital satisfaction, divorce rates, child well-being, and parental earnings — expressed as percentages of likely control group levels, based on recent experiments with low-income families.

Exhibit B1.1

Minimum Detectable Effects for Key Survey Outcomes in the 12-Month Follow-Up

Illustrative outcomes as percent of control group mean

Size of Program and Control Group	Effect size	Relationship Satisfaction	Divorced or Separated	Child behavior problem index
160/160	0.28	22	53	123
320/320	0.2	16	38	87
640/640	0.14	11	27	62
960/960	0.11	9	22	50
2560/2560	0.17	6	13	31

NOTE: MDEcs are for two-tailed tests at .10 significance with 80 percent power. Relationship satisfaction based on results presented in Widenfeldt et al. (1996); child behavior problem index and annual earnings based on results from the analysis of the MTO demonstration (Orr et al., forthcoming); outcomes on divorce or separation from the three year evaluation of MFIP (Miller et al., 2000).

As stated above, we expect each site to randomly assign 400 couples to a program group and 400 couples to a control group. We expect 80 percent of the sample (320 control and 320 program group couples in each site) to complete surveys at the 12-month follow-up. The exhibit therefore

shows MDEs for several sample sizes: (1) 160 in each research group, which could represent a subgroup of half of the sample in a site, (2) 320 in each research group, representing a single site, (3) 640 in each research group, representing results for the two curricula that will be used in two sites, (4) 960 in each research group, representing results for the curriculum that will be used in three sites, and (5) 2,560 in each research group, representing results for all sites pooled.

As the exhibit indicates, the MDE in each site is 0.20 standard deviations. This means that if the true effect of an intervention is 0.20 standard deviations, then the difference in survey-based outcomes between program and control groups would be statistically significant in 80 percent of experimental tests of that intervention. Compared with many marital interventions studied using random assignment with middle-class white couples, a short-term impact of 0.20 standard deviations is not especially large. Meta-analyses of marriage education and marital and family therapy have found average effect sizes at post-program assessment of 0.50 standard deviations or more.

If sites are pooled, the study has a much better chance of finding statistically significant impacts on survey-based outcomes. For the two curricula being testing in two sites, for example, the MDE is about 30 percent lower when the two sites are combined than when they are looked at separately. For the curriculum being tested in three sites, the MDE is more than 40 percent smaller when the three sites are pooled. Finally, since it might be difficult to find statistically significant impacts in any individual site, we plan to estimate results pooling all eight sites. This will reduce the MDE by nearly two thirds.

Exhibit B1.2 shows the minimum detectable effects (MDEs) that can be achieved with different sample sizes using the observational data at the 12-month follow-up. The first column of the table shows minimum detectable effect sizes. The remaining columns show the expected MDEs for several key outcomes using observational data of couple and family interactions – positive and negative couple communication, as well as supportive parenting outcomes – expressed as percentages of likely control group levels, based on recent experiments with married couples with children (Halford, et al., 2004; Cowan & Cowan, 2000).

Exhibit B1.2

Minimum Detectable Effects for Key Outcomes of Observational Study

Illustrative outcomes as percent of control group mean

Size of Program and Control Group	Effect Size	Positive Communication	Negative Communication	Parenting
110/110	0.34	16	27	8
220/220	0.24	11	19	6
330/330	0.19	9	16	5
880/880	0.12	6	10	3

NOTE: MDEs are for two-tailed tests at .10 significance with 80 percent power. Communication based on results presented in Halford et al., 2004. Parenting based on results from Love et al., 2004 that measure supportiveness.

As stated above, we expect that 306 couples in each site will be asked to participate in the observational study. We expect that 72 percent of the sample (110 control and 110 program group couples in each site) will complete the videotaped observations of couple, parent-child, and/or co-parenting interactions. The exhibit therefore shows MDEs for several sample sizes: (1) 110 in each research group, which could represent the sample in a site, (2) 220 in each research group, representing results for the two curricula that will be used in two sites, (4) 330 in each research group, representing results for the curriculum that will be used in three sites, and (5) 880 in each research group, representing results for all sites pooled.

As the exhibit indicates, the MDE in each site is 0.34 standard deviations. This means that if the true effect of an intervention is 0.34 standard deviations, then the difference in observational study outcomes between program and control groups would be statistically significant in 80 percent of experimental tests of that intervention. Compared with many marital interventions with mostly white middle-class couples, a short-term impact on observed couple interactions of 0.34 standard deviations is about average. Meta-analyses of marriage education and marital and family therapy have found average effect sizes at post-program assessment of 0.34 standard deviations using observational data.

Because our power to detect statistically significant effects of the intervention using observational data is somewhat limited, we plan to estimate results for observational outcomes by pooling across multiple sites. If sites are pooled, the study has a much better chance of finding statistically significant impacts. For the two curricula being testing in two sites, for example, the MDE is about 29 percent lower when the two sites are combined than when they are looked at separately. For the curriculum being tested in three sites, the MDE is more than 44 percent smaller when the three sites are pooled. Furthermore, since it might be difficult to find statistically significant impacts in any individual site, we plan to estimate results pooling all eight sites. This will reduce the MDE by nearly 65 percent. Lastly, any subgroup analyses using the observational data will require pooling across all eight sites so that the resulting subgroup sample sizes will be sufficient to detect statistically significant intervention effects.

B2. Procedures for Collection of Information

The following approaches will be used to collect the follow-up data:

- About 6 month following their random assignment, couples enrolled in the SHM study will be contacted by Abt Associates with a letter asking them to update their contact information. (See Appendix E.)

- About 12 months following their random assignment, couples enrolled in the SHM study will be contacted by Abt Associates with a letter reminding them of their participation in the SHM study and informing them that they will soon receive a phone call from an Abt representative who will want to interview them over the phone about their marriage and children. (See Appendix F.)

- Abt Associates interviewers will call the specified contact numbers for SHM study participants and administer the 50-minute follow-up survey to all willing participants.

- For the observational study, Abt will contact a subset of SHM study participants to ask them if they would be willing to participate in some in-home observations with an Abt representative. Abt representatives will then enter the homes of willing participants and videotape 41 minutes of interactions for intact couples—21 minutes of couple interactions and 20 minutes of co-parenting and parenting interactions (for intact couples at follow-up)—and 10 minutes of parent-child interactions (for couples who are separated at follow-up).

All completed interviews will be reviewed to ensure that all applicable questions are correctly completed and that all relevant interviewer notes are included in the data set. Any open ended and "other, please specify" items will be coded based on codes approved by MDRC. A preliminary data file will be created in the first few months of data collection and provided, with documentation, to MDRC.

B2.1 Procedures for the 12-Month Data Collection

Interviewer training. We propose having the same field interviewers who administer the 12-month survey conduct the videotaped observations in study participants' homes. MDRC will work with Abt Associates and other members of the research team to ensure sufficient interviewer training. In the past, this has typically involved two training sessions, each of which lasts about three to four days. Personnel who are new to interviewing will be trained in general interviewing techniques and approaches in the first day of the session. Interviewers will then be trained on the administration of the videotaped observations for the remaining three days of the training session. They will receive extensive training in how to administer these assessments. This training will consist of pre-training exercises and mock set ups of the videotaping equipment and protocol for the activity and discussion-based interactions. In the next 3-day training session, interviewers will be trained on the administration of the survey and will receive a refresher on the administration of the videotaped observations. Some pre-training exercises are likely to be required, and the actual training will include an item-by-item or task-by-task review of the survey instrument, practice interviews and administrations, and critiques of those interviews. Finally, each interviewer will undergo a certification process prior to fielding to ensure that the interviewer is qualified to set up the videotaped observations. The SHM research team will also work with Abt Associates to monitor early interviews and conduct periodic reviews of the observations over the course of fielding the data collection instruments to ensure that interviewers are following procedures and protocols with a high degree of fidelity.

In addition, the interviewer training will include extensive training on a protocol for handling adverse events while fielding the data collection instruments at the 12-month follow-up. We are currently developing a protocol for handling adverse events in the field with Abt Associates. This protocol will be submitted for review by IRBs at MDRC, Abt, and relevant sites prior to fielding any of the data collection activities.

Training will take place close to the time when the first cohorts of research subjects reach the 12-month anniversary of their random assignment date.

All interviewers will sign a confidentiality pledge during training. They will be instructed on the importance of maintaining confidentiality and told that breaches of confidentiality will lead to dismissal.

MDRC will also work with Abt Associates to monitor early interviews for each interviewer and periodically monitor interviews and administrations over the course of fielding the data collection instruments (e.g., listening in on telephone interviews, reviewing videotapes of administrations of direct child assessments). Feedback will be provided to the interviewers based on these monitoring efforts.

All interviewers will also undergo a certification process before administering any videotaped observations in the field to ensure that interviewers are qualified to collect this information and that a high quality of data is collected.

B3. Maximizing Response Rates

The goal will be to administer the 12-month survey to all sample members in each site, and the observational study will be targeted to 306 randomly selected couples in each site. Procedures for obtaining the maximum degree of cooperation include:

- Conveying the purposes of the study and follow-up survey to respondents so they will thoroughly understand the purposes of the data collection and perceive that cooperating is worthwhile;
- Providing a toll-free number for respondents to use to ask questions about the survey;
- Training site staff to be encouraging and supportive, and to provide assistance to respondents as needed;
- Training interviewers to maintain any pre-existing one-on-one personal rapport with respondent; and
- Offering appropriate payments to respondents.

In addition to the above procedures, the discretion that the CAPI follow-up affords respondents during the administration of sensitive questions (e.g., relationship quality, drug use) has been found to increase response rates by decreasing the number of refusals and break offs (Turner, et al., 1998). Moreover, these methods have also been shown to positively affect response rates by enabling people with limited literacy skills (particularly important given that the low-income married population is disproportionately Latino) to respond to sensitive questions while maintaining their privacy (Belcher, et al., 2001).

B4. Pre-testing

Most of the questions proposed for this instrument are either identical to questions used in prior MDRC evaluations or are similar, if not identical, to questions used in previous national surveys or major evaluations. Consequently, many of the items have been thoroughly tested on larger

samples.

The proposed SHM 12-month survey has undergone a number of revisions, following critiques by internal staff, by project consultants, and by staff at HHS/ACF. Revisions were also made on the basis of cognitive testing that assessed the comprehensibility of the draft survey instruments on small samples of low-income married couples in Washington, DC, Oklahoma, and Texas. Dr. Lina Guzman and colleagues at Child Trends analyzed the results from the cognitive interviews and recommended appropriate revisions to all of the instruments that will be used to collect follow-up.

The 12-month survey instrument and observational study protocol have yet to be formally pretested by Abt Associates.[1] The pretests will provide information about the length of the various instrument components. The pretests will also be undertaken with the goal of improving the quality of the data the instruments would yield, and thus great care was taken in gleaning information about question wording. Following each pretest, respondents will be debriefed and asked about question clarity and about any problems or confusions that arose. Research personnel assisting 12-month survey and observational study protocol administration will also be debriefed about problems they encountered and about their recommendations for improving the instruments. Based on Abt Associates' pretest results, we expect to make minor revisions to the instruments. These revisions will be limited to cutting items from the survey to fit within the targeted (and budgeted) times for the instrument administration, streamlining skip patterns within the survey to simplify administration, and improving/clarifying (and often simplifying) the wording of questions.[2]

B5. Consultants on Statistical Aspects of the Design

There are no consultants on the statistical aspects of the design. We have drawn on the considerable expertise of the SHM team members including Charles Michalopoulos and Howard Bloom of MDRC and Larry Orr and David Fein of Abt Associates.

[1] Drafts of the 12-month data collection instruments will be tested prior to fielding the actual instruments. The survey will be pre-tested with up to nine parents and the protocol for the observational study will be tested with up to nine parents and nine children. The pre-test sample will be similar in demographic characteristics to the study sample. None of the pre-test respondents will be part of the actual study sample. The design of the pre-test is intended to reflect the realistic conditions that of the actual full-scale fielding of the data collection instruments. By doing so, the research team aims to mimic those conditions that are likely to pose difficulties during fielding. As such, the survey will be administered to pre-test respondents in person and/or over the phone. Videotaped observations will be conducted in person.

[2] While using a larger number of items increases the reliability of the information gathered, we felt that, in some cases, fewer measures would also provide adequate reliability for measuring the constructs of interest, and we did not expect those cuts to have a substantial impact on the quality and the reliability of the data being collected.

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