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Evaluation of perinatal pilots for delivery of relationship advice

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A report of research carried out by IFF Research Ltd and The Tavistock Institute on behalf of the Department for Work and Pensions

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Summary

Previous research suggests that it is normal for relationship quality to decline over time, with particular severe decline at stress points such as becoming a parent[1].

The Department for Work and Pensions (DWP) commissioned IFF Research Ltd and The Tavistock Institute to evaluate the feasibility and effectiveness of the Perinatal Pilots, which consisted of providing relationship education to new parents in NHS antenatal classes and home visits.

The research investigates the extent to which the Pilots met the following objectives:

- Raising parents' awareness of the impact a baby can have on their relationship;
- Raising parents' awareness of the impact their relationship with one another has on their baby;
- Preparing parents for the changes and challenges to their relationship: physical, emotional, sexual, financial and practical; and
- Helping parents develop skills of communication and managing conflict.

The evaluation looks to establish the 'impact' of taking part in the Pilots on parents. It does this primarily through comparing the views and attitudes of parents expressed in the surveys before and after receiving support. There are some limitations in this methodology which means results for the impact of the Pilots should be treated with some caution. The evaluation consisted of quantitative and qualitative methods involving interviews with practitioners and parents, site visits and surveys with participants.

Key findings

- The parents that participated in the Pilot avoided the decline in relationships that would normally be expected in the period immediately after the birth of a baby and showed a small positive improvement in communication.
- Findings from the surveys suggest that the Pilots did influence participants' willingness to seek relationship support, with respondents significantly more inclined to seek support at the follow-up survey than at the initial survey.
- In the follow-up survey, the majority of parents reported that the session had raised their awareness of each of the four objectives of the relationship education materials at least a little.
- Over half of participants stated that they changed their behaviour as a result of something they learned from the session.

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1 Twenge *et al.* (2003).

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List of abbreviations

DAS	Dyadic Adjustment Scale
DWP	Department for Work and Pensions
FAQs	Frequently Asked Questions
NHS	National Health Service

Glossary of terms

Aims	This term is used to refer to the intent of the evaluation, i.e. to: **1.** measure the extent to which the pilots met the objectives in terms of impact on new parents' relationships and attitudes towards seeking relationship support; and **2.** collect relevant learnings and points of best practice for wider access to relationship advice through perinatal services.
Delivery leads	Individuals such as head midwives at each Trust who acted as the main source of contact throughout the pilot and the evaluation.
Education training programme	All of the relationship education content that practitioners were trained to deliver; this includes all the OnePlusOne content they were given to choose from and then deliver to participants.
Existing antenatal session	Antenatal education already included in either antenatal classes or home visits.
Follow-up survey	Telephone survey conducted with parents when their baby was four months old, and around six months since attending the relationship education session. This included the same key relationship measures, as well as recall of the session.
Initial survey	Short paper questionnaire completed during the session in which they received the OnePlusOne relationship education which included some key relationship measures and demographic questions.
Objectives	This term is used to refer to the targets for the new relationship education that the material developed by OnePlusOne was structured around: • Objective 1: 'Me, you and baby too' Designed to raise parents' awareness of the impact a baby can have on their relationship. • Objective 2: 'Why does it matter?' Designed to raise parents' awareness of the impact their relationship with one another has on their baby. • Objective 3: 'Changes and challenges' Designed to prepare parents for the changes and challenges to their relationship: physical, emotional, sexual, financial and practical.

	• Objective 4: 'Communicating and managing conflict' Designed to help parents develop skills of communication and managing conflict.
OnePlusOne	OnePlusOne are specialists in the area of relationship support and developed the materials that Trusts used in the relationship education sessions. They also delivered training on how to use these materials to practitioners.
OnePlusOne pack	Resources provided by OnePlusOne to practitioners in order to aid their delivery. This was a booklet containing information on objectives to cover, and activities and materials to be used.
Practitioners	Nurses and midwives that delivered the relationship education sessions to parents.
Practitioner training programme	The training that practitioners received ahead of delivering the relationship education session, which was comprised of an e-learning exercise and a one-day skills workshop.
Relationship education session	The antenatal class or home visit where the selected OnePlusOne relationship education content was delivered.
Wider support materials	Resources and free materials given to parents at the relationship education session, as well as use of materials and websites they may have been signposted to during the relationship education session.

Executive summary

Introduction

Background

Previous research suggests that the normal pattern for relationships is for relationship quality to decline over time.[2] Indeed, a pattern observed in many longitudinal studies of married relationships is for relationship quality to start off well and then show a decline over time.[3] However, such declines are most severe at particular stress or transition points. This includes becoming a parent, which, on average, has been shown to have a negative effect on relationship quality for both mothers and fathers.[4] Some interventions to support relationships have been targeted at those about to, or who have just, become parents, as this stage is seen as a 'window of opportunity' to reach parents, and particularly those at higher risk of experiencing relationship problems and instability.[5] It may be a time when parents are generally receptive and eager to learn more about their new role as parents, and are already in contact with perinatal services, making it easier to identify and engage people at this stage.

Against this backdrop, the perinatal pilots – a Department for Work and Pensions (DWP) initiative – sought to test the feasibility and effectiveness of introducing relationship education into antenatal provision to:

- prepare couples for the impact having a baby will have on their relationship;
- help couples develop particular relationship and communication skills, e.g. in recognising and managing conflict; and
- signpost couples to further support, where relevant.

The intention was to use the pilots to inform wider access to relationship advice through perinatal services.

The pilots involved the delivery of relationship education to new parents using materials that were developed by OnePlusOne[6] around four objectives:

1. Raising parents' awareness of the impact a baby can have on their relationship.

2. Raising parents' awareness of the impact their relationship with one another has on their baby.

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2 Twenge *et al.* (2003).

3 For example, Glenn. (1998); Kurdek. (1999); Halford *et al.* (2007).

4 Belsky and Pensky. (1988); Shapiro *et al.* (2000); Twenge *et al.* (2003); Schulz *et al.* (2006); Mitnick *et al.* (2009); Kluwer. (2010).

5 Petch *et al.* 2012

6 OnePlusOne are specialists in the area of relationship support and provided Trusts with the session materials used in the pilots.

3. Preparing parents for the changes and challenges to their relationship: physical, emotional, sexual, financial and practical.
4. Helping parents develop skills of communication and managing conflict.

The evaluation

Aims

IFF Research and Tavistock Institute were commissioned by DWP to evaluate the feasibility and effectiveness of the pilots.

There were two key evaluation aims:

1. To measure the extent to which the pilots met the objectives in terms of impact on new parents' relationships and attitudes towards seeking relationship support.
2. To collect relevant learnings and points of best practice for wider access to relationship advice through perinatal services.

The evaluation consisted of a mixture of qualitative and quantitative methods with two discrete phases, an initial 'exploratory phase' and a 'survey fieldwork phase':

- **Exploratory phase – scoping interviews:** Eight qualitative telephone interviews were conducted with delivery leads in the early stages of pilot delivery.[7] These interviews collected background information about the areas under the remit of each NHS Trust and the Trust's initial plans for delivery. Interviews were also conducted with OnePlusOne representatives.
- **Exploratory phase – site visits:** Four site visits conducted involved session observations, in-depth qualitative interviews with practitioners (nurses and midwives responsible for delivering the relationship support) and short exit interviews with parents. They were used to explore best practice for delivery and also to pilot approaches to the dissemination of the quantitative self-completion survey.
- **Survey fieldwork phase – initial quantitative self-completion survey:** This involved a paper survey, filled out by parents at the start of the relationship education session. The questions focused on relationship quality and likelihood to seek relationship support. A total of 335 parents completed this initial survey.
- **Survey fieldwork phase – follow-up quantitative telephone survey:** Follow-up quantitative telephone interviews were conducted with initial survey participants. These interviews again collected data on relationship quality and likelihood to seek relationship support. They also covered parents' recall of the session and how effective and useful they found it. A total of 124 parents completed this phase of the evaluation.
- **Survey fieldwork phase – Qualitative follow-up survey:** forty in-depth discussions were conducted with quantitative follow-up survey participants to explore their views on the sessions and their impact.

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[7] Delivery leads – such as head midwives – were individuals at each National Heath Service (NHS) Trust who acted as the main source of contact throughout the pilot and the evaluation.

The evaluation looks to establish the 'impact' of taking part in the pilots on parents. It does this primarily through comparing the views and attitudes of parents expressed in the surveys before and after receiving support. There are some limitations in this methodology but alternative approaches (such as a randomised control trial or other similar approaches involving a control group of parents who did not take part) were ruled out because of practical and analytical constraints (e.g. the variation in how the intervention was expected to be implemented across areas, and also the resources involved in ensuring accurate randomisation limited the evaluation options available).

This means results for the impact of the pilots should be treated with some caution, although the use of standardised scales used in other evaluations and comparison with these other studies helps to give more confidence in the results than would otherwise have been possible.

Part one – What are the key learnings for pilot design?

Was the practitioner training optimally designed?

The practitioner training – which consisted of an e-learning platform followed by a one-day skills workshop – was designed to assist practitioners with delivering the material effectively.

The exploratory phase of the evaluation revealed that there was limited uptake of the e-learning platform. This was due to a lack of practitioner time and clarity about how the materials were to be used, along with limited IT resources. These issues, coupled with the large volume of information held on the platform, overwhelmed some practitioners and put them off from engaging with the resource fully.

Reaction to the skills workshop was more positive and was often described by practitioners as interactive, enjoyable and informative.

How confident did NHS staff feel when delivering the education sessions?

In qualitative interviews, health visitors tended to report having more experience in delivering relationship advice and facilitating discussions than midwives, who were more used to delivering sessions with a medical and instructional focus. Consequently, health visitors tended to report that they came away from the sessions with more confidence.

It was also noted that the option to signpost parents to online materials was reassuring to those less confident with the materials and for subjects neither practitioners nor parents were comfortable with (notably conversations around sex).

How could the practitioner training programme be improved?

Key suggested improvements to the practitioner training were:

- Signposting practitioners to the e-learning materials after the skills workshop (rather than before) so that practitioners are more familiar with the content first and might find the large resource easier to navigate. A key area in which midwives were keen for more information was on how to handle parents' questions; this is covered in the e-learning materials, so clearer and more effective signposting to this following the skills workshop would be useful.
- Delivering separate health visitor and midwife training, as there were varied levels of experience and therefore confidence.
- Aligning the order of the workshop with the OnePlusOne pack[8] to make it easier to digest and retain.

What delivery models did different NHS Trusts adopt?

DWP provided guidance on the minimum content that should be delivered though, due to the different approaches to antenatal service provision across the different areas, it was not possible to issue prescriptive guidance on how the sessions should be run. Hence, a variety of delivery models and approaches emerged. However, from the early scoping interviews with delivery leads and site visits, it was clear that there were a few consistencies:

- No areas introduced the relationship education to parents in a standalone session, but instead integrated it into existing provision. Initially, one area planned to add the relationship education as a standalone session, but had a lack of interest from parents and so integrated it into existing provision.
- Areas chose to disseminate the relationship education to parents through either home visits or antenatal classes via midwives or health visitors, consistent with their current approach to antenatal provision.
- Relationship education sessions delivered through antenatal classes generally lasted an hour, whereas home visits tended to be shorter, as the relationship education content was only drawn upon if conversations naturally emerged (though all practitioners received guidance from DWP on the minimum content that should be delivered).
- Pre-existing antenatal education content was not typically displaced in the home visits; as relationship education was previously part of this kind of provision anyway, the new content simply added tools and structure. Conversely, in antenatal classes, certain aspects of pre-existing content were either covered in less depth or were displaced completely.
- Areas typically targeted parents that were around 30 weeks pregnant[9] for the relationship education sessions. However, in two areas the support was first introduced at the 16-week home visit and then later in the pregnancy, closer to birth.

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8 Resources provided by OnePlusOne to practitioners in order to aid their delivery. This was a booklet containing information on objectives to cover and activities and materials to be used.

9 Parents that took part in the initial self-completion survey stated how many weeks pregnant they, or their partner, were and this varied from 23 weeks to 39 weeks pregnant when they received the relationship education, with the majority (79 per cent) between 30 and 36 weeks pregnant.

Did fathers and hard-to-reach groups participate in the programme?

Delivery leads indicated in the scoping stage that the approach to recruitment was 'business as usual'. Consequently, the profile of parents who received the information generally reflected the profile of those who attended existing antenatal sessions; and harder to reach groups[10] were not always represented.

During the site visits, practitioners suggested that a combination of home visits and classes was most likely to reach the best cross-section of parents:

- Because of their 'opt in' nature, antenatal classes were less likely to reach disadvantaged groups than home visits; however
- Fathers were more likely to attend classes than home visits, which often took place during the working day. The initial survey data also showed this pattern with a roughly even split in terms of gender at classes compared to home visits (46 per cent male and 54 per cent female at classes versus 14 per cent male and 86 per cent female at home visits).

Was the education training optimally designed?

At the outset of the pilot, there was concern among delivery leads and practitioners that a lack of parent interest or a high dropout rate would be a key barrier to timely and effective delivery of the relationship education session, and that this might impact on attendance levels to antenatal sessions more generally. However, these concerns were not realised, with attendance levels being unaffected, and instead the key barriers to delivery mentioned by delivery leads in the scoping interviews and practitioners at the site visits were a lack of time allocated to fulfil this role of delivering the new content, high levels of staff turnover and the prevalence of competing priorities.

These issues, raised throughout the scoping stage interviews with delivery leads and site visits, point to several best practice suggestions for implementation of relationship education sessions:

- Readily-cascaded training: To allow for a more efficient handover in the event of staff turnover.
- Direct communication from OnePlusOne to practitioners rather than through delivery leads: This would have freed up delivery lead time and ensured a quick and efficient line of communication for practitioners.
- Ongoing engagement with delivery leads is critical: If areas had been asked to report monthly attendance figures to DWP then this might have been beneficial to sustaining momentum.

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[10] Harder-to-reach groups were defined as those such as: teenage or younger parents; minority ethnic groups; refugees and asylum seekers; those who do not speak English as their first language; those experiencing domestic violence, mental health problems and severe disabilities; as well as those living in poverty and from the travelling community. In the site visit practitioner interviews, practitioners were asked about the proportion of these groups that attended their existing antenatal sessions, which showed these were not always represented.

- Demonstrating the effectiveness of the material: If practitioners had been given data on the impact that the provision of relationship support has been shown to have then this might have helped to keep its profile high among competing priorities.

Part two – To what extent have the pilots met the objectives?

Did the pilots impact on parents' relationship quality, post-birth?

To track change over time, parents responding to the quantitative initial and follow-up surveys were asked two sets of statements on identical scales[11] around relationship quality and communication:

1. **The DAS-7 – Relationship quality:** Parents were asked the extent to which they agree with their partner on the first three issues below, then how often the second three activities occur. They were then asked to rate the overall happiness of their relationship.
    1. Philosophy of life (their overall approach to life).
    2. Aims, goals and things they believe to be important.
    3. The amount of time spent together.
    4. Calmly discuss things together.
    5. Work together on a project when planning something.
    6. Have a stimulating exchange of ideas.
2. **ENRICH Marital Satisfaction Scale – Communication:** Parents were asked to indicate the extent to which they agree with the following statements:
    1. When we have a disagreement, we openly share our feelings and decide how to resolve our differences.
    2. I am very satisfied with how my partner and I talk with each other.
    3. When we are having a problem, my partner often gives me the silent treatment.
    4. I do not always share negative feelings I have about my partner because I am afraid he/she will get angry.
    5. I am aware of how my relationship with my partner might change after having a new baby.

[11] The question wording was amended very slightly to accommodate the mode of completion, with the initial survey being conducted via a paper questionnaire and the follow-up survey over the telephone.

A comparison of the responses to these questions at initial survey with responses at the follow-up survey showed that there was no significant change across the mean scores derived from the DAS-7 questions and a significant increase in the mean score derived from the ENRICH questions, from 11.70 before the intervention to 12.83 after the intervention. For context, if all respondents had given the lowest possible response for each statement on the ENRICH subscale, the mean score would have been 4, and if they had all given the highest possible response then the mean score would have been 20. This difference in mean scores equates to an effect size of 0.37[12], which can be considered a relatively small improvement.

Previous studies have suggested that becoming a parent is normally associated with a decline in relationship quality[13]. Consequently, it is positive that the findings indicate that involvement within the pilots has led to no change in relationship quality (as measured by the DAS-7) and a small improvement in communication (as measured by the ENRICH communication subscale).

To what extent, if at all, did the sessions influence participants' willingness to seek relationship support?

Findings from the surveys suggest that the pilots did influence participants' willingness to seek relationship support, with respondents significantly ($p<0.001$) more inclined to report that they were likely to seek support at the follow-up survey than at the initial survey (mean scores 3.48 versus 4.31 respectively on a scale of one to seven). Added to this, the pilots appear to have impacted on parents' awareness around where to go to seek support at the follow-up survey, 63 per cent stated that they would know where to go for relationship support and of these, 45 per cent had not been aware before the session.

In qualitative interviews, parents explained that the session changed their attitude to seeking support, more than their awareness of where to go. For example, it highlighted the importance of doing so, removed the stigma, or helped them to realise that they would not be alone in doing so. Those who felt the session had not impacted on their likelihood to seek advice explained that they either already felt comfortable to do so beforehand, that they simply were not the type to seek support or that they would prefer to try and 'sort it out' themselves, either directly with their partner or through discussing with friends and family, or looking online.

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12 Effect sizes are used to judge how substantial a change is observed, in a way that can be compared across different outcome measures and interventions. The extent to which an effect size should be regarded as small or large usually depends on the context of the study and the intensity of the intervention. However, in general, effect sizes of around d=0.2 to d=0.3 are regarded as small, around d=0.5 as medium, and effect sizes from around d=0.7 to d=0.8 and upward as large.

13 Twenge *et al.* (2003).

To what extent, if at all, did couples feel more informed and prepared for the impact having a baby may have on their relationship?

In the follow-up survey, the majority of parents reported that the session had raised their awareness of each of the four objectives of the relationship education materials[14] at least a little (between 73 per cent to 89 per cent agreed that the session had increased their awareness a great deal or a little in each of the areas) and 28 per cent to 51 per cent felt it had done so a great deal.

Did participants recall relationship advice and skills taught during the programme?

From the follow-up survey[15] findings it was evident that levels of recall were mixed. About two thirds of respondents (64 per cent) said that they could remember the relationship advice and guidance covered in the session very well or quite well. Yet for 36 per cent, recall was poor (26 per cent said not very well and 11 per cent said not at all well).

Did level of recall vary across different aspects of the programme?

Parents who took part in the follow-up survey who indicated that they could remember the session very well or quite well were asked what specific conversations they had a good recollection of (on an unprompted basis). Objective four – around communicating and managing conflict – was recalled the most, and objective two – around awareness of the impact parents' relationship have on their baby – the least, as shown in the bullet points below:

- **Objective four:** 'Communicating and managing conflict'. Designed to help parents develop skills of communication and managing conflict (61 per cent of all who claimed to recall the session very well or quite well).
- **Objective three:** 'Changes and challenges'. Designed to prepare parents for the changes and challenges to their relationship: physical, emotional, sexual, financial and practical (51 per cent).
- **Objective one:** 'Me, you and baby too'. Designed to raise parents' awareness of the impact a baby can have on their relationship (37 per cent).
- **Objective two:** 'Why does it matter?'. Designed to raise parents' awareness of the impact their relationship with one another has on their baby (16 per cent).

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[14] As mentioned earlier, these were:
1. raising parents' awareness of the impact a baby can have on their relationship;
2. raising parents' awareness of the impact their relationship with one another has on their baby;
3. preparing parents for the changes and challenges to their relationship: physical, emotional, sexual, financial and practical; and
4. helping parents develop skills of communication and managing conflict.

[15] The follow-up survey took place around six months after attending the session.

In the qualitative interviews, parents typically remembered exercises or discussions with an interactive element, such as cartoons and hand-outs.

Did participants act upon the advice after the sessions?

The majority (83 per cent) of participants taking part in the quantitative survey reported that they had discussed the content covered in the relationship session with their partner, and over half (56 per cent) of participants stated that they changed their behaviour as a result of something they learned from the session.

Those who reported in the qualitative interviews that they had changed their behaviour gave examples such as making more time for each other, being more honest with each other when feeling stressed or down, and being more laid back where possible.

Did participants make use of wider support materials?

The results suggest that there was some uptake of the wider support materials, but that it was not commonplace. For example, of the follow-up survey respondents who reported that they had received free materials at the session (59 per cent), about a third (35 per cent) said they used them and a further 45 per cent explained that they only dipped into them briefly. That said, 69 per cent reported that they had at least kept them.

In terms of signposting to further materials, just over two-fifths (42 per cent) of follow-up survey participants said they were signposted to other sources of information/advice, though only about a third (32 per cent) used these.

Conclusions

The main conclusions that it is possible to draw from the results of this evaluation are:

- **Rolling relationship support into existing provision is effective for reaching parents.** Antenatal classes were a particularly good route for reaching fathers. The findings indicate that participation rates would have been much lower for stand-alone classes (i.e. not integrated into current antenatal provision) and that some participants initially found the concept of relationship support either intimidating or irrelevant to them at this point (despite going on to find the sessions useful). The fact that parents were particularly likely to attend antenatal classes as couples made them particularly well suited to this type of provision (although the reach of home visits is possibly more diverse as it encompasses harder-to-reach groups).
- **Cementing the provision might need more direct contact with practitioners.** Maintaining the longevity of an initiative delivered by health visitors and midwifes is hard. Staff turnover is high (in terms of individuals leaving the organisations but also in terms of movement between roles). The key lessons learnt in terms of making this type of provision work in future are that the training should be designed in such a way to make it possible for it to be cascaded on to others (without relying heavily on digital resources as access to IT equipment at work is limited) and that establishing direct links between practitioners themselves and the organisation delivering/supporting the training would be more effective than working through centralised contacts in each area.

- **The results from the pilot point to a small positive impact on the quality of relationships.** The parents that participated in the pilot avoided the decline in relationships that would normally be expected in the period immediately after the birth of a baby and showed a small positive improvement in communication. Furthermore, they were slightly more likely to consider seeking relationship advice if they encountered difficulties after the intervention than before.
- **This is encouraging given the light-touch nature of the intervention.** The amount of time dedicated to covering the material within antenatal sessions was quite small (around an hour in class settings and considerably less than this in home visits).
- **However, the nature of the evaluation means that these results should be interpreted with some caution.** The methodology used to establish impact has some limitations. The assessment of impact has been made by comparing views and experiences before and after the intervention. With this approach it is difficult to control for any change that might have taken place anyway. The use of standardised scales and making comparisons with other studies that have explored changes in relationship around the time of the birth of a child makes it possible to have more confidence in the interpretation of results than would otherwise be possible. However, these other studies were obviously conducted among different groups of parents who may have had different characteristics to the pilot participants.

1 Introduction

1.1 The pilots

1.1.1 Background

Previous research suggests that the normal pattern for relationships is for relationship quality to decline over time.[16] Indeed, a pattern observed in many longitudinal studies of married relationships is for relationship quality to start off well and then show a decline over time.[17] The precise trajectory of the decline has been debated, with some authors reporting a relatively steep decline in the first ten years[18], and others a more gradual, linear decline.[19] However, such declines are most severe at particular stress or transition points. This includes becoming a parent, which, on average, has been shown to have a negative effect on relationship quality for both mothers and fathers[20]. For example, Twenge *et al.* (2003) found that the overall average effect size comparing parents with childless couples was not large (d=0.19), but at the extreme it translated as a difference between 38 per cent of mothers of infants reporting high levels of satisfaction, compared with 62 per cent of childless women.[21]

Some interventions to support relationships have been targeted at those about to become, or who have just become parents, as this stage is seen as a 'window of opportunity' to reach parents, and particularly those at higher risk of experiencing relationship problems and instability.[22] It may be a time when parents are generally receptive and eager to learn more about their new role as parents, and are already in contact with perinatal services, making it easier to identify and engage people at this stage.

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16 Twenge *et al.* (2003).

17 For example, Glenn. (1998); Kurdek. (1999); Halford *et al.* (2007).

18 Kurdek. (1999).

19 Karney and Bradbury. (1995).

20 Belsky and Pensky. (1988); Shapiro *et al.* (2000); Twenge *et al.* (2003); Schulz *et al.* (2006); Mitnick *et al.* (2009); Kluwer. (2010).

21 Effect sizes are used to judge how substantial a change is observed, in a way that can be compared across different outcome measures and interventions. The extent to which an effect size should be regarded as small or large usually depends on the context of the study and the intensity of the intervention. However, in general, effect sizes of around d=0.2 to d=0.3 are regarded as small, around d=0.5 as medium, and effect sizes from around d=0.7 to d=0.8 and upward as large.

22 Petch *et al.* (2012).

Against this backdrop, the perinatal pilots – a Department for Work and Pensions (DWP) initiative – sought to test the feasibility and effectiveness of introducing relationship education into antenatal provision to[23]:

- prepare couples for the impact having a baby will have on their relationship;
- help couples develop particular relationship and communication skills, e.g. in recognising and managing conflict; and
- signpost couples to further support, where relevant.

The intention was to use the pilots to inform decisions about wider access to relationship advice through perinatal services.

1.1.2 Delivery

Pilot areas

The pilots took place in six NHS Trusts:

1. Croydon Health Services NHS Trust.
2. Derby Hospitals NHS Trust.
3. Suffolk County Council and Ipswich Hospital NHS Trust.
4. Leicestershire Partnership Trust[24].
5. South Tyneside Foundation Trust and Sunderland Royal Hospital.
6. St Helens and Knowsley NHS Trust.

Nottingham City Care were also due to participate but withdrew from the pilot in December 2015, ahead of incorporating the OnePlusOne content, due to staff turnover and a lack of time to train new practitioners.

DWP selected these Trusts with a view to covering a broad range of areas. Priority was given to areas that the DWP felt would benefit from the support the most, i.e. those with higher levels of separation and deprivation and a greater reliance on state-provided health care provision.

Pilot roles

Delivery leads at each Trust, such as a head midwife, acted as the main source of contact throughout the pilot and the evaluation.

The sessions themselves were delivered by 'on the ground' staff or 'practitioners' (i.e. midwives and health visitors). Typically, practitioners were approached by Trusts if they had a real interest or experience in relationship education or in delivering antenatal classes more generally. The Trusts also considered workload and capacity. For example, one area made sure not to approach practitioners who were already involved in other research projects.

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[23] The four key objectives that are discussed throughout the report stem from these overarching aims of the pilot.

[24] Leicestershire Partnership Trust were unable to participate for the whole fieldwork period due to a lack of staff availability and time. They participated until July 2016.

Design of content/objectives of sessions

The relationship advice content was devised by OnePlusOne, specialists in this area.[25]

OnePlusOne provided Trusts with a relationship education resource pack and trained selected practitioners at each Trust, in delivering the pack materials to parents. This training was delivered through a combination of online resources and a face-to-face training day. This pack included session materials and links to wider online support and covered four core objectives:

1. **'Me, you and baby too':** Designed to raise parents' awareness of the impact a baby can have on their relationship.
2. **'Why does it matter?':** Designed to raise parents' awareness of the impact their relationship with one another has on their baby.
3. **'Changes and challenges':** Designed to prepare parents for the changes and challenges to their relationship: physical, emotional, sexual, financial and practical.
4. **'Communicating and managing conflict':** Designed to help parents develop skills of communication and managing conflict.

Trusts were asked to cover all four objectives in their antenatal sessions, but were not required to make use of all the materials to do so.

Beyond this, practitioners were not given prescriptive guidance on how the material should be delivered. Consequently, different delivery models emerged. The key differences were the staff responsible for delivering sessions (midwives or health visitors) and the format of the sessions (antenatal classes or home visits). These and other differences – such as the length of the session – are discussed in greater detail in Chapter 3.

1.2 The evaluation

1.2.1 Aims

IFF Research and Tavistock Institute were commissioned by DWP to evaluate the feasibility and effectiveness of the pilots.

There were two key aims:

1. **To measure the extent to which the pilots met the objectives in terms of impact on new parents' relationships and attitudes towards seeking relationship support.**

   This was addressed through the following research questions:

   - Did the pilots impact on parents' relationship quality post-birth?
   - To what extent, if at all, did the sessions influence participants' willingness to seek relationship support?
   - To what extent, if at all, did couples feel more informed and prepared for the impact having a baby may have on their relationship?
   - Did participants recall relationship advice and skills taught during the programme?

[25] www.OnePlusOne.org.uk

- Did level of recall vary across different aspects of the programme?
- Did participants act upon the advice after the sessions?
- Did participants make use of wider support materials?

2. **To collect relevant learnings and points of best practice for wider access to relationship advice through perinatal services.**

   This was addressed through the following research questions:

   - Was the practitioner training programme optimally designed?
   - How confident did NHS staff feel when delivering the education sessions?
   - How could the practitioner training programme be improved?
   - What delivery models did different NHS Trusts adopt? How was the programme delivered, by whom, where and when?
   - Did fathers and hard-to-reach groups participate in the programme? If not, how could this be addressed?

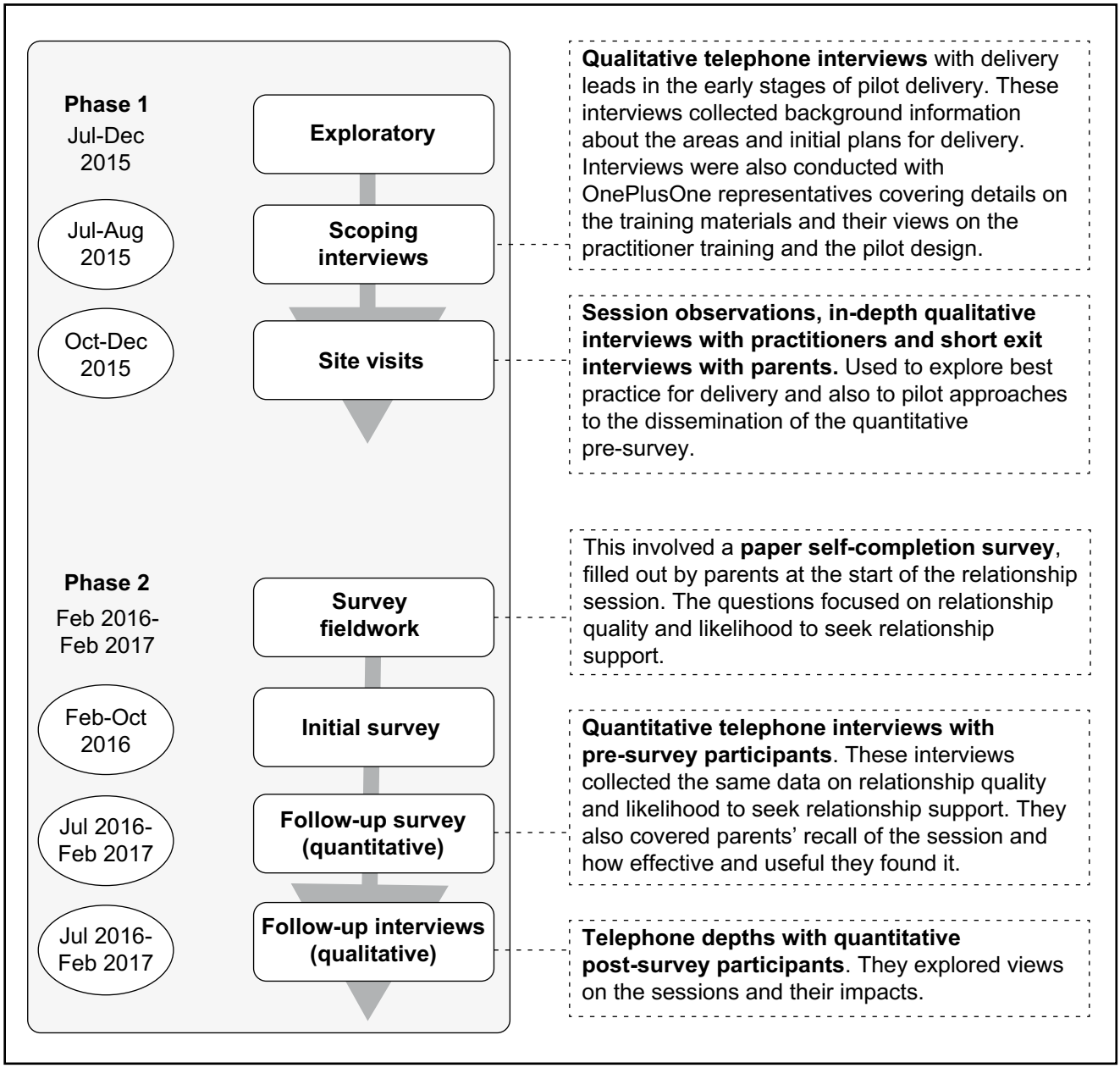
1.2.2 Evaluation approach

The evaluation was made up of a mixture of qualitative and quantitative methods with two discrete phases, an initial ‘exploratory phase’ and a ‘survey fieldwork phase’.

The entire evaluation programme is set out in Figure 1.1.

A breakdown of the interviews and surveys conducted at each stage can be found in Appendix A, with demographic breakdowns of initial and follow-up survey participants.

Figure 1.1 Evaluation programme



Exploratory phase

This phase of the research was used to draw out best practice and key learnings for the pilot delivery. It was also used to inform the design of the survey fieldwork phase.

It consisted of an initial round of scoping interviews, followed by site visits.

Scoping interviews

Eight telephone depth interviews, lasting around 45 minutes, were conducted with delivery leads between 29 July 2015 and 12 August 2015.

1. Croydon Health Services NHS Trust (one interview with Community Midwife Team Manager).
2. Derby Hospitals NHS Trust (one interview with Matron for Community Midwifery and Antenatal Services).

3. Suffolk County Council and Ipswich Hospital NHS Trust (one interview with Deputy Head of Midwifery).
4. Leicestershire Partnership Trust (one interview with Health Visiting Professional Lead).
5. Nottingham City Care (one interview with Acting Health Visiting Team Manager).
6. South Tyneside Foundation Trust and Sunderland Royal Hospital (two interviews with Health Visiting Lead and Midwifery Lead)[26].
7. St Helens and Knowsley NHS Trust (one interview with Specialist Midwife).

The interviews were conducted at very early stages of pilot implementation in each area and sought to understand:

1. Existing perinatal provision and the local context in each area;
2. Delivery to date, plans and views on the training provided by OnePlusOne;
3. The feasibility of telephone-based initial and follow-up surveys;
4. Views on the OnePlusOne training; and
5. Which Trusts to include in the site visits.

A paired telephone depth interview was also conducted with two representatives from OnePlusOne. The interview focused on: the OnePlusOne training materials and how they were devised; the practitioner training delivered by OnePlusOne – what it involved and how attendees reacted; and their general thoughts about the pilot itself.

Site visits

Four of the Trusts were visited towards the end of 2015. They were selected using information from the scoping interviews, based on the following criteria:

1. Whether delivery had started in the area.
2. Logistics of the site visit (e.g. being able to conduct multiple observations in home visit areas within the same day).
3. Type of delivery (antenatal class or home visit).
4. Amount of new relationship content included and time devoted to it.

Each visit consisted of:

1. In-depth qualitative interviews with practitioners, lasting around an hour: these explored practitioners' views on the OnePlusOne practitioner training, the OnePlusOne relationship education materials, plans for delivery, early reactions from parents and feasibility of disseminating the initial survey.

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[26] Two separate telephone depths were conducted in South Tyneside and Sunderland as there were two delivery leads in this area, one for the midwifery team and one for the health visiting team. Similarly, in two areas (Suffolk County Council and Ipswich Hospital NHS Trust and Croydon Health Services NHS Trust), an interview was conducted with a delivery lead who dealt primarily with either the health visiting or the midwifery side and did not have a sufficient overview of both. In these cases, shorter follow-up calls took place with other contacts to fill in any information gaps (particularly around the feasibility of contact detail collection).

2. Session observations whereby researchers sat in on the classes and paid attention to how the material was delivered and how parents reacted.
3. Short, face-to-face exit interviews with parents, lasting 5-10 minutes: collecting parents' thoughts on the session, what they learnt and their reaction to the initial surveys.

While observing the session, attention was paid to the way in which the initial surveys were introduced and administered by the practitioners. Parents' reactions to the prospect of filling out the survey were also monitored. As a result of this, small revisions were made to the initial survey ahead of the mainstage dissemination. Further detail on these changes is discussed later.

Survey fieldwork phase

This phase of the research was primarily designed to measure the impact of the sessions on parents' relationships and inclination to seek further support. It also collected some data on parents' views on the sessions, for example how helpful and effective they found them in terms of preparing them for the impact having a baby would have on their relationship.

There was a quantitative and qualitative element:

- **Quantitative element:** involved two separate questionnaires; the first was disseminated immediately before the session via a paper questionnaire – the 'initial survey', and the second around six months after the session over the telephone – the 'quantitative follow-up survey'.

A selection of questions around relationship quality and likelihood to seek relationship support were included in both questionnaires, making it possible to track change over time and critically, provide an indication as to whether the sessions influenced the relationship quality of those who attended.

Without a control group it can be difficult to establish the nature of change that would have taken place without participation in the pilots (particularly since the birth of a child is a period when change in the nature of relationships between parents would be expected anyway). The relationship quality questions were therefore carefully selected from other evaluations of relationship advice interventions – specifically the DAS-7 scale and the communication element of the ENRICH scale – which makes it possible to draw comparisons between the findings of this evaluation and other studies. Such comparisons are made in Chapter 7.

- **Qualitative element:** the final phase of the evaluation involved follow-up qualitative interviews with quantitative follow-up survey participants, allowing a more in-depth exploration of parents' views.

Initial survey – Scoping interview feedback

Ideally, the initial survey would have been conducted over the telephone to maximise the response rate and maintain consistency with the follow-up survey. However, two key issues with this approach became apparent during the scoping interviews:

1. **Time: allowing for enough time to conduct a telephone initial survey before the sessions would require the Trusts to transfer parents' contact details well in advance.**

   It was revealed that parents in all areas could sign up to the sessions in very short timeframes and even on the day of the session, leaving little time to transfer the contact details and conduct the interviews.

At the time, delivery was fragmented and practitioners were time-pressed, calling into question the available resource, to pass on the contact details in a timely manner.

2. **Requirement for written consent: DWP needed written consent from parents to facilitate the transfer of their contact details from the Trusts to IFF Research and Tavistock Institute.**

   Most parents would sign up to the session over the telephone which made it difficult to collect written consent in advance.

   A paper-based survey allowed for the data collection to take place before the session, without the need to build in time for the transfer of contact details, and facilitated the collection of written consent.

Initial survey – pilot and mainstage

The initial survey was piloted at three site visits in October and November 2015.

From this, minor amends were made, such as changes to the consent wording and the addition of a detachable Frequently Asked Questions (FAQ) sheet.

In January 2016, packs containing the finalised questionnaires and instructions for the delivery leads and practitioners were sent to the leads at each Trust.

Trusts were asked to distribute the surveys over a six-month period, from February 2016 until August 2016. This was later extended to October 2016, owing to a lower number of returned surveys than desired. As will be discussed later in the report, this was due to lower number of attendees than originally anticipated.

A total of 335 initial surveys were collected across the whole fieldwork period. The response rate this represents cannot be ascertained, as the precise number of attendees is unknown. This is because there was no centralised register and areas were not asked to report attendance figures back to DWP. Further detail on this can be found in Chapter 5. This also means that it is difficult to be entirely confident that those completing the survey are representative of all those who took part in relationship education sessions.

Follow-up survey (quantitative)

The majority (88 per cent) of initial survey participants provided an email address or telephone number and gave permission to be re-contacted for the later stages of the evaluation.

A total of 124 interviews were achieved between 19 July and 7 February.

This survey was conducted by telephone, using CATI software, around four months post-birth.[27]

It was agreed that contacting parents four months after the birth of their child would strike the right balance between allowing for the impact of having a baby to become fully apparent and parents' ability to recall the session (which had typically taken place four to six months prior).

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[27] The likely age of the baby was determined using the date the parents attended the session and the number of weeks pregnant they were at that time. Parents were then assigned to a sample batch and called according to time elapsed. Parents were also asked the age of their baby as part of the screening process. If their baby was too young, an appointment was made to re-contact them later.

The precise timings of the survey in conjunction with the age of the baby are shown in Table 1.1 below.

Table 1.1 Age of baby and time since session

Age of baby	Time since session			
	4-5 months	6 months	7+ months	Total
4 months	42	32	11	85
5-6 months	13	9	14	36
7 months	–	–	2	2
Total	**55**	**41**	**27**	**123**

Note: Base sums to 123 as one session date is unknown.

Non-response weight

A non-response weight was applied the follow-up survey data at the analysis stage, to account for slight variations in the initial and follow-up survey profiles according to gender, relationship status and class type (i.e. antenatal classes versus home visits).

Follow-up survey (qualitative)

At the end of the quantitative follow-up survey, parents were asked if they were happy to take part in the final stage of the evaluation, and around two-thirds (65 per cent) agreed.

This stage involved 40–45-minute telephone depth interviews and took place a month or two after the quantitative follow-up survey interview.

A total of 40 interviews were conducted between 5 October 2016 and 1 March 2017.

At the analysis stage, individual analysis of each discussion was entered into an analysis framework. This is a database which is structured under key research questions, allowing sessions to be compared and objective judgements made about the commonality of experiences.

1.3 Report Structure

This report presents findings from all stages of the evaluation. It consists of two parts, each with a focus on certain aspects of the evaluation more than others.

Part one – What are the key learnings for pilot design?

This focuses on data from the scoping and site visit stage and touches on findings from the qualitative follow-up survey where relevant:

- Chapter 2: Practitioner training.
- Chapter 3: Integrating the relationship content.
- Chapter 4: Recruitment.
- Chapter 5: Challenges and best practice.

Part two – To what extent have the pilots met the objectives?

This focuses predominantly on the survey fieldwork phase and touches on relevant findings from the exploratory phase:

- Chapter 6: Relationship quality, communication and likelihood to seek advice.
- Chapter 7: Parents' views on the session.

The study looks to establish the 'impact' of taking part in the pilots on parents. It does this primarily through comparing the views and attitudes of parents before and after taking part. This approach has some methodological limitations, but logistical considerations ruled out other approaches (such as a randomised control trial or other similar approaches involving a control group of parents who did not take part). This means results for the impact of the pilots should be treated with some caution, although the use of standardised scales used in other evaluations and comparison with these other studies helps to give more confidence in the results than would otherwise have been possible.

Subgroup analysis has been conducted on initial and follow-up survey data by gender and session type (whether a class or home visit). Owing to low base sizes, subgroup analysis has not been carried out by other demographics, such as age, ethnicity and pilot area.[28]

[28] A demographic breakdown of the initial and follow-up survey response can be found in Appendix A.

Part One Summary

What are the key learnings for pilot design?

Key research questions

- Was the practitioner training programme optimally designed?
- How confident did National Heatlh Service (NHS) staff feel when delivering the education sessions?
- How could the practitioner training programme be improved?
- What delivery models did different NHS Trusts adopt? How was the programme delivered, by whom, where and when?
- Did fathers and hard-to-reach groups participate in the programme? If not, how could this be addressed?
- Was the education training programme optimally designed? How could the education training programme be improved?

Part one summary

Research question	Findings
Was the practitioner training programme optimally designed?	• Practitioner training consisted of two parts, an e-learning platform followed by a one-day skills workshop. • There was limited uptake of the e-learning platform among practitioners, owing to the volume of information coupled with a lack of time, clarity about the purpose of the resources and IT resources. • Reactions to the skills workshop were more positive, often described as interactive, enjoyable and informative.
How confident did NHS staff feel when delivering the education sessions?	• Health visitors generally reported that they felt more confident (than midwives) as they tended to have had more experience in delivering relationship advice and facilitating discussions. • However, practitioners designed their own sessions to include the content that they felt most comfortable with.
How could the practitioner training programme be improved?	• It would have, perhaps, been more effective to sign post practitioners to the e-learning materials after the skills workshop, as practitioners would have been more familiar and engaged with the content. • There may have been value in delivering separate health visitor and midwife training. • Aligning the order of the workshop with the OnePlusOne pack may have made it easier to digest and retain.
What delivery models did different NHS Trusts adopt? How was the programme delivered, by whom, where and when?	• Although there were consistencies, areas were not given prescriptive guidance, so variations naturally emerged. • No areas introduced the material in a stand-alone session but instead integrated it into existing provision. • The material was disseminated through either home visits or antenatal classes via midwives or health visitors. • Classes generally lasted an hour, whereas home visits tended to be shorter. • Delivery leads reported that antenatal sessions generally targeted parents that were around 30 weeks pregnant. However, in two areas the material was first introduced at the 16-week home visit and then again closer to the baby's birth.
Did fathers and hard-to-reach groups participate in the programme? If not, how could this be addressed?	• The profile of parents who received the information generally reflected the profile of those who attended existing antenatal sessions. • The approach to recruitment was 'business as usual'. Consequently, harder-to-reach groups (such as teenage or young parents, ethnic minority groups, fathers and those with relationship issues) were not always represented. • Practitioners suggested a combination of home visits and classes would be mostly likely to reach the best cross-section of parents: – Because of their 'opt in' nature, antenatal classes were less likely to reach disadvantaged groups than home visits. – Fathers were more likely to attend classes than home visits, which often took place during the working day.

Research question	Findings
Was the education training programme optimally designed? How could the education training programme be improved?	• There was originally fear that a lack of parent interest or a high drop-out rate would be a key barrier to timely and effective delivery, and to attendance levels more generally. • Original concerns not realised: the key barriers – felt at practitioner and delivery lead level – were a lack of time, high levels of staff turnover and the prevalence of competing priorities. • Suggestions for best practise and improvements include: – devising readily cascaded training to allow for a more efficient handover in the event of staff turnover; – keeping direct communication from OnePlusOne to practitioners rather than through delivery leads. This would have freed up delivery lead time and ensured a quick and efficient line of communication for practitioners; – ensuring ongoing engagement with delivery leads. If areas had been asked to report monthly attendance figures to DWP, this might have been beneficial to sustaining momentum; and – demonstrating the effectiveness of the material. If practitioners had been given data on the impact that the provision of relationship support has been shown to have, this might have helped to keep its profile high among competing priorities. • The pilots pointed to a number of findings around 'what content works', which are worth keeping in mind for designing or improving sessions: – There is a balance to strike between covering a lot of material at a higher level or fewer in more depth. Covering fewer activities in more depth is more conducive to successful delivery. – The materials can, and should, be tailored according to the delivery setting and parents attending. Unlike a class setting, there is more opportunity to talk to parents about issues in the context of their own relationship in home visits, and for specific questions to be asked by the practitioner to encourage less forthcoming parents. However, this does risk being more intense and causing offense. – Content should be tailored to specific needs, such as to those on subsequent pregnancies, those in a co-parenting relationship, single parents, etc. – Interactive activities work particularly well. – It is helpful to include the relationship session as close to the beginning of the antenatal provision as possible, to reduce fatigue or as an 'ice-breaker' exercise. – The material can be daunting or awkward, so maintaining a friendly and informal atmosphere is important.

2 Practitioner training

Research questions:

- Was the practitioner training programme optimally designed?
- How confident did National Health Service (NHS) staff feel when delivering the education sessions?
- How could the practitioner training programme be improved?

This chapter draws upon findings from the site visits and scoping interviews, and considers reactions to the practitioner training.

2.1 The training

The training was designed to assist practitioners with delivering the material effectively. It consisted of two stages; an initial e-learning platform – which was to be completed independently and in advance of the session – followed by a one-day skills workshop.

2.1.1 E-learning

The e-learning site covered all of the materials in the OnePlusOne training pack, information about how to use the materials and guidance on understanding and supporting couple relationships more generally. It also included a space to record personal notes.

Use of the materials was limited. In the scoping interviews, OnePlusOne suggested that only half of those who attended the skills workshop had been told about the e-learning by the delivery leads, and although most of the site visit practitioners were aware, they did not feel it was necessary to give it more than a cursory glance. That said, some did acknowledge that it was useful for understanding what would be covered in the skills workshop, though it was rare for practitioners to feel the need to complete it before the skills workshop, as originally intended.

The conversations with practitioners at the site visits suggested that the overarching barrier to the use of the e-learning materials was a lack of time, coupled with a lack of clarity about how the materials were to be used. Without proper signposting and explanation, busy practitioners were sometimes overwhelmed by the sheer depth and breadth of the information contained on the e-learning site. This may have been exacerbated by a lack of IT equipment, with practitioners unable to access the material easily during working hours and unlikely to do so in their free time. This issue around technology was mentioned by site visit practitioners – some of whom felt over-reliance on IT resources should be avoided altogether – and by OnePlusOne.

> *'I would have liked to have known about it.* [But] *would I have time to do it in work? Would I have chosen to do it at home on one of my very valuable days off? Probably not.'*
>
> (Midwife)

'IT posed a surprising problem: practitioners may not have a desktop never mind smartphone or tablet.'

(OnePlusOne)

2.1.2 One-day skills workshop

The skills workshop involved practitioners going through the OnePlusOne training materials with the trainers, as they would do with the parents attending their sessions.

Practitioners were generally more positive about the skills workshop than the e-learning, and it was often described as interactive, enjoyable and informative.

The trainers who ran the workshops were also well regarded. In the site visits, practitioners praised the training style used and said that trainers were engaging.

'The lady who delivered it was absolutely fantastic at what she did. I really like the use of humour in education because I think a lot of it is retained when it's in a fun environment, and that definitely was the case.'

(Midwife)

Practitioners welcomed the opportunity to try out the activities with the trainers in advance, as it enabled them to picture how they would work in practice. That said, it was mentioned that it would have been even better if the workshop followed the same order as the OnePlusOne pack. It was suggested that this would help practitioners to feel more comfortable and familiar with the materials as well as aid decisions about which activities to take forwards in their own sessions.

'We did some of the exercises that we would do with the couples and that was good. It gave us an idea of how you might present it yourself and also what the couples would gain from it.'

(Midwife)

Levels of confidence coming away from the sessions were mixed. Health visitors tended to report that they had more experience in delivering relationship advice and facilitating discussions than midwives, who were more used to delivering sessions with a medical and instructional focus. Consequently, they sometimes felt the session was too long, whereas midwives would have liked more time. Specifically, midwives were keen for more information around how to handle parents' questions. Such advice is included in the e-learning resource, which suggests it would have been useful to have signposted practitioners to this more effectively.

'I felt it was a bit like teaching a granny to suck eggs.'

(Health visitor)

'Health visitors have the skills to accommodate this relationship content probably more easily than midwives. This content isn't anything that new for health visitors.'

(Health visitor)

'I sometimes feel out of my comfort zone. One quick day I don't think gave me the ammunition I need to support people if they tell me that they've got issues in their relationship.'

(Midwife)

2.1.3 Suggested improvements

Three key suggestions emerged from the findings during the scoping and site visits phases:

1. It would perhaps have been more effective to signpost practitioners to the e-learning materials after the skills workshop: practitioners were more familiar with the content following the session and may have been more inclined to log on to the e-learning platform to follow-up on specific areas of interest, without becoming disengaged at the prospect of covering it all. It would also have helped with supporting the less confident or experienced practitioners. For example, midwives could have logged on for the guidance about dealing with queries from parents.
2. There may have been value in delivering separate health visitor and midwife training, given the varied levels of experience.
3. Aligning the order of the workshop with the OnePlusOne pack may have made it easier to digest and retain.

3 Integrating the relationship content

Research questions:

- What delivery models did different NHS Trusts adopt? How was the programme delivered, by whom, where and when?
- Was the education training programme optimally designed?
- How could the education training programme be improved?

This chapter draws heavily on findings from the initial exploratory phase, but notes relevant findings from the qualitative follow-up survey in the 'key considerations' section (3.1.3). It starts by looking at the delivery models adopted before delving into more detail around the selection of the materials.

3.1 Delivery models

As there was no prescriptive guidance, a variety of delivery models emerged. These are outlined in Table 3.1.

Table 3.1 Delivery models at each Trust

Trust	Setting	Practitioner	Length
Croydon Health Services NHS Trust	Class	Midwives	1 hour as part of a full-day antenatal course
Derby Hospitals NHS Trust	Class	Midwives	1 hour as part of a 2-hour evening class (one of three 2-hour sessions)
Suffolk County Council and Ipswich Hospital NHS Trust	Class	Midwives	1 hour as part of a full-day antenatal course
Leicestershire Partnership Trust	Home visit	Health visitors	Less than an hour
South Tyneside Foundation Trust and Sunderland Royal Hospital	Home visit	Health visitors and midwives	Less than an hour
St Helens and Knowsley NHS Trust	Class	Midwives	1 hour as part of a 2-hour evening class (one of three 2-hour sessions)

As shown, areas chose to disseminate the intervention through either home visits or antenatal classes.

This impacted on the amount of time devoted to the materials; in home visits the content was only drawn upon if conversations naturally led that way. Consequently, it was typical for less than an hour of content to be covered. Antenatal classes were more structured. As they were devised in advance, they made use of the same set of activities in every session and thus tended to last an hour.

When the pilot was initially introduced, four of the six areas planned to deliver the new content in antenatal classes. Three of these planned to integrate the content into their current antenatal programme and the other initially planned to hold a stand-alone relationship class for couples. There was low uptake of this class when first offered however, which led to them also integrating it into an existing antenatal programme.

The timing of the delivery was broadly consistent across all of the areas; mothers were targeted when they were around 30 weeks pregnant. The only different approach was in Sunderland and South Tyneside where the material was first introduced at the 16-week home visit. The content was then referred to again later on in the pregnancy, in home visits closer to birth.

Each area had a different number of practitioners trained and therefore delivering the content, varying from one trained practitioner to around eight. High staff turnover proved to be a challenge in some areas. This and other challenges to delivery are discussed in Chapter 5.

3.1.1 Displacing existing content

The impact of integrating the OnePlusOne content into existing provision in each area was slightly different, depending on whether they were delivering it through home visits or antenatal classes.

In home visits, generally, no existing content was displaced in order to incorporate the OnePlusOne content. Relationship education was previously part of this kind of provision anyway. The new content simply added tools and structure to aspects that they would have originally covered.

In antenatal classes, the OnePlusOne content displaced other content, which had to be covered elsewhere instead. For example, in one area, an infant feeding section was dropped and made into a stand-alone session. In other cases, it was less extreme and simply meant certain aspects were covered in less depth or there was less time at the end for questions and answers.

Even though midwives saw value in including relationship education in their provision, as it made parents think about issues they might not have considered that closely before, some felt that the existing content was sometimes more important, at least from the perspective of the parents.

> *'We have an open question session and a lot of the questions are the bits we've missed out so you do think, "is there a need for* [relationship education]*?" when the questions we are getting are not about relationship issues.'*
>
> (Midwife)

3.1.2 Selecting new content

As previously noted, the session materials were developed and devised by OnePlusOne. Typically the practitioners at each trust decided which materials to use, with less involvement from their delivery lead.

The selection process was influenced by two interlinking factors; how easy or practical the activity or materials were to deliver and how comfortable they would feel delivering it. During this process, practitioners reflected on their experiences of taking part in the training and judged how much they enjoyed it, as well as how memorable and relevant it felt.

> *'It'd be a really futile exercise if we were giving information we weren't comfortable with as* [the parents] *would get that vibe from us.'*
>
> (Midwife)

3.1.3 Key considerations

Broad points

The qualitative follow-up survey interviews with parents pointed to a couple of key points that were important to them in maximising the benefit of the relationship sessions:

- **Parents felt that it was helpful to include the relationship session as close to the beginning of the antenatal provision as possible.** Those who mentioned this commented that they struggled, or would struggle, to concentrate or recall the session if it was to be delivered at the end, after the existing antenatal content, and others mentioned that it was a good way to start the day as it '*got everyone involved and made everyone feel like friends*'.
- **The material can be daunting or awkward, so maintaining a friendly and informal atmosphere is important.** Respondents were generally very positive about the practitioners, describing them as friendly, approachable, understanding, and knowledgeable. Some of these respondents praised the midwives and health visitors for keeping the session informal and for their appropriate use of humour to make conversations around potentially difficult topics easier.

  > *'They were approachable, understanding and gave us ideas if people weren't talking.'*
  >
  > (Female, antenatal class)

  Information collected during the site visits from parents and practitioners also pointed to a number of key points:

- **There is a balance to strike between covering a lot of material at a higher level or fewer in more depth.** At the time of the site visits, each of the observed areas were covering all four modules (structured around the four pilot objectives) in their sessions but they did so to varying degrees. They either chose to cover a lot of activities in little depth or fewer activities in more depth.

The observations suggested that covering fewer activities in more depth is more conducive to successful delivery; covering too many activities risks making the session a more confusing and less engaging experience. Specifically, it:

- limits the accuracy and depth of the session;
- creates a sense of 'information overload', with parents feeling as though they are being 'talked at' rather than 'talked to'; and
- makes for a more daunting experience, particularly as some of the content can be emotionally demanding.

- **The materials can, and should, be tailored according to the delivery setting and parents attending.** In terms of delivery setting, being aware of the pros and cons to each environment is key to incorporating the content effectively and will help practitioners to use the materials effectively.

  Antenatal classes do not allow for people to talk about any specific relationship difficulties they have, but they do allow for more light-hearted and interactive discussion that may promote more engagement in the material. Contrastingly, in home visits, there is opportunity to talk to parents about issues in the context of their own relationship and for specific questions to be asked by the practitioner to encourage less forthcoming parents. However, this does risk being more intense and causing offense.
- **It was also highlighted that tailoring to specific needs would be beneficial.** For example parents who were on subsequent pregnancies, couples who were in a co-parenting relationship but not romantically involved, single mothers and where one of the parents already had a child and the other did not. Although this can be covered to some extent in the OnePlusOne training, OnePlusOne felt that practitioners were better positioned to understand the needs of their parents and to tailor the material accordingly. Therefore, it is more a point for practitioners to be aware that they can have this flexibility and adapt the materials as they see fit.
- **Interactive activities work particularly well.** At a broad level, activities with an interactive element were seen as good for the atmosphere and for encouraging engagement with the materials. Indeed, in the follow-up survey, one parent mentioned the diagrams and activities were very useful in consolidating the information, and another pointed out that it was good that '*it wasn't just one person talking*'. Within this, activities that involved splitting the session by gender were praised by parents and practitioners, as they felt doing so helped to facilitate more open discussion. For example, Activity 5 'What do couples argue about most?'.

  'I think it's worked well with the splitting of the mums and dads up because they can be a bit more open and a bit more honest, and they have their little jokes amongst themselves.'

  (Midwife)

  'I thought it [Activity 5] *was a good concept because you could talk about potential issues by gender.'*

  (Male, antenatal class)

- **Signposting to online materials can be useful, but their worth must be properly emphasised if parents are actually going to go on and use them.** The option to signpost to online materials was seen as reassuring for those less confident with the materials and for subjects that neither practitioners, nor parents were comfortable with (notably conversations around sex). However, some site visit observations suggest that practitioners did not always proactively encourage parents to use them.
- **Cartoons and relationship insights can work but need to be used as prompts for discussion to work well.** For example, Cartoon 2 sparked a lot of conversation in one area but was not very well explained in other areas and did not prompt much conversation.

Specific content

At the site visits, the following points emerged:

- Hand-out 3 – '*I feel loved and cared for when*'. Very well regarded at the site visits, with parents often taking it away as a 'key take out'.
- Hand-out 1 – '*Time for us*'. Praised as interactive.
- Videos. Received mixed feedback. Some found them useful but others found them patronising. There were also often technological issues which interrupted the flow of the session. Indeed, the qualitative follow-up survey parents recalled these issues.
- Relationship insight 6 – '*Relationships in trouble*'. Not well received; seen as very pessimistic and depressing.

During the qualitative follow-up survey, parents were asked what specific details they could recall from the session. Levels of recall were variable but where parents did draw out specifics, the same hand-outs (hand-outs 1 and 3, detailed in the bullet points above) emerged, adding credence to the site visit observations. Parents also recalled hand-out 2 '*Who does what?*'. These findings are discussed in more detail in Chapter 7.

4 Recruitment

Research questions:

- Did fathers and hard-to-reach groups participate in the programme? If not, how could this be addressed?

Following on from the process of devising the training, this section looks at recruitment practices and attendance levels. Findings from the scoping interviews and site visits are discussed in the main, with reference to the quantitative initial survey and qualitative follow-up survey where relevant.

4.1 Sign-up process

Scoping interviews revealed that recruitment to the sessions was 'business as usual', as the materials were simply integrated into existing provision. Typically, the relationship content was only briefly introduced in advance – as part of the 'package' – with parents given a headline summary of all of the topics that would be covered.

This meant that levels of drop-out or lack of uptake were no more or less likely than those seen for regular antenatal classes or visits. The fact that one area tried to deliver the relationship content as a stand-alone session before opting to integrate it into existing sessions due to low uptake suggests that the idea of registering specifically for a relationship support session can be off-putting. Delivery leads felt that, with a stand-alone session, parents may have questioned the personal relevance of the session or have been concerned about the sensitive nature. Importantly, parents with such concerns may have included those who would particularly benefit from the session and would have therefore missed out. Indeed, this sentiment was echoed by some qualitative follow-up survey parents:

> *'I personally wouldn't have gone to that one because my relationship is fine, so I think having it mixed into the classes helps.'*
>
> (Female, antenatal class)

> *'I think if it was separate, not many people would attend. If it's within the classes … I think that would help certain people.'*
>
> (Female, antenatal class)

That said, it is important to strike the right balance and give parents some forewarning. In one site visit area, a recently separated mother became distressed at the content and would have liked more advanced notice that relationships were going to be covered as part of the sessions.

> *'I would have appreciated some warning. I found the whole thing really distressing. I don't even know what my relationship status is as it's so recent.'*
>
> (Female, antenatal class)

Introducing the material within an existing antenatal programme or programme of visits was also beneficial, as it allowed for rapport to be built with the practitioner (and, in classes, with other parents) before it was delivered.

'I would say to do it probably in the 3rd or 4th week because then you are really confident with the people. I still speak to my group now and meet up.'

(Female, home visit)

During the qualitative follow-up survey, some parents who attended the session with their partners commented on how important it was for them to attend together, and a few women who attended on their own mentioned that there would be more value in the session if their partners were present. Consequently, this is also worth bearing in mind when introducing the session to parents.

'It was all very well one side hearing it, but he needs to hear it as well; he just heard snippets through me when I got home.'

(Female, antenatal class)

4.1.1 Profile of attendees

As the approach to recruitment was 'business as usual', the profile of parents who received the information generally reflected the profile of existing antenatal sessions. Areas were not asked to target specific groups, and they did not. Consequently, harder-to-reach groups (such as teenage or young parents, ethnic minority groups, fathers and those with relationship issues) were not always represented.

Practitioners generally felt that, because of their 'opt in' nature, antenatal classes were less likely to reach disadvantaged groups than home visits. However, they also commented that fathers were more likely to attend classes than home visits, which often took place during the working day.

'A lot of people who don't speak English won't feel confident [to come to a class] *and will therefore miss out.'*

(Midwife)

Table 4.1 outlines demographic data collected at the quantitative initial and follow-up surveys. These findings can only be treated as indicative of the profile of individuals who attended sessions, as they do not account for non-response bias – i.e. not everyone at the session filled in an initial survey.

That aside, the findings from the scoping stage and site visits are, to some extent, borne out in quantitative initial survey data:

- **More fathers attended antenatal classes than home visits.** There was a roughly even split in terms of gender at classes compared to home visits (46 per cent male and 54 per cent female at classes versus 14 per cent male and 86 per cent female at home visits) and more couples attended classes together (96 per cent at classes versus 45 per cent home visit).
- **Young parents accounted for a higher proportion of those receiving support through home visits.** 22 per cent aged 18-24 versus 7 per cent at classes.

The majority of initial and follow-up survey respondents were in a relationship. The ethnicity and age profiles were also broadly similar. That said, the latter two demographics are only available for follow-up survey respondents which includes a small base of 18 home visit parents. Consequently, these findings must be treated with caution.

Table 4.1 Demographic profile of initial and follow-up survey participants

Demographic	Class (%)	Home visit (%)	Total (%)
Gender (initial survey):			
Male	46	14	42
Female	54	86	58
Ethnicity (follow-up survey):			
White	88	84	87
Asian	11	9	11
Other	1	5	2
Relationship status (initial survey):			
Together (married, living together, steady relationship)	99	98	100
Single	-	2	<1
Attended the session with partner (initial survey):			
Yes	96	45	89
No	4	55	11
Age (follow-up survey):			
18-24	7	22	9
25-34	67	44	64
35-44	24	34	25
Initial survey base	**291**	**44**	**335**
Follow-up survey base	**106**	**18**	**124**

5 Challenges and best practice

Research questions:

- Was the education training programme optimally designed? How could the education training programme be improved?

This chapter considers the key challenges and points of best practice – with regard to wider access to relationship advice through perinatal services – uncovered throughout the evaluation, particularly the exploratory phase.

5.1 Challenges

The pilot was due to commence in summer 2015 and run for 9-12 months. Although areas were not prescribed any targets, it was estimated that 5,000 parents would receive the content in that time.

In reality, the pilot ran for around 6-9 months: most areas did not start delivering until the autumn; a couple were delayed until early 2016; and some were forced to stop and start in this period, due to staffing and resource issues.

Although attendance levels are largely unknown – as there was no centralised register and areas were not asked to report these back to the Department for Work and Pensions (DWP) – findings from the evaluation also suggest much lower attendance levels, particularly if looking at the number of initial surveys received.

5.1.1 Initial survey predictions

Information collected at the site visits was used to estimate likely attendance numbers, and these estimates are outlined in Table 5.1. It should be noted that these were very rough, made early on in the design phase and were likely the 'ideal', 'at best' figures.

Table 5.1 Attendance predictions collected at the site visits

Area	No. per session	No. sessions	Anticipated per month	Anticipated overall (6 months)
Derby	Up to 10 couples	2-4 per month	c.25 couples	150 couples (300 individuals)
Sunderland and South Tyneside	1 (or 2 if father present)	75 per month	c.75 mothers	450 individuals, potentially more if fathers present
St Helens and Knowsley	15-20 couples	c.3 per week	c.60 couples	360 couples (720 individuals)
Suffolk	3-4 couples	1 per month	c.4 couples[29]	24 couples (48 individuals)

[29] The expected numbers in Suffolk over the course of the pilot were lower than other pilot areas due to the session being run less often, and the session only being delivered to three to four couples each time.

5.1.2 Reasons for lower attendance figures

Originally, it was feared that a lack of parent interest or a high drop-out rate would be a key barrier to timely and effective delivery and attendance levels. However, these concerns were not realised. As discussed in the previous chapter, levels of uptake and drop-out were similar to regular antenatal sessions. Instead, the issue was a lack of available resources, at practitioner and delivery lead level.

Practitioner-level issues

The practitioners were clearly very busy individuals with a lot of work commitments, and were often based in different locations at different times, due to the nature of their jobs. Consequently, they sometimes found it difficult to find the time to meet up and agree on the materials to use in their sessions, and this led to delays in getting the pilots underway.

> *'We've not had any protected time to put it into practice effectively. We've kind of winged it, on a text message on a Friday night and that's not ideal.'*
>
> (Midwife)

> *'It's the logistics. Some are on night shifts, some are in clinics, some are on holiday.'*
>
> (Midwife)

Delays were also caused by staff turnover, as time was spent waiting for new team members to be trained.

Delivery lead issues

Delivery leads tended to feel that they had a lot of competing priorities and stated that they were under time pressure in their role. Therefore, as this was a pilot, tasks relating to it were sometimes seen as a more discretionary part of the job than other parts. Maintaining momentum for the delivery of the relationship content needed a constant driving force behind it and this was not present in all areas. Although delivery leads were generally very interested and enthusiastic about the pilots, they were extremely busy individuals. In some areas, this was also exacerbated by staff turnover at this level.

5.1.3 Best practice suggestions

These findings point to a number of best practice suggestions:

1. **Readily-cascaded training.** This would have allowed for a more efficient handover in the event of staff turnover. Perhaps this is something that would happen naturally over time outside of a pilot scenario, as structures became more established.
2. **Direct communication from OnePlusOne to practitioners rather than through delivery leads.** This would have freed up delivery lead time and ensured a quick and efficient line of communication for practitioners. This was actually suggested by OnePlusOne in the context of the lack of awareness of the e-learning materials.

3. **Ongoing engagement with delivery leads is critical.** If areas had been asked to report monthly attendance figures to DWP, this might have been beneficial to sustaining momentum.
4. **Demonstrating the effectiveness of the material.** If practitioners had been given data on the impact the provision of relationship support has been shown to have, this might have helped to keep its profile high among competing priorities.

Part Two Summary

To what extent have the pilots met the objectives?

- Did the pilots impact on parents' relationship quality, post-birth?
- To what extent, if at all, did the sessions influence participants' willingness to seek relationship support?
- To what extent, if at all, did couples feel more informed and prepared for the impact having a baby may have on their relationship?
- Did participants recall relationship advice and skills taught during the programme?
- Did level of recall vary across different aspects of the programme?
- Did participants act upon the advice after the sessions?
- Did participants make use of wider-support materials?

Part two summary

Research question	Findings
Did the pilots impact on parents' relationship quality, post-birth?	• Parents were asked to respond to a set of relationship quality and communication questions in both the initial survey and the follow-up survey. These questions used rating scales, from which mean scores could be derived. • A comparison of the mean scores given to these questions at the initial and follow-up surveys showed that there was no significant change across the relationship quality questions, but a significant increase across communication questions: the mean score increased from 11.70 before the intervention to 12.83 after the intervention, which equates to an effect size of 0.37, which can be considered as relatively small.[30] • Previous studies have suggested that becoming a parent is normally associated with a decline in relationship quality.[31] Consequently, it is positive that the pilot findings indicate no change in relationship quality (as measured by the DAS-7) and a small improvement in communication.
To what extent, if at all, did the sessions influence participants' willingness to seek relationship support?	• Respondents were significantly ($p<0.001$) more inclined to report that they were likely to seek relationship support at the follow-up survey than they were at the initial survey (mean score 3.48 versus 4.31 respectively)[32]. • At the quantitative follow-up survey, 63 per cent stated that they would know where to go for relationship support and of these, 45 per cent had not been aware before the session. • Parents who took part in the qualitative follow-up interviews explained that the session changed their attitude to seeking support, more than their awareness. For example, it highlighted the importance of doing so, removed the stigma, or helped them to realise that they would not be alone in doing so.
To what extent, if at all, did couples feel more informed and prepared for the impact having a baby may have on their relationship?	• In the follow-up survey, the majority of parents reported that the session had raised their awareness of each of the four objectives of the relationship education materials[33] at least a little (between 73 per cent and 89 per cent agreed that the session had increased their awareness a great deal or a little in each of the areas), and around a quarter to a half felt it had done so a great deal.

30 Effect sizes are used to judge how substantial a change is observed, in a way that can be compared across different outcome measures and interventions. The extent to which an effect size should be regarded as small or large usually depends on the context of the study and the intensity of the intervention. However, in general, effect sizes of around d=0.2 to d=0.3 are regarded as small, around d=0.5 as medium, and effect sizes from around d=0.7 to d=0.8 and upward as large.

31 Twenge *et al.* (2003).

32 Mean scores have been calculated by attributing numeric scores to responses from 1 for very unlikely to 7 for very likely.

33 As mentioned earlier these were:
1. raising parents' awareness of the impact a baby can have on their relationship;
2. raising parents' awareness of the impact their relationship with one another has on their baby;
3. preparing parents for the changes and challenges to their relationship: physical, emotional, sexual, financial and practical; and
4. helping parents develop skills of communication and managing conflict.

Research question	Findings
Did participants recall relationship advice and skills taught during the programme?	• There were mixed levels of recall: in the quantitative follow-up survey, 64 per cent of respondents said that they could remember the relationship advice and guidance covered in the session very well or quite well. Yet for 36 per cent, recall was poor (26 per cent said not very well and 11 per cent said not at all well). • In the qualitative interviews, parents typically fell into one of three camps: – **Good/specific recall.** These parents recalled the general message – that having a baby will impact upon their relationship – and the importance of communicating with and supporting one another, and drew out specific exercises or conversations as examples. – **General/broad recall.** These parents mentioned general conversations around how having a baby would impact on their relationship and the importance of communicating with and supporting one another, but did not draw out specific examples of exercises or conversations held. – **Poor recall.** These parents struggled to distinguish the relationship session from the antenatal session overall.
Did level of recall vary across different aspects of the programme?	• There were indications that objective four – around communicating and managing conflict – was recalled the most and objective two – around awareness of the impact parents' relationship have on their baby – the least: – **Objective four:** 'Communicating and managing conflict'. Designed to help parents develop skills of communication and managing conflict (61 per cent of quantitative follow-up survey respondents claimed they could recall the session 'very' or 'quite' well). – **Objective three:** 'Changes and challenges'. Designed to prepare parents for the changes and challenges to their relationship: physical, emotional, sexual, financial and practical (51 per cent). – **Objective one:** 'Me, you and baby too'. Designed to raise parents' awareness of the impact a baby can have on their relationship (37 per cent). – **Objective two:** 'Why does it matter?'. Designed to raise parents' awareness of the impact their relationship with one another has on their baby (16 per cent). • In the qualitative interviews, parents typically remembered exercises or discussions with an interactive element.
Did participants act upon the advice after the sessions?	• The majority (83 per cent) of quantitative participants reported that they had discussed the content covered in the relationship session with their partner, and almost three-fifths (56 per cent) of participants stated that they changed their behaviour because of something they learned from the session. Those who reported in the qualitative interviews that they had changed their behaviour gave examples such as making more time for each other, being more honest with each other when feeling stressed or down, and being more laid back where possible.

Did participants make use of wider-support materials?	• Of the follow-up survey respondents who received free materials at the session (59 per cent), just over a third (35 per cent) explained they used them and 45 per cent explained that they only dipped into them. • At the time of the follow-up survey, 69 per cent of participants who received free materials reported that they had kept them. • In terms of signposting to further materials, just over two-fifths (42 per cent) of follow-up survey participants said they were signposted, though only about a third (32 per cent) used these.

6 Relationship quality, communication and likelihood to seek advice

Research questions:

- Did the pilots impact on parents' relationship quality, post-birth?
- To what extent, if at all, did the sessions influence participants' willingness to seek relationship support?

This chapter covers the key findings from the quantitative initial survey and follow-up survey relating to the impact on relationship quality, and likelihood to seek advice. It also draws comparisons with other relevant studies from 6.1.3 onwards.

6.1 Selecting questions to assess relationship quality

As mentioned earlier, a challenge arises in using the findings from participants before and after an intervention to understand the impact that the intervention has had, making a judgement about what sort of change might have been expected to occur anyway.

To strengthen the assessment of impact that it was possible to make using the survey data, the initial and follow-up survey questionnaires used established question sets that have been tested in other evaluations and for which comparisons can be drawn – although, of course, they were carried out with different populations and in different contexts, so any comparisons should be treated with caution.

Previous studies have used a variety of measures to identify the outcomes of relationship education interventions aimed at new parents. Given the expected negative impact of becoming a parent on relationship quality, these often measure relationship quality before and after the intervention.[34] Measures that have been used include, for example, The Locke-Wallace Marital Adjustment Test, The Quality of Marriage Index, the Golombok-Rust Inventory of Marital State and The Dyadic Adjustment Scale (DAS), as well as the shorter DAS-7 (which consists of seven questions drawn from 32 questions of the full-length DAS).

For this evaluation, the two question sets chosen were:

- the DAS-7; and
- a selection of questions from the 15-item ENRICH Marital Satisfaction Scale.

[34] For example, Spanier (1976); Sharpley and Rogers (1984).

The DAS-7 was selected because it was in a suitable length and format for the telephone survey. In addition, it was used recently in a study (Spielhofer *et al.*, 2014) to measure the impact of a short post-natal relationship education programme ('Let's Stick Together') aimed at first-time parents – which was similar to the perinatal pilots – as well as for two other types of relationship support (marriage preparation and couple counselling). Parts of the ENRICH scale were also used as they were judged to be relevant to the stated objectives of the pilot. However, in order to keep the survey to a manageable length – and also to avoid asking questions not of relevance to the pilot – a subscale consisting of only four key questions was developed for this evaluation.

6.1.1 Results

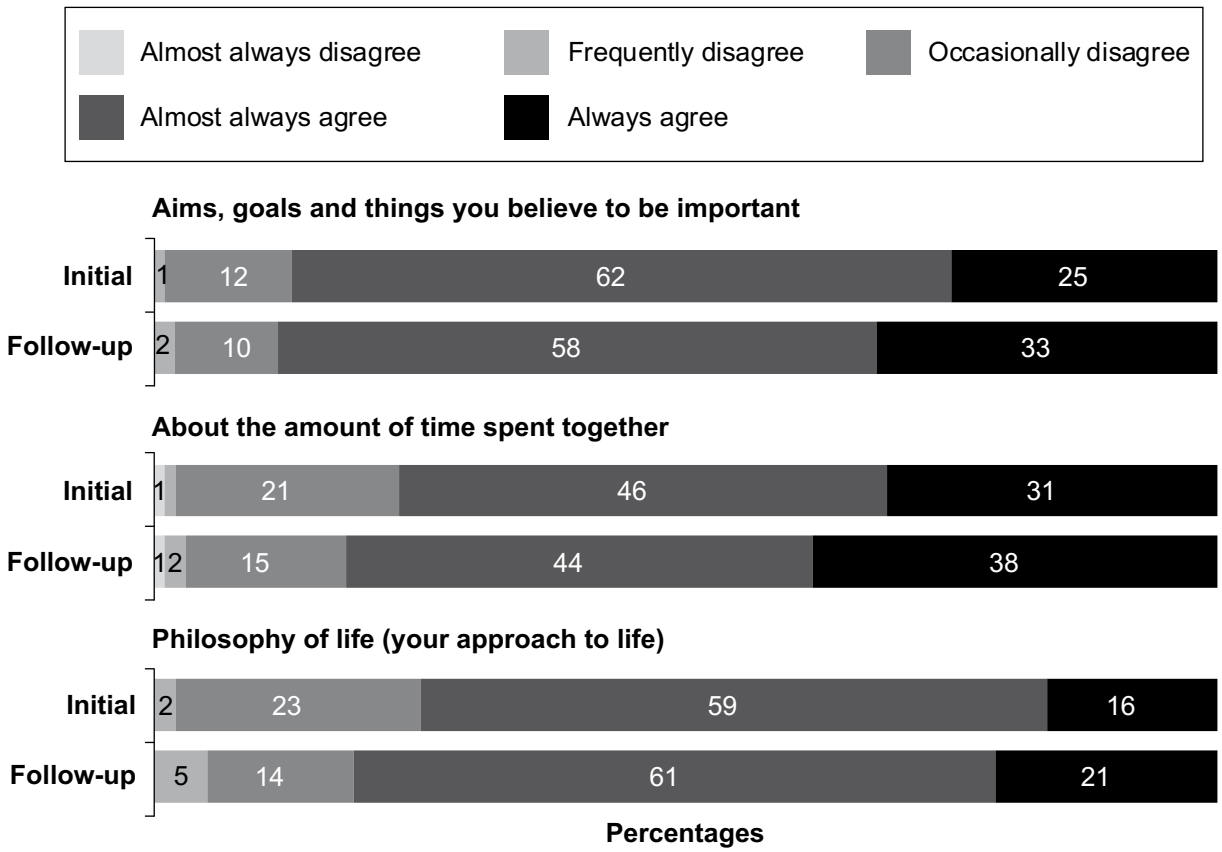
The DAS-7 question set includes seven measures of relationship quality shown in Figures 6.1 to 6.3. As part of the quantitative initial and follow-up survey, respondents were asked to state the extent to which they agree with three statements on a 5-point scale, about how often they participate in three activities with their partner and then to rate the overall happiness of their relationship.

The communication section of the ENRICH scale consists of the statements shown in Figures 6.4 and 6.5. Respondents in the quantitative initial and follow-up survey are asked about the extent to which they agree with each of these, again on a five-point scale.

Both the DAS-7 and ENRICH scales are typically analysed by looking at the mean scores given across all of the elements within the scale. This analysis is covered in section 6.1.3.

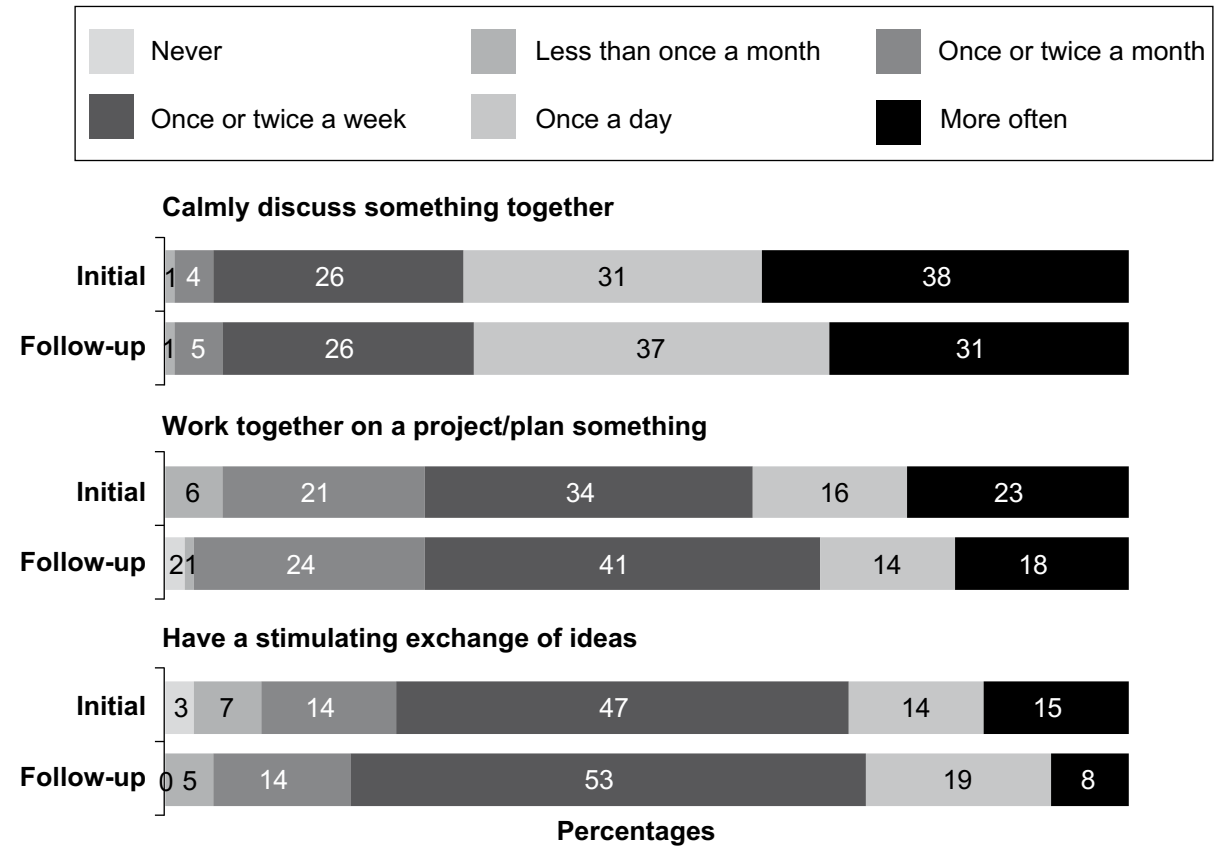
These findings are reported on a base of 122 respondents. These are the respondents that were still in a relationship at the point of the follow-up survey and had answered the question in both the initial and follow-up surveys, to allow for consistency.

Figure 6.1 Extent of agreement with DAS-7 items 1 to 3



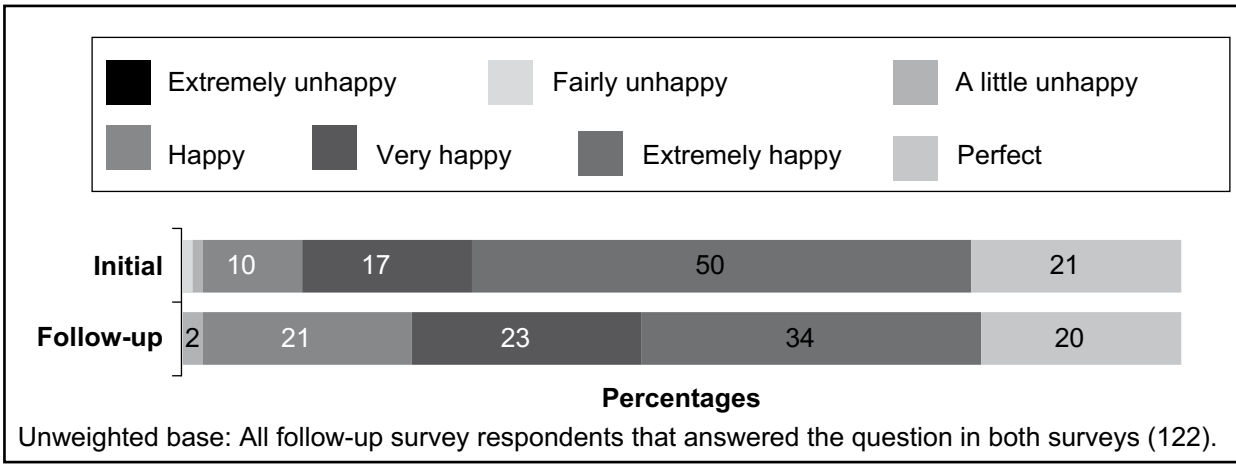
Unweighted base: All that were still in a relationship at follow-up survey (122).

Figure 6.2 Agreement with DAS-7 statements 4 to 6



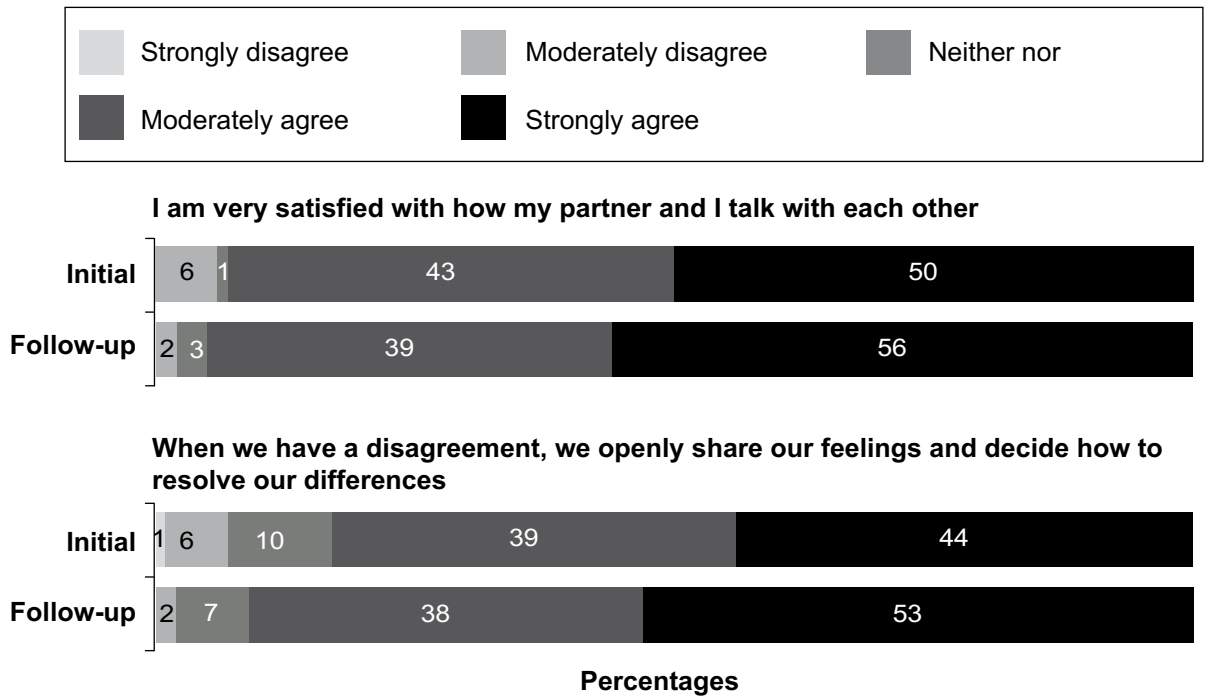
Unweighted base: All that were still in a relationship at follow-up survey (122).

Figure 6.3 Agreement with DAS-7 statement about relationship happiness



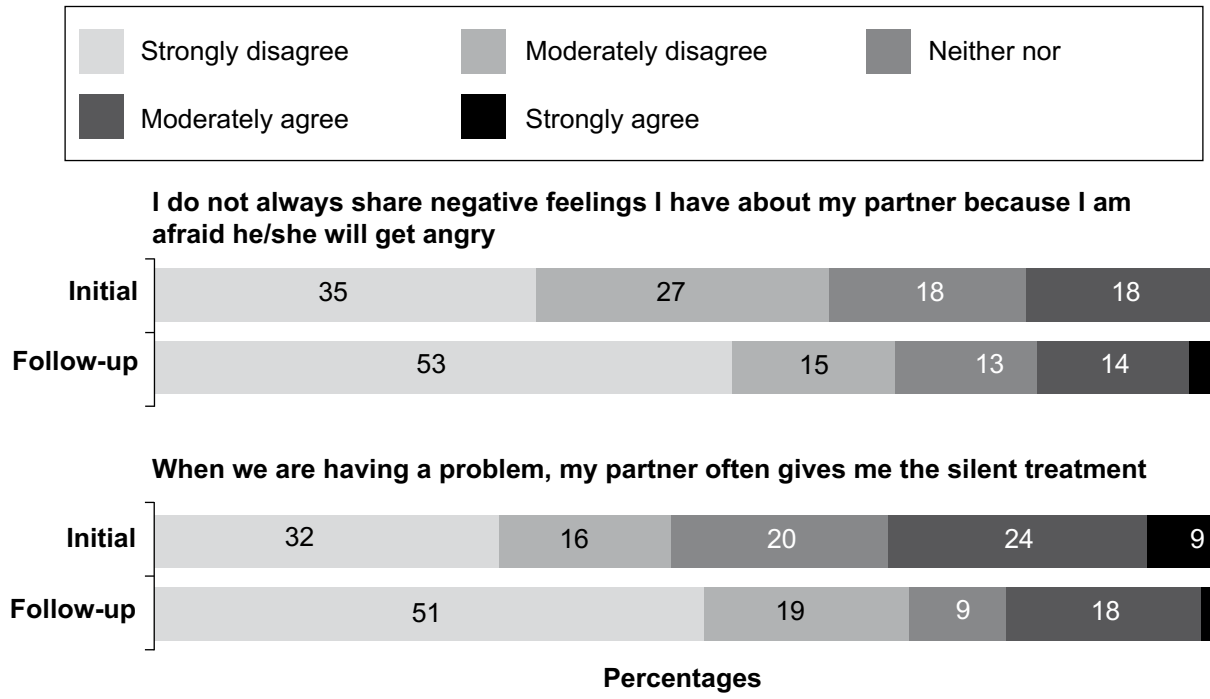
Unweighted base: All follow-up survey respondents that answered the question in both surveys (122).

Figure 6.4 Extent of agreement with ENRICH communication statements 1 and 2



Unweighted base: All that were still in a relationship at follow-up survey (122).

Figure 6.5 Extent of agreement with ENRICH communication statements 3 and 4



Base: All that were still in a relationship at follow-up survey (122).

6.1.2 Interpreting the DAS-7 and ENRICH results

Table 6.1 compares the initial and follow-up mean scores for each of the two scales.

The overall score for the DAS-7 scale is calculated by attributing numeric scores to the responses for each statement. Statements 1-3 are scored between 0 (for almost always disagree) and 5 (for always agree), statements 4-6 between 0 (for never) and 5 (for more often) and item 7 between 0 and 6 (for strongly disagree and strongly agree, respectively). This means that total scores range from 0 to 36, with higher scores representing better levels of adjustment/relationship quality.

The overall score for the ENRICH subscale is calculated by attributing numeric scores to the responses for each statement (from 1 for strongly disagree to 5 for strongly agree). This means that there is a minimum score of 4 and a maximum score of 20 on the scale.

This analysis shows that while there was no significant change for the mean scores on the DAS-7 (relationship quality) scale, a significant difference was found for the mean scores on the communication subscale (of the ENRICH scale) at a five per cent level of significance. No significant differences in change were identified by the gender of participants and the types of support received (at home or in a group setting).

For the ENRICH subscale, the mean score increased from 11.70 before the intervention to 12.83 after the intervention, which equates to an effect size of 0.37. Effect sizes are used to judge how substantial a change is observed, in a way that can be compared across different outcome measures and interventions. The extent to which an effect size should be regarded as small or large usually depends on the context of the study and the intensity of the intervention. However, in general, effect sizes of around d=0.2 to d=0.3 are regarded as small, around d=0.5 as medium, and effect sizes from around d=0.7 to d=0.8 and upward as large. The effect size for this intervention can therefore be considered as relatively small.

Table 6.1 Change over time for DAS-7 and communication subscale

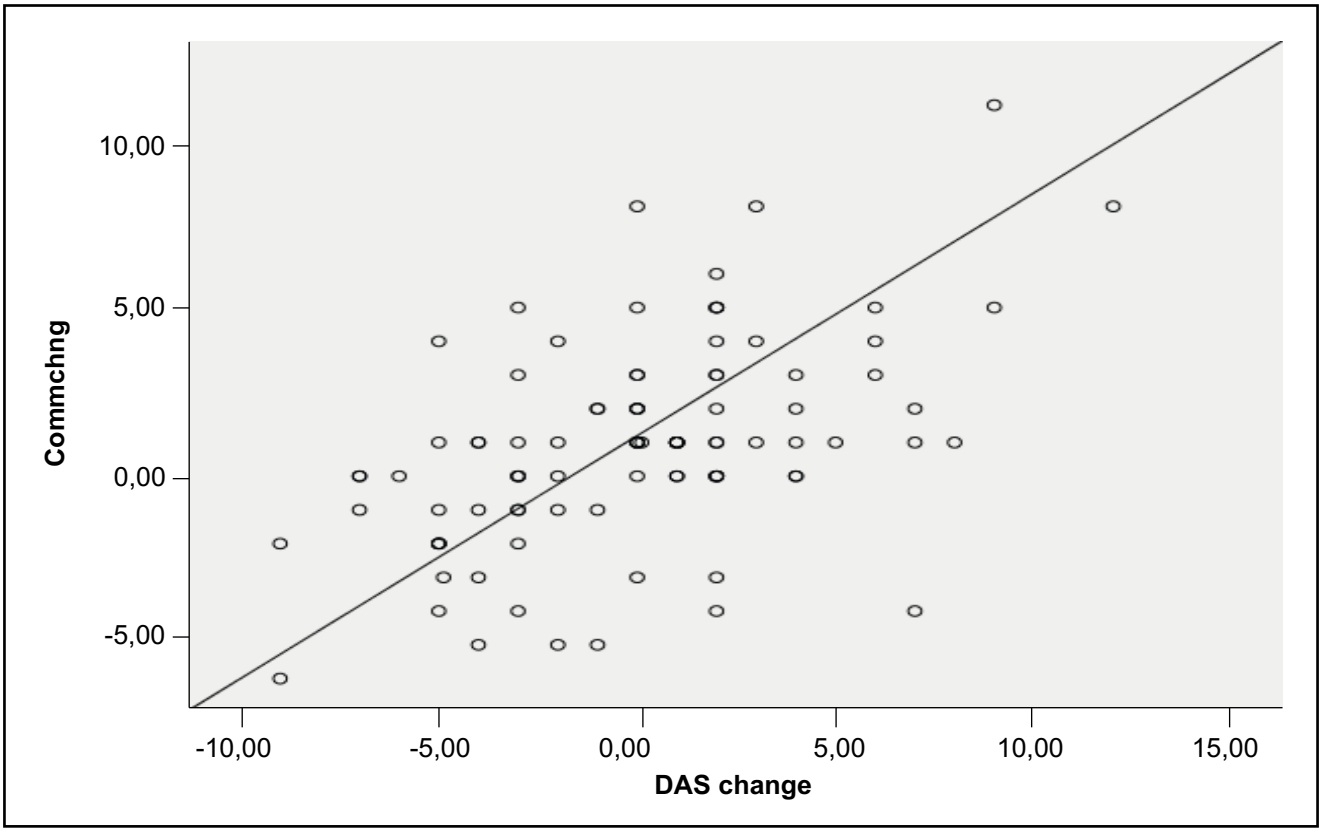
	Initial		Follow-up				95% CI		Effect size
Scale	Mean	SD	Mean	SD	t(94)	p	LL	UL	Cohen´s d
DAS 7	27.10	4.29	27.04	4.02	-.167	.87	-.86	.72	-.02
Communication	11.70	2.93	12.83	2.90	4.08	<.001	.58	1.68	.37

Note: CI = confidence interval; LL = lower limit; UL = upper limit.

As discussed earlier, previous studies have suggested that becoming a parent is normally associated with a decline in relationship quality for both partners. For example, Twenge *et al.* (2003) found that the overall average effect size comparing parents with childless couples was not large (d=0.19), but at the extreme it translated as a difference between 38 per cent of mothers of infants reporting high levels of satisfaction, compared with 62 per cent of childless women. Consequently, it is positive that the findings indicate that involvement within the pilots has led to no change in relationship quality (as measured by the DAS-7) and a small improvement in communication.

This is supported by the fact that there was a statistically significant positive correlation ($p<0.001$) between mean changes from initial to follow-up survey on the communication subscale and the DAS-7 scale, as shown in Figure 6.6 below.[35] This means that positive changes in communication were generally associated with positive changes in relationship quality, and vice versa. Thus, the correlation indicates that participants who benefited from the programme in terms of improving their relationship quality are also more likely to have improved their communication skills.

Figure 6.6 Correlation of changes in relationship quality and couple communication



6.1.3 Benchmarking the results

These findings for the pilots support those from other previous studies[36] which have shown that relationship education can lessen the negative impact on relationship quality of the arrival of a new baby.

Let's Stick Together evaluation

One of the key reasons for choosing the DAS-7 as the measure for relationship quality was to compare the results with the *Let's Stick Together* evaluation which looked at three types of relationship support (Spielhofer *et al.*, 2014).

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35 For this correlation change, scores for both scales were created by subtracting the mean score at the baseline measurement point from the mean score at the follow-up point. Pearson's r was calculated to measure this correlation ($r(121) = .51$, $p<0.001$) and was found to be large according to conventions.

36 Schulz *et al.* (2006).

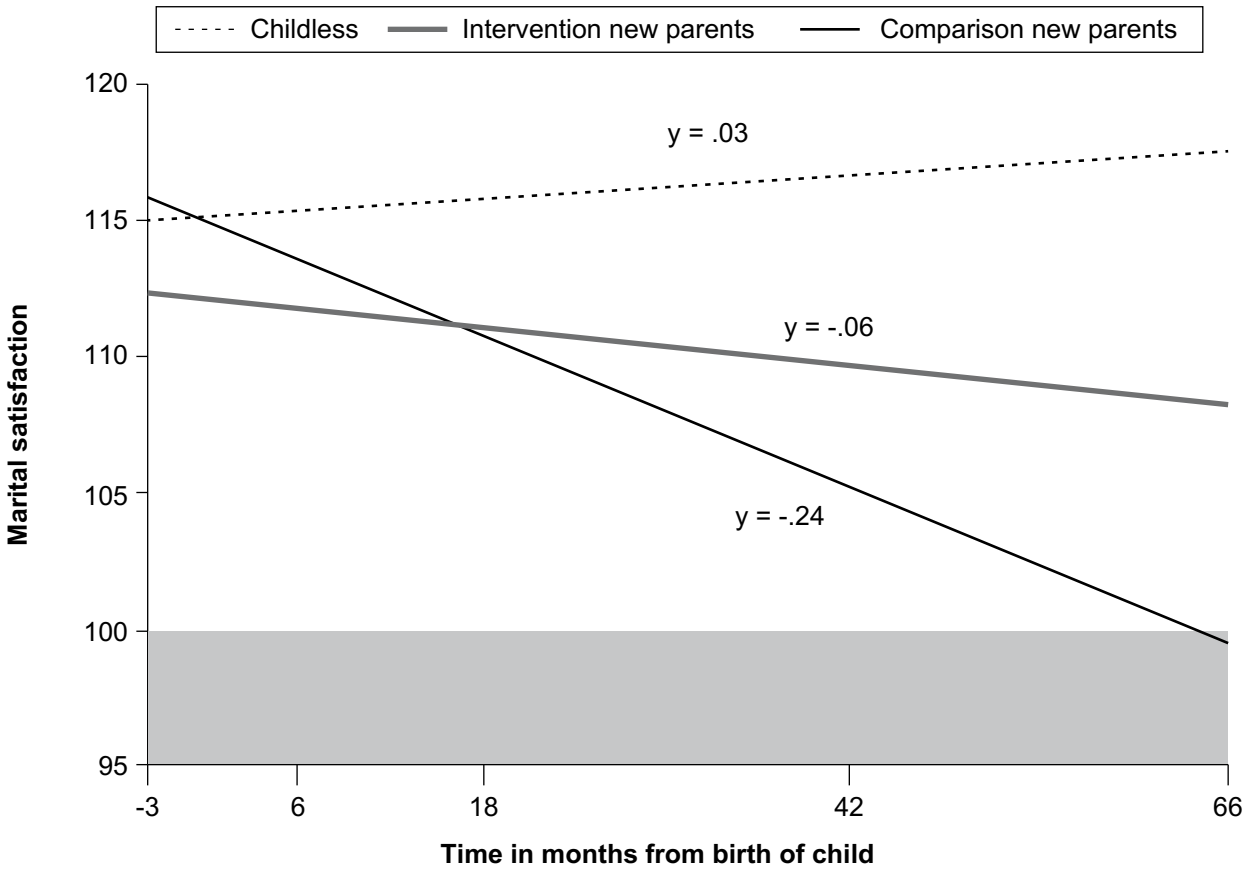
The sample for the *Let's Stick Together* evaluation included 78 first-time parents who were assessed using the DAS-7 and other measures before receiving the support and 12 weeks later. This study found a slight improvement in the mean score on the DAS-7 (from 25.23 to 25.72) over this time period; however, this was not statistically significant. Of relevance is also the fact that the study found higher mean scores on the DAS-7 for participants receiving marriage preparation (27.54 at the initial survey stage) and significantly lower for those about to receive couple counselling from Relate (18.32) or Marriage Care (17.68).

This means that the relationship quality of pilot participants measured by the DAS-7 (at around 27.10 at the initial survey stage) was comparable to that of those accessing marriage preparation, which means that, in general, their relationship quality was very good. This indicates that couples who received the relationship education sessions were generally happy in their relationship, so the programme was effectively working with these couples to maintain their relationship quality after the arrival of their baby, rather than improve their relationship quality. The observed change between initial and follow-up scores for these pilots provides evidence that short relationship support interventions may help to reduce the negative impacts of the transition to parenthood on relationship quality.

Promoting Healthy Beginnings trial

Another relevant study to which these results can be compared is that conducted by Schulz *et al.* (2006), whose study looked at the impact of an intervention using a randomised control trial design. The study involved 66 new-parent couples in the United States who were randomly assigned to a couple relationship intervention or a no-treatment control group, and assessed at five time points until five and a half years after birth. While there was a decline in marital satisfaction in both groups, there was a significantly smaller decline for intervention participants than for the control group. There was also a small comparison group of 13 couples that remained childless who did not experience a decline in marital satisfaction over the same period. They also found that the intervention reduced the normal, expected decline in marital quality following the transition to parenthood (see Figure 6.7). The outcome of the study was still a reduction in marital quality in the intervention group when compared with a non-parent group, but it was significantly smaller than that in the control group of parents.

Figure 6.7 Marital quality following transition to parenthood[37]



From: Schulz, M. S., Cowan, C. P. and Cowan, P. A. (2006). *Promoting healthy beginnings: A randomised controlled trial of a preventive intervention to preserve marital quality during the transition to parenthood. Journal of Consulting and Clinical Psychology*, 74 (1), 20–31.

Meta-analysis of couple interventions

These findings from the pilots are particularly positive considering the short nature of the intervention. A key finding from the literature is that low-intensity relationship support programmes for new parents that are short in duration are typically not as effective as more high-intensity programmes. In particular, a meta-analysis by Pinquart and Teubert (2010) of 21 controlled relationship interventions with expectant and new parents found that effects were larger for interventions that included more than five sessions. This is supported in previous meta-analyses and studies[38] where the low-intensity programmes were not found to improve outcomes. Pinquart and Teubert (2010) conclude that given the many new demands and stressors that couples experience in the transition to parenthood, multiple sessions (ideally at least six) are needed to promote positive change and prevent relationship decline. That said, the literature also recognises that low-intensity programmes such as the perinatal pilots have the potential to reach more diverse target-groups, especially where intensive psycho-education may not appeal to transitioning couples focusing on a new baby.[39]

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37 The y-scores noted in this chart are effect sizes; the negative effect size for marital satisfaction for intervention parents of y=-.06 was significantly smaller than the negative effect size for comparison group parents (at -.24) who did not receive the intervention.

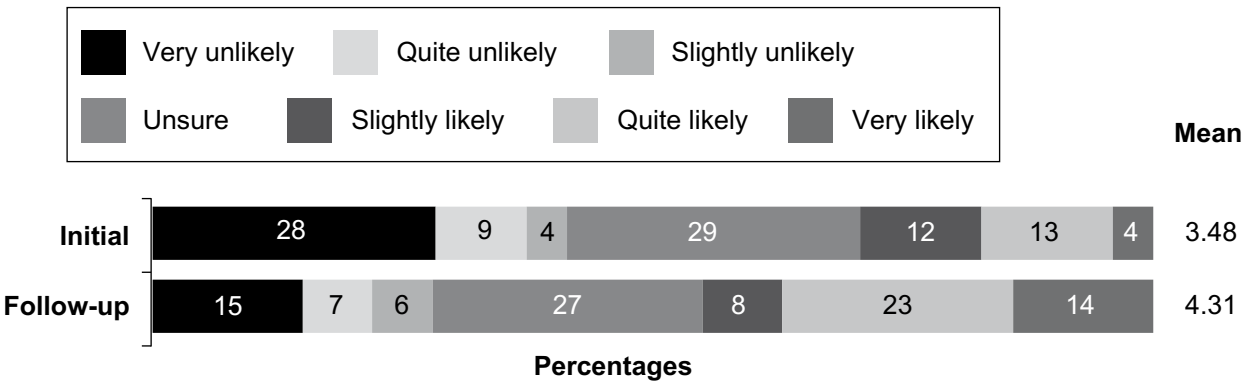
38 Hawkins *et al.* (2006); Hawkins *et al.* (2008).

39 Markman and Rhoades (2012); Hawkins *et al.* (2006).

6.1.4 Likelihood to seek advice

Another key area that the pilots aimed to influence was the likelihood of parents to seek advice as and when they experience problems in their relationship.

Figure 6.8 Likelihood of seeking relationship support



Unweighted base: All follow-up survey respondents (124).

Figure 6.8 shows that after the perinatal education, respondents were significantly ($p<0.001$) more inclined to say that they were likely to seek relationship support than beforehand (mean score 3.48 at initial survey compared with 4.31 at follow-up survey)[40]. This suggests that the perinatal relationship education encouraged some individuals to be more receptive to help in future.

At the quantitative follow-up survey almost two-thirds (63 per cent) stated that they **would** know where to go for relationship support. Of this 63 per cent, 45 per cent explained that they had not been aware before the session.

In the qualitative interviews, parents who felt the session had impacted on their likelihood to seek support often explained that it changed their attitude towards it, rather than their awareness. They explained that it had helped them to feel comfortable to seek support because it highlighted the importance of doing so, removed the stigma, or that it made them realise that they would not be alone in doing so (i.e. that plenty of other people are in similar situations).

A couple explicitly stated that the session gave them more information on where to seek this support, but a common explanation was they would search independently, either through the internet or contacting a medical or social care professional.

> *'I think one thing that came from this is that it's OK to do that* [seek support] *and there are lots of people there to help you.'*
>
> (Female, home visit)

> *'Like I say, it's not just you, all couples go through these things.'*
>
> (Female, antenatal class)

[40] Mean scores have been calculated by attributing numeric scores to responses from 1 for very unlikely to 7 for very likely.

'I didn't realise there was so much help out there.'

(Female, home visit)

Those who felt the session had not impacted on their likelihood to seek advice explained that they either already felt comfortable to do so beforehand, that they simply were not the type to seek support, or that they would prefer to try and 'sort it out' themselves, either directly with their partner or through discussing with friends and family, or looking online.

'[The session did not impact likelihood to seek advice] *I would have got help anyway if I was having problems.'*

(Female, antenatal class)

'I would be more likely to discuss things with friends and family first, and would only think of counselling as a last resort.'

(Female, antenatal class)

'Would go to a friend, but not a professional person like a midwife. Not someone who bottles things up.'

(Female, antenatal class)

7 Parents' views on the sessions

Research questions:

- To what extent, if at all, did couples feel more informed and prepared for the impact having a baby may have on their relationship?
- Did participants recall relationship advice and skills taught during the programme?
- Did level of recall vary across different aspects of the programme?
- Did participants act upon this advice after the sessions?
- Did participants make use of wider-support materials?

This chapter draws upon the quantitative and qualitative follow-up survey findings.

It starts by looking at parents' overall thoughts on the session – in terms of how useful they found it and how effective they felt it was in raising their awareness of the challenges and changes they would face – before looking at their ability to recall specific detail, and therefore, how effective the session was for building longer-term awareness.

Throughout the chapter it is worth keeping the time elapsed in mind. As noted previously, quantitative conversations were typically held 4-6 months after the session and qualitative discussions were held around 6-8 months after the session. This is likely to have impacted on the extent to which parents were able to recall specific details.

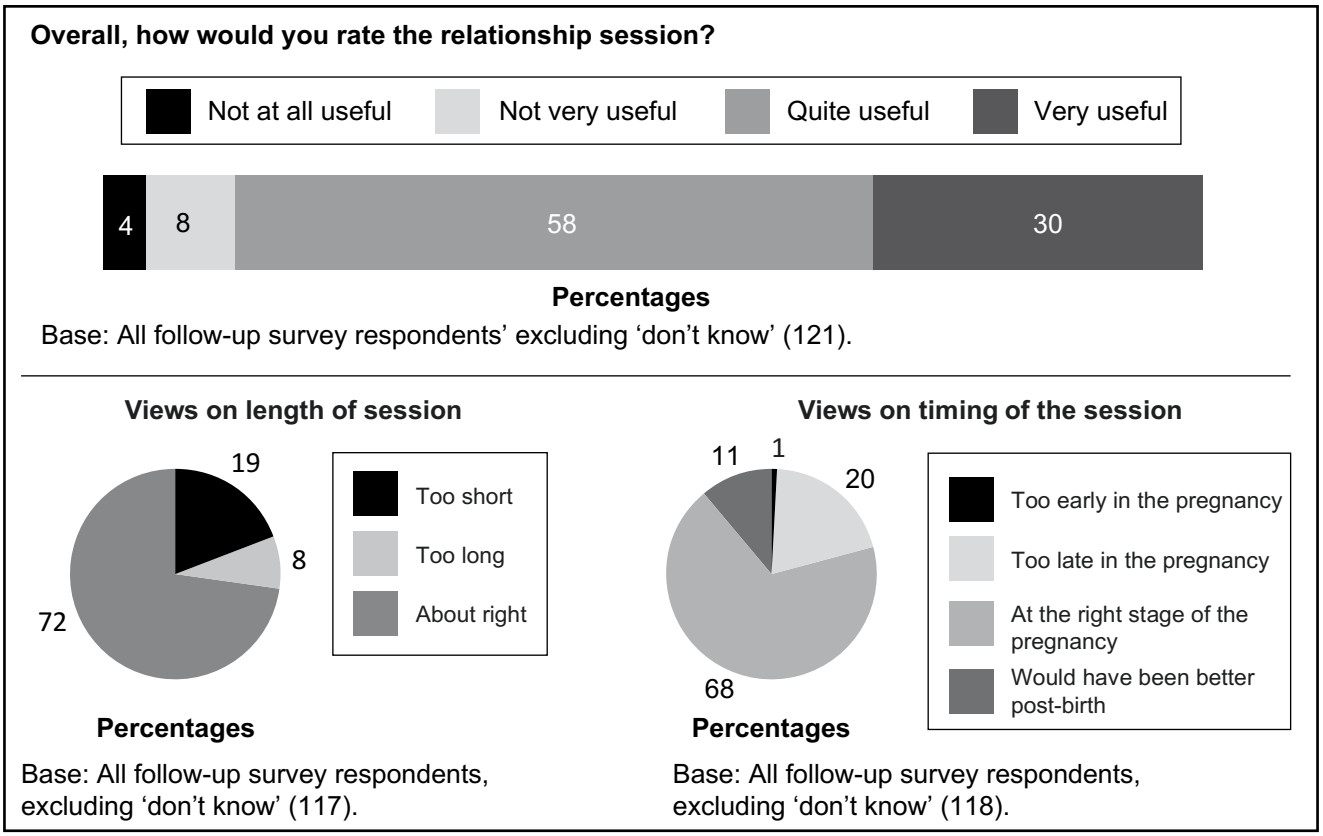
7.1 Overall thoughts – follow-up survey findings

7.1.1 Usefulness

Quantitative

Parents were asked in the quantitative follow-up survey to rate the session in terms of usefulness, length and timing. Results from this are outlined in Figure 7.1.

Figure 7.1 Summary of usefulness



As shown, the majority rated the session as 'useful' (88 per cent; 58 per cent as 'quite useful' and 30 per cent as 'very useful') and were content with the length and timing (72 per cent described the length as 'about right' and 68 per cent felt it was delivered 'at the right stage of pregnancy'). That said, there were significant minorities who saw room for improvement with 20 per cent stating it was 'too short' and roughly the same proportion (19 per cent) 'too late in the pregnancy'.

Qualitative

In the qualitative interviews, parents who thought it was best to deliver the session before the birth explained that this was because they felt it was important to use the information as preparation but also that they might be too busy to attend a session after the birth. That said, others were of a view that a pre- and post-birth session would be the most beneficial as it would be difficult to imagine the situation in advance or that the information would be forgotten by the time the child was born. Indeed, one mother who did receive the pre- and post-session format pointed out that the follow-up was useful.

> *'Though possibly for some parents, it wouldn't have been a bad idea to be invited back to a session after the birth. Because you can have rose-tinted glasses and can't imagine any rows after the baby has come!'*
>
> (Male, antenatal class)

> *'Before is better, because prevention is better than cure … and also because you have time; there's no way I would have gone afterwards.'*
>
> (Female, antenatal class)

Those who did not think it was delivered at the right stage of the pregnancy either mentioned that the timing was ok, but that a post-birth 'refresher' session would be beneficial or that a little earlier would have been better, with one respondent explaining that, towards the end of the pregnancy, her attention was more focused on 'getting things ready'.

There was a stronger feeling among parents that the sessions were useful because they were encouraged to pay more attention to issues that had been on their periphery rather than because they raised new issues. Among those who did mention that it caused them to think about things they had not previously considered, no single issue stood out as new, with examples given from the whole range of topics, from financial to sexual matters.

> *'I had considered most of it peripherally and used the session as an important building block.'*
>
> (Female, antenatal class)

> *'Handy as a reminder. Already do these things, but I don't really think about the fact that we do.'*
>
> (Male, antenatal class)

Parents also felt the sessions were useful for facilitating conversation and validating their opinions and experiences. They found it helpful to have some of the subjects that they previously felt uncomfortable discussing with their partner raised by a third party (the practitioner) and to share their views with other parents (if delivered in the class setting). They also felt the sessions covered issues they might not have been confident to bring up on their own.

> *'It brings up things you want to discuss with other half, but are maybe reluctant to, so the midwife brings them up. For example, emotional aspects and how women are going to feel about their body afterwards.'*
>
> (Female, antenatal class)

Those who did not find the session useful typically felt the information was not new – with one describing it as 'common sense' and 'patronising' – or that they were simply not interested; for example, they felt it did not sit well within the existing perinatal support framework.

> *'If I'm honest the relationship education felt like an interruption. It interrupted the flow quite a lot, felt misplaced in that session and most people there didn't really need it because they were already aware.'*
>
> (Male, antenatal class)

> *'There was too much to take in in one session … we were not worried about relationship issues.'*
>
> (Female, antenatal class)

'Good place to start the day, as it got everyone involved from the start and made everyone feel like friends. If it hadn't been there I would have thought something was missing.'

(Female, antenatal class)

Site visits

During the site visits, practitioners commented that the relationship content was a particularly good way to get fathers involved in the conversations. In some cases, the fathers were felt to be more engaged than the mothers.

'Usually it's focused on labour, pain relief, the mum's health etc., so nice for the dads to have something to talk about that directly involves them.'

(Midwife)

'Sometimes in pregnancy, you can be very focused on what the woman wants but we incorporate a lot of male involvement and participation … The dads absolutely love it … sometimes I can't shut the dads up.'

(Midwife)

7.2 Recall

7.2.1 Quantitative

In the quantitative interviews, parents were first asked to indicate how well they remembered the relationship advice and guidance covered in the session, using a scale of 'very well', 'quite well', 'not very well' and 'not at all well'.

Results from this were mixed; 64 per cent of respondents said that they could remember the relationship advice and guidance covered in the session 'very well' or 'quite well'. Yet for 36 per cent, recall was poor (26 per cent said not very well and 11 per cent said not at all well).

Those who said they could remember the session 'very well' or 'quite well' were asked what specific conversations they had a good recollection of. Their responses were then coded up and assigned to each of the objectives at the analysis stage. Levels of recall of aspects of the different objectives were:

- **Objective four: 'Communicating and managing conflict'.** Designed to help parents develop skills of communication and managing conflict (61 per cent of all who claimed to recall the session 'very' or 'quite' well).
- **Objective three: 'Changes and challenges'.** Designed to prepare parents for the changes and challenges to their relationship: physical, emotional, sexual, financial and practical (51 per cent).
- **Objective one: 'Me, you and baby too'.** Designed to raise parents' awareness of the impact a baby can have on their relationship (37 per cent).
- **Objective two: 'Why does it matter?'.** Designed to raise parents' awareness of the impact their relationship with one another has on their baby (16 per cent).

7.2.2 Qualitative

Like the quantitative interviews, parents participating in the qualitative follow-up survey were first asked to outline the conversations they remembered covering in the session (unprompted recall) before they were prompted with detail about each of the objectives (prompted recall).

Generally, levels of unprompted recall reflected the quantitative findings: there were signs of recall, but it was often more broad than specific. Parents typically fell into one of three camps:

- **Good/specific recall** – These parents recalled the general message – that having a baby will impact upon their relationship – and the importance of communicating with and supporting one another, and drew out specific exercises or conversations as examples.
- **General/broad recall** – These parents mentioned general conversations around how having a baby would impact on their relationship and the importance of communicating with and supporting one another, but did not draw out specific examples of exercises or conversations held.
- **Poor recall** – These parents struggled to distinguish the relationship session from the antenatal session overall.

Once prompted, parents did not tend to clearly distinguish between each of the objectives. For example, it was not uncommon for prompted conversation about objective one – how having a baby changed their relationship – to spark conversations during the interview about how parents would have less time together as a couple (objective 2) and how important it was to make time for each other and divide chores equally (objective 3). This is not necessarily a negative finding, as it is arguably more important that parents took actionable and memorable information away from the sessions, rather than knowledge of which precise objective said information aligns to.

The key areas recalled are outlined in Figure 7.2.

Figure 7.2 Extent to which parents felt the session raised their awareness

Objective one 'Me, you and baby too'

Having a baby can cause unexpected changes in relationships

'*I think I was very naive and thought "the relationship wont change, it will be fine, it will always be the same*".' **Female**

Objective two 'Why does it matter'

Parents' relationship can impact on the baby

Importance of making time for each other

'*Like a sponge, they absorb everything.*' **Female**

Objective three 'Changes and challenges'

The impact of tiredness/ exhaustion and the importance of supporting each other

Common things parents may argue about and how to deal with these arguments

The importance of sharing chores and responsibilities

'*A huge burden lifted, we were able to talk about it before so my husband was supportive later when I was so tired.*' **Female**

Changes to sex life

'*It's about looking after each other.*' **Female**

Objective four 'Communicating and managing conflict'

The importance of communication

How to cheer each other up/do nice things for each other

'*Even if your relationship is good, little things can cause arguments.*' **Male**

'[We talk more]... *before, we didn't want an argument so we probably just wouldn't speak about it and brush it off.*' **Female**

Other specific points raised:

- Discussion around where to go for help, e.g. online, although hardly any had used these materials as they did not feel they needed it (pilot objective 2: signposting couples to futher support).
- Information and support around post-natal depression: often came out during discussion around objective 3 (not specifically covered in the OnePlusOne materials, likely part of existing provision).

Handout 1-3 pulled out as specific examples of activities/conversations held during sessions.

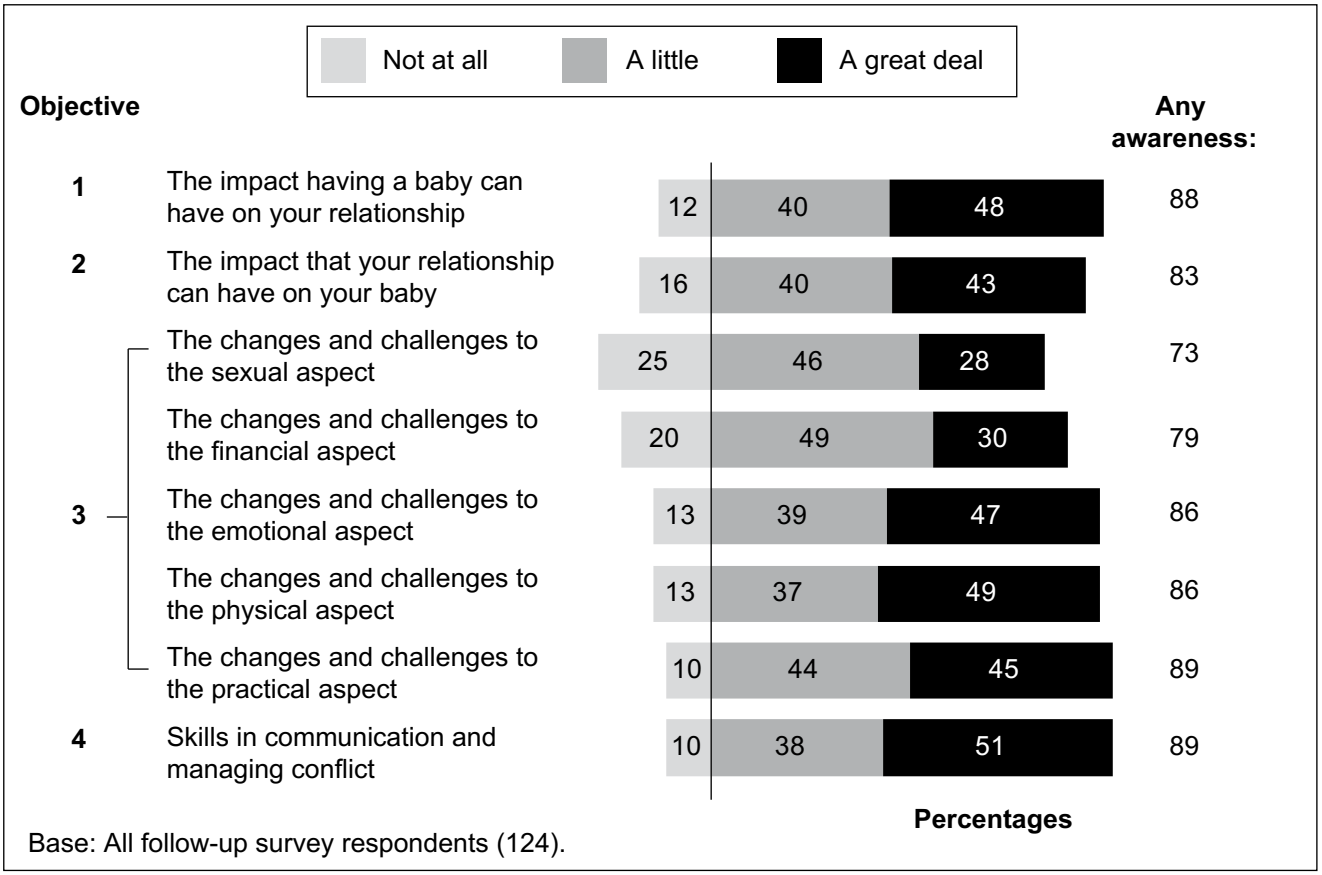
7.3 Effectiveness

7.3.1 Quantitative findings

Awareness

In order to unpick how effective the sessions were, parents were asked to reflect on how well they had raised their awareness of each of the objectives[41] – as listed in Figure 7.3.

Figure 7.3 Extent to which parents felt the session raised their awareness[42]



Base: All follow-up survey respondents (124).

As shown, the majority felt it had raised their awareness of each issue at least a little (ranging from 73 per cent to 89 per cent), and around a quarter to a half on each felt it had done so 'a great deal'.

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41 As mentioned earlier these were:
1. raising parents' awareness of the impact a baby can have on their relationship;
2. raising parents' awareness of the impact their relationship with one another has on their baby;
3. preparing parents for the changes and challenges to their relationship: physical, emotional, sexual, financial and practical; and
4. helping parents develop skills of communication and managing conflict.

42 Rows do not total to 100 per cent due to rounding.

Results were least positive for the third objective about changes to the sexual aspect of the relationship (25 per cent stated that it did not raise their awareness at all).

Fathers were more likely than mothers to report that the session raised their awareness of a number of the objectives:

- The impact having a baby can have on your relationship generally (63 per cent reported the session raised their awareness 'a great deal' compared to 37 per cent of mothers).
- The changes and challenges having a baby can bring to the physical aspect of your relationship (63 per cent reported the session raised their awareness 'A great deal' compared to 39 per cent of mothers).
- The changes and challenges having a baby can bring to the emotional aspect of your relationship (only 4 per cent reported that the session did not raise their awareness of this at all, compared to 19 per cent of mothers).
- The changes and challenges having a baby can bring to the sexual aspect of your relationship (only 10 per cent reported that the session did not raise their awareness of this at all, compared to 36 per cent of mothers).
- The impact that your relationship can have on your baby (56 per cent reported the session raised their awareness 'a great deal' compared to 33 per cent of mothers).

Key messages

Respondents in the quantitative survey were asked an open-ended question about what they took away as the key messages of the session. From this, the following emerged:

- Importance of communication and of speaking openly and honestly about their feelings.

  'Communication between you and your partner, if anything is wearing you down; just confide in your partner and just support each other.'

  (Female, antenatal class)

- Importance of making time for each other as a couple after the birth.

  'Making time for myself and my partner, and making time for each other on a one-to-one basis and not letting the baby take over everything in the relationship.'

  (Female, home visit)

- Understanding that it is perfectly normal for a relationship to change after childbirth.

  'Normal for parents with newborn babies to have difficulties; normal to have ups and downs.'

  (Female, home visit)

- Having an understanding of the exhaustion that comes with becoming parents, which may make each other more irritable.

  'It's more about liaison, remember that tolerance levels will be shattered and you have to work together. Things could be quite difficult.'

  (Male, antenatal class)

- Accepting help from friends and family, and of not having to do 'everything' by themselves.

  'Bringing a child into the world is a team effort. I should allow people to help rather than doing everything on my own.'

  (Male, antenatal class)

7.3.2 Qualitative findings

Parents in the qualitative interviews who felt the session had increased their awareness of the key issues, at least to some extent, struggled to recall the specifics of what conversations had increased their awareness and how it had changed their behaviour.

'Nothing that I can pick out individually, but practically I think all those points have made their way into our behaviour and how we have prepared for having a child in some way.'

(Male, antenatal class)

That said, parents did note that the sessions raised their awareness of the importance of:

- Communicating more and making greater efforts to discuss things calmly rather than letting feelings and tension build up.

  '[We talk more]*, whereas before, we didn't want an argument so we probably just wouldn't speak about it and brush it off.'*

  (Female, home visit)

- Being more aware of the impact things like tiredness can have and how this can lead to arguments.
- Making time for each other. For example, one respondent said right after the birth she had felt underappreciated and that they had tackled this by agreeing on a weekly date night.

  'Yes, trying to have that little bit of time, just us without the baby and then just having more hugs as opposed to anything else.'

  (Female, antenatal class)

7.4 Changes in behaviour

7.4.1 Quantitative

The majority (83 per cent) of quantitative participants reported that they had discussed the content covered in the relationship session with their partner (31 per cent 'a lot' and 52 per cent 'a little'). Additionally, almost three-fifths (56 per cent) of participants stated that they changed their behaviour because of something they learned from the session (18 per cent 'definitely' and 38 per cent 'a little').

7.4.2 Qualitative

In qualitative interviews, parents often mentioned action they took as a result of hand-out 3 'I feel loved and cared for when …'. Others mentioned that they talked with their partner about splitting the housework and discussing any problems before they turn into an argument.

'After the session he [husband] *said we needed to be a bit closer, not falling out over who's loading the dishwasher. We both had the same sort of thoughts.'*

(Female, antenatal class)

Those who reported in the qualitative interviews that they had changed their behaviour gave examples such as making more time for each other, being more honest with each other when feeling stressed or down, and being more laid back where possible. One respondent explained that they will simply periodically think back to the session and make a conscious effort to talk more.

'Yes, trying to have that little bit of time just us without the baby'

(Female, antenatal class)

'We do think back to the sessions and talk about things more, so it has helped.'

(Female, home visit)

'Nothing that I can pick out individually, but practically I think all those points have made their way into our behaviour and how we have prepared for having a child in some way.'

(Male, antenatal class)

7.5 Use of free materials

Around three-fifths (59 per cent) of quantitative follow-up survey parents stated that they received some free materials from the session. When asked which hand-outs they received, most (80 per cent) simply mentioned hand-outs and leaflets, without being specific. Of those participants that received free materials, just over a third (35 per cent) said they used these, and a further 45 per cent said they dipped into them or briefly referred to them. At the time of the follow-up survey, 69 per cent of those who had received free materials reported that they had kept them.

In terms of signposting to further materials, 42 per cent of parents said they were signposted to further sources of information or advice, though only about a third (32 per cent) used these (21 per cent used them and 11 per cent dipped into them or only briefly used them). The majority (90 per cent) of participants that used materials they were signposted to found them useful. In terms of what they were signposted to, the sources mentioned were:

- Apps or websites (35 per cent of those signposted).
- Charities or Trusts (15 per cent).
- Counselling (11 per cent).
- Groups or classes (10 per cent).

In the qualitative follow-up survey, parents recalled being told about websites they could visit, though but could rarely name the specific websites that they were directed to.

8 Conclusions

The main conclusions that it is possible to draw from the results of this evaluation are:

Rolling relationship support into existing provision is effective. Antenatal classes were a particularly good route for reaching fathers. The findings indicate that participation rates would have been much lower for stand-alone classes and that some participants initially found the concept of relationship support either intimidating or irrelevant to them at this point (despite going on to find the sessions useful). The fact that parents were particularly likely to attend antenatal classes as couples made them particularly well-suited to this type of provision, given that the content is aimed at helping couples deal with the arrival of a new baby (although the reach of home visits is possibly more diverse).

Cementing the provision might need more direct contact with practitioners. Maintaining the longevity of an initiative delivered by health visitors and midwifes is hard. Staff turnover is high (in terms of individuals leaving the organisations but also in terms of movement between roles). The key lessons learnt, in terms of making this type of provision work in future, are that the training should be designed in such a way to make it possible for it to be cascaded on to others (without relying heavily on digital resources, as access to IT equipment at work is limited). Establishing direct links between practitioners themselves and the organisation delivering/supporting the training would also be more effective than working through centralised contacts in each area: unlike the delivery leads, the practitioners were trained in delivering the content and had more of a hands-on role in its integration. Therefore, it might have been more effective and efficient for them to liaise directly with OnePlusOne, without the need to go through the delivery leads.

The results from the pilot point to a small positive impact on the quality of relationships. The parents that participated in the pilot avoided the decline in relationships that would normally be expected in the period immediately after the birth of a baby and showed a small positive improvement in communication. Furthermore, they were slightly more likely to consider seeking relationship advice if they encountered difficulties after the intervention than before.

This is encouraging given the light-touch nature of the intervention. The amount of time dedicated to covering the material within antenatal sessions was quite small (around an hour in class settings and considerably less than this in home visits).

However, the nature of the evaluation means that these results should be interpreted with some caution. The assessment of impact has been made by comparing views and experiences before and after the intervention. With this approach, it is difficult to control for any change that might have taken place anyway. The use of standardised scales and making comparisons with other studies that have explored changes in relationship around the time of the birth of a child makes it possible to have more confidence in the interpretation of results than would otherwise be possible. However, these other studies were obviously conducted among different groups of parents who may have had different characteristics to the pilot participants.

Possible implications for best practice are:

- If both midwives and health visitors are involved in delivery then it might be worth running **separate sessions** for each audience as their levels of experience with and comfort with delivering relationship education differ.
- **Hard copy/printed** packs of materials to use and the training to support them are likely to be required. Lack of access to technology in the workplace means that midwives and health visitors struggle to make use of e-learning materials. Durable hard copy materials also make it easier for training to be cascaded (which is likely to be important in ensuring the longevity of a new initiative, given levels of staff turnover and movement between roles).
- Ideally, relationship education sessions should take place **early on** in antenatal provision (as parents become more preoccupied with more practical aspects of new parenthood later on) but **after** there has been a bit of time for rapport to be built between the practitioner and parents (and between parents in a group set-up).
- Ideally, relationship education sessions should involve **both partners** (fathers were sometimes the most positive about the provision and felt that it gave them a role).
- **Interactive exercises** worked well to stimulate debate and help parents apply some of the relationship education content to their own scenarios. Parents were also most likely to find the visual stimulus (e.g. the **cartoons**) memorable.
- There was some indication that a **follow-up or refresher session** (possibly after the birth of the baby) could help to cement some of the learning.

Appendix A
Interview details

This appendix provides a full breakdown of the interviews conducted at each stage of the evaluation:

- Site visits by area (Table A.1).
- Initial surveys by area (Table A.2).
- Demographic profile of quantitative initial and follow-up survey participants (Table A.3).
- Demographic profile of qualitative follow-up survey participants (Table A.4).

Table A.1 Breakdown of site visits conducted by area

NHS area	Date of visit	Type of visit	Interviews conducted
Derby Hospitals NHS Trust	Monday 2 November 2015	Observation of a 2-hour evening antenatal class	Midwives Exit interviews with parents
Suffolk County Council and Ipswich Hospital NHS Trust	Friday 4 December 2015	Observation of day session	Midwives Exit interview with parent
South Tyneside Foundation Trust and Sunderland Royal Hospital	Wednesday 4 November 2015	Observation of 3 30-minute home visits with health visitor	Health visitor
St Helens and Knowsley NHS Trust	Thursday 29 October 2015	Observation of 2-hour evening antenatal class	Midwife Exit interviews with parents

Table A.2 Breakdown of initial surveys received by area

NHS area	Quantitative initial surveys	Quantitative follow-up surveys	Qualitative follow-up surveys
Croydon Health Services NHS Trust	22	10	4
Derby Hospitals NHS Trust	29	13	8
Suffolk County Council and Ipswich Hospital NHS Trust	5	2	1
Leicestershire Partnership Trust	34	16	6
South Tyneside Foundation Trust and Sunderland Royal Hospital	10	2	1
St Helens and Knowsley NHS Trust	235	81	20
Total	**335**	**124**	**40**

Table A.3 Demographic profile of initial survey participants

Demographic	Class (%)	Home visit (%)	Total (%)
Gender (pre):			
Male	46	14	42
Female	54	86	58
Relationship status (pre):			
Together (married, living together, steady relationship)	99	98	100
Single	-	2	<1
Attended the session with partner (pre):			
Yes	96	46	89
No	5	55	11

Note: Initial survey base – class: 291, home visit: 44.

Table A.4 Demographic profile of follow-up survey participants

Demographic	Class (%)	Home visit (%)	Total (%)
Gender (pre):			
Male	36	11	32
Female	64	89	68
Ethnicity (post):			
White	89	83	88
Asian	10	11	10
Other	2	6	2
Relationship status (post):			
Together (married, living together, steady relationship)	98	100	98
Single	2	-	2
Attended the session with partner (pre):			
Yes	97	33	88
No	3	67	12
Age (post):			
18-24	8	22	11
25-34	68	44	65
35-44	22	33	23
Refused	1	-	1

Note: Follow-up survey base – class: 106, home visit: 18.

Table A.5 Demographic profile of qualitative follow-up survey participants

Demographic	Class (n)	Home visit (n)	Total (n)
Gender (pre):			
Male	6	0	6
Female	27	7	34
Ethnicity (post):			
White	30	7	37
Asian	3	0	3
Relationship status (pre):			
Together (married, living together, steady relationship)	33	7	40
Attended the session with partner (pre):			
Yes	31	2	33
No	1	6	7
Age (post):			
18-24	2	2	4
25-34	21	2	23
35-44	10	3	13

Appendix B
Perinatal pilots: survey instruments

1 Scoping Stage – Topic guide for delivery leads

Perinatal pilots

Scoping interviews with delivery leads Teledepth

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1 Introduction to the research

- **Introduce self**
- **On behalf of the Department for Work and Pensions, IFF Research and the Tavistock Institute are conducting some research into the Perinatal Pilots. You should have received an e-mail about this project. We would like to ask you about the background of your area and the perinatal provision you currently have in place. We're also keen to hear how you became involved in the pilot and any early thoughts you may have on the delivery of the pilot and its goals and collect some information.**
- **As you are aware, the pilot will introduce relationship education into perinatal provision in several NHS trusts and local authority areas. The training for those delivering relationship education was provided by OnePlusOne; experts in relationship advice. Ultimately the pilot intends to:**
  - Prepare couples for the impact having a baby will have on their relationship;
  - Provide relationship and communication skills; and
  - Signpost to further support.
- **Jointly with the Tavistock Institute, IFF will be conducting qualitative and quantitative research with delivery leads, midwifes and health visitors as well as those who receive sessions.**
- **The information you give will be used for informing decisions about whether the DWP should encourage wider adoption of this approach. It will also be used to draw out key lessons learned and examples of best practice.**
- **Your participation in the research is entirely voluntary and will not affect your future dealings with the department. You can withdraw from the research at any time.**

- **Any information you provide will be held in the strictest of confidence and will be handled securely throughout the study in line with the requirements of the Data Protection Act (1998). The information you provide will be used only for research purposes and the research findings will not identify you.**
- **The study has not applied for approval under the MCA which means it can only include respondents who have the capacity to consent to their own participation.**
- **Do you consent to take part in this research?**
  - Yes
  - No
  - Don't Know [Ask if they would like further information or time to consider]

A: Job role and background

- **To begin, could you tell me a little about your job role?**

PROBE:

- Job title and what this means in practice
- How much is related to perinatal provision specifically; do they have contact with parents?
- How many staff do they manage / are they responsible for
- Where they are based on a day-to-day basis; within a hospital vs. community setting.

- **And could you tell me a little about how maternity services are set up in the area?**

PROBE:

- How many hospitals, clinics and children centres are there?
- Are there any particular issues/challenges that are specific to the area?

- **How / why did you get involved with the pilots?**

PROBE:

- Did you volunteer? Or were you asked?
- How keen were you to participate? *IF VOLUNTEERED:* Why did you volunteer?

- **Did you have any involvement in deciding which practitioners went on the training course?**

PROBE IF YES:

- What considerations did the selection process involve e.g. what levels of staff? Prior experience / job roles e.g. midwives vs. health visitors? Whether had suitable skills for delivering the support?

- Did employees volunteer or were they approached / was it mandatory?

PROBE IF NO:

- Do you know how individuals were selected?

- **And how involved do you anticipate you will be in the day-to-day running of the pilot?**

PROBE:

- How much of your time do you anticipate it will take up?
- Will you be the first point of contact for those delivering the support? IF NO; who will that be and what is your working relationship with them?
- Will you attend any of the sessions yourself either to monitor progress or make suggestions?
- Will you expect those delivering the support to report into you?
    - *PROBE IF EXPECT REPORTING:* What sort of thing will you require them to report? How often?

B: Current perinatal provision

KEY QUESTION: FULLY PROBE TO UNDERSTAND CURRENT LANDSCAPE OF PERINATAL PROVISION

- **Beyond standard antenatal appointments, scans and postnatal checks, what other perinatal support or information are usually offered in this area?**

PROBE:

- Content and length of sessions? Structure (e.g. one off or course)?
- Antenatal vs. postnatal provision? At what point in pregnancy / postnatally?
- Delivered in hospital vs. community? (e.g. household visits or children centres)
    - ~ *IF VARIES:* Why does it vary? Does it depend on; resourcing? Parent needs / preferences?
- Who is it delivered by? Health Visitors or Midwives or combination?
- Does provision vary across your area? (e.g. in different hospitals) and if yes, in what way?

INTERVIEWER NOTE: PROBE FOR EACH ELEMENT OF PROVISION MENTIONED:

- **Is this support offered universally or selectively?**

PROBE:

- *IF SELECTIVE:* Who gets offered this support? How are decisions made on who to offer to?

- When do you usually offer support and/or information to parents; at what stage of pregnancy? At what stage of the postnatal period?

- **What types of parents typically take up perinatal sessions in this area? How does it compare with the typical profile in the area?**

PROBE IF DIFFERS:

- How does the profile of attendees differ to the typical area profile?
  - ~ Older or younger?
  - ~ Over or under representative of a particular ethnicity or socioeconomic status?
  - ~ Relationship status?

- **Does it tend to be one parent or both parents who take up sessions? Does anyone else attend e.g. friends, other family members / in-laws?**

PROBE:

- How common is it…
- For mothers to come on their own
- For fathers to attend (with the mother and/or on their own)
- For family members or friends to attend

- **Are there any sessions fathers are more likely to attend (in terms of content, location / time)?**
  - *PROBE:* content, location / time

- **How common is it for:**
  1. Those who already have a child/children to attend
  2. Same sex parents to attend
  3. Adoptive parents to attend

- **Are there any other providers of antenatal/postnatal provision active in your area (e.g. NCT or similar)?**
  - *PROBE IF NOT EMERGED ALREADY:* Who typically chooses alternative provision? Do they differ from those who attend your sessions?

- **To what extent do you think relationship support is something that is currently missing from perinatal provision in your area?**

  INTERVIEWER NOTE: I.E. DO THEY THINK THE PILOTS WILL BE USEFUL / ARE A GOOD IDEA?

PROBE:

- Who do you think it will be most suitable for?
- Do you think the OnePlusOne content is right for your area? Why / Why not?

C: Delivery of the perinatal pilots

INTERVIEWER NOTE: THIS SECTION IS LOOKING FOR MORE DETAIL ABOUT HOW THE PILOT WILL BE DELIVERED AND EARLY THOUGHTS ABOUT ANY CHALLENGES.

READ OUT: **As you may be aware, the information from OnePlusOne covers an hour's worth of content.**

KEY QUESTION: FULLY PROBE TO UNDERSTAND CURRENT LANDSCAPE OF PERINATAL PROVISION

- **How will this be delivered in your area?**

PROBE:

- **In <u>one session</u> vs. <u>multiple sessions</u>? Or will it be <u>left to the discretion</u> of those delivering the support?**
- **Whether the <u>whole hour</u> will be covered (either in one session or in multiple sessions) or again will it be left to the discretion of those delivering the support?**
  - *IF LEFT TO DISCRETION IN TERMS OF DELIVERY AND / OR CONTENT:* How much consistency are you expecting? For example, will midwives have a different approach to health visitors?
- **Offered universally to parents or selectively?**
  - *IF SELECTIVELY:* How will decisions be made about who to offer it to? When?
- **How widely are you offering the relationship education in your area?**
  - All areas vs. just some? IF SOME: How many?
- **Is it intended that the relationship support will be provided on top of what is already delivered or will it replace content elsewhere?**
  - *PROBE IF ON TOP OF:* How will this be resourced? In terms of practicality and financially?
  - *IF DISPLACE:* What will it displace? What are your views on this?
- **What steps did you take to ensure the relationship education session could be fitted into your existing provision?**

- **Are there any plans to record whether parents have received the relationship support?**
  - *PROBE IF YES:* How will this be recorded E.g. on their antenatal notes/ red book, or any internal notes?

- **Do you envisage the delivery to change as the pilot progresses?**

  INTERVIEWER NOTE: i.e. is this a 'test the waters' approach or is it set in stone?
  - *PROBE:* in terms of how and when e.g. content covered, whether covered in one session or multiple sessions, at what stage in the pregnancy or postnatal period, where e.g. focused more on 'in-hospital' or community setting?

- **Do you have any plans to monitor or seek feedback on how the pilots are going?**
  - *PROBE:* Who will you speak to as part of this evaluation? When will you speak to them? How will you collect their feedback (e.g. informal discussions, a survey?)

- **Do you have any early thoughts on anything you think might work well?**

PROBE:
  - In terms of practicality of delivery
  - In terms of the value / impact of the support for parents

- **Do you have any early thoughts on anything you think might prove challenging?**

PROBE:
  - In terms of practicality of delivery
  - In terms of the value / impact of the support for parents

IF ONLY SOME AREAS INVOLVED IN PILOT:

- **Do you have a sense yet of whether you are likely to encourage other areas in your Trust to integrate the relationship education into perinatal provision?**
- **What support would you find helpful if you were to expand the delivery of the relationship education sessions?**

D: Obtaining contact details / permission for pre-survey

As part of the evaluation of the perinatal pilots we are doing for the DWP we really want to speak to parents before they receive the relationship support as well as after. This will help in tracking any changes in their situation and / or attitude and ultimately how the support has impacted on their relationship. It's really important that we understand from you whether there is scope for getting contact details of parents who will likely be receiving the support in the future (at least a few weeks in advance).

KEY AREA TO EXPLORE

INTERVIEWER NOTE: EXPLORE ALL AVENUES OF GETTING CONTACT DETAILS OF SIGN-UPS IN ADVANCE BASED ON WHAT RESPONDENT HAS TOLD US IN SECTION B AND C ABOUT DELIVERY PLANS.

AS WELL AS CONTACT DETAILS WE NEED A SIGNED PERMISSION FORM FROM PARENTS TO ALLOW US TO CONTACT THEM FOR PURPOSES OF THE RESEARCH – AND SO SIGN UPS WILL NEED TO BE FACE TO FACE.

INTERVIEWER NOTE: IF NOT ALREADY EMERGED, ASK QUESTIONS BELOW:

- **How and when will the relationship support be introduced to parents; will they be invited to attend in advance or will those delivering the support cover relevant content as and when deemed appropriate?**

PROBE IF INVITED IN ADVANCE:

  - How far in advance?
  - What levels of drop outs might they expect between sign up and session?
  - Will / can their contact information be taken when they sign-up? Can they collect telephone numbers and ask permission for them to be contacted by us?
  - Do they anticipate fathers being there at the point of sign up? (rarely / sometimes / mostly)

- *IF NOT IN ADVANCE / NOT VERY FAR IN ADVANCE:* **Is there any scope at all for collecting details in advance / earlier?**

PROBE:

  - At any earlier appointments or sessions?
  - Any possibility of inviting them to sessions earlier?

E: Final thoughts on the pilots

To wrap up, we'd just like to get your final thoughts about the perinatal pilots, specifically in terms of involvement from the DWP and support provided and given by OnePlusOne:

- **How much involvement are you expecting from DWP in implementing and delivering these pilots?**
  - *PROBE:* Will you be required to report progress to them? If yes, what do you anticipate reporting and how often?

- **Did you take up the grant funding offer from the DWP?**
  - Why / why not?
  - *IF YES:* How helpful was this? In what ways?

- **How much involvement are you expecting from OnePlusOne?**
  - PROBE: If you or those delivering the support require further information or support will you be able to go to OnePlusOne for advice?

- **Have you seen the training materials from OnePlusOne?**
  - *PROBE IF YES:* What do you think of them?
  - *PROBE IF NO:* Do you have an idea of what the relationship support involves?

- **Have you had any feedback on the OnePlusOne training from those who have been on the course?**
  - PROBE: Does this tend to be positive or negative? What sort of things are coming out?

  READ OUT: **As you may be aware, the training has been designed to help providers to encourage parents to reflect on their relationship and to facilitate discussions.**

- **Do you have a feel for how different or similar the support is to what those delivering the support are used to / experienced in?**

PROBE:

- In terms of the content and the way it is to be delivered (i.e. to facilitate discussion rather than give advice)?
- In terms of their experience of delivering support of this nature.

F: Thank and Close

INTERVIEWER NOTE: ASK ALL

- **Further down the line we will be selecting five areas to visit and conduct more in-depth evaluation work with. This will involve viewing perinatal sessions and speaking to health visitors and midwives as well as participants. The visits are likely to be in October / November 2015 time. Would you see any issues with this if your area was selected?**

- **Thank you for your time today, would it be ok for us to come back to you and clarify any of this information if we need to?**

Yes (CHECK BEST TELEPHONE NUMBER TO CALL)	1	
NO	2	

I would just like to confirm that this survey has been carried out under IFF instructions and within the rules of the MRS Code of Conduct. Thank you very much for your help today.

2 Site visits – Health visitor / midwife topic guide

5520 – Site visit topic guide with midwives / health visitors

Introduction to the research

- **My name is [name] from IFF Research, an independent research company.**
- **[Name of local NHS or LA area] is including relationship education in perinatal provision, as part of a Department for Work and Pensions (DWP) pilot study.**
- **On behalf of the Department for Work and Pensions, IFF Research and the Tavistock Institute are conducting some research into this pilot. The research will be used to understand the effectiveness of this pilot and inform decisions about whether to include relationship education more widely within perinatal provision.**
- **We would like to ask you about your experience being involved with the pilot and to collect some information. The interview will cover your thoughts about the OnePlusOne training, and your experience of delivering the pilot. The interview will take up to one hour.**
- **Your participation in this research is entirely voluntary and will not affect your future dealings with the department. If you agree to take part you do not have to answer all of the interview questions, and you can also choose to end the interview at any time.**
- **Any information you provide will be held in the strictest confidence and will be handled securely throughout the study in line with the requirements of the Data Protection Act (1998). The information you provide will be used only for research purposes and the research findings will not identify you. You will not be identified in any published research reports.**
- **The study has not applied for approval under the MCA which means it can only include respondents who have the capacity to consent to their own participation.**
- **Do you consent to take part in this research?**
  - Yes
  - No
  - Don’t Know [Ask if they would like further information or time to consider]
- **With your permission, the interview will be audio recorded to ensure that we report all views as accurately as possible. The information recorded will be used for research purposes only and will be deleted once the research is completed. It is entirely up to you whether we record the interview and we can take notes if you’d prefer.**
- **Are you happy to be recorded during the interview?**
  - Yes
  - No
  - Don’t Know [Ask if they would like further information or time to consider]

Key discussion points

- **Background**
  - What is your job title?
  - What were your initial reactions/thoughts about being involved in the pilot?
  - Do you have to report in to anyone (and, if so, what do you have to report?)
  - What is your level of experience/how long they have you been working in your current role?

- **Thoughts on the OneplusOne training / content**
  - How did you find the e-learning?:
  - What are your overall views on the content (e.g. in terms of the breadth of information covered and level of detail)?
  - What are your views on the e-learning resources?
    - ~ How useful did you/do you find it?
    - ~ How much of it did you use before the face-to-face workshop (if any))?
    - ~ How often do you refer back to it now (if at all)?
  - What do you think is the most useful part of the e-learning?
  - What do you think is the least useful part of the e-learning?
  - What do you think about the length of the e-learning?
  - Do you think there was anything missing from the e-learning?
  - How could the e-learning be improved?
- **How did you find the skills workshop?:**
  - What are your overall views on the content (e.g. breadth of information covered and level of detail)?
  - What do you think is the most useful part of the workshop?
  - What do you think is the least useful part of the workshop?
  - What do you think about the length of the workshop?
  - What do you think about the style of delivery / teaching style?
  - How did the training course compare to other courses you have attended?
  - Do you think there was anything missing from the training?
  - What are you views on the printed resources provided by OnePlusOne ?
  - How could the training programme be improved?
- **Which part of the training was most helpful: the e-learning or skills workshop?**

- **Have you used the free app (from the apple store) which includes all the materials and e-learning resources? If yes, what do you think of it?**

- **Delivery**
  - What setting(s) do you deliver your training in NOTE: if talking to the midwife observed, just ask if they deliver it in any other session/setting
  - How many sessions are you responsible for?
  - When are the sessions that you run (e.g. day, time of day etc.)

- **The sessions**

  <u>Recruitment for the sessions</u>
  - How and when are parents introduced to the session?
  - What are parent's reactions when introduced to the session?
  - Are there any difficulties with recruiting harder to reach groups? *USE SHOWCARD WITH EXAMPLES*
  - *IF MENTION DIFFICULTIES:* Do you have any suggestions for how this/these recruitment difficulties could be overcome?

  <u>Attendance</u>
  - Who attends the sessions? (fathers, friends/family, same sex parents, adoptive parents)
  - Are there any sessions fathers are more likely to attend? E.g. on certain days, at certain times, at classes or in home sessions, anything related to the content of the class itself etc. If yes, which ones and why?
  - [IF PARENTS REGISTER FOR THE SESSIONS IN ADVANCE]:
    - ~ What are the typical levels of drop-outs/no shows for the perinatal pilot sessions?
    - ~ How does this compare with other perinatal sessions?
    - ~ Are any particular types of parents more likely to drop-out or not show up?

<u>Delivery of the sessions</u>
- How confident are you in delivering the material?
- Are there any sections that feel uncomfortable to deliver / parents seem uncomfortable receiving?
  - ~ Is there anything particular to a given type of parent? USE SHOWCARD WITH EXAMPLES
  - ~ Do you think the extent to which you feel comfortable has anything to do with your prior experience (e.g. do you feel equipped with the right skills to be delivering the training/ certain aspects of the training)

The content

- What parts of the training did you initially decide to use and why (if not all of them)?
- How did you initially decide which content to deliver?
- Has what you deliver changed from what you initially decided to deliver? If yes, how and why?
- Do you use the same parts with all parents, or tailor to the individual person/ couple? How / why?
- If sensitive issues were to arise, to what extent would you feel able to signpost parents to services for help (e.g. counselling service, domestic violence support, etc?)
- IF HAS NOT EMERGED: Have you signposted parents to the additional online material e.g. materials on www.meyouandbabyto.co.uk? Why / why not? IF NOT: Do you intend to?

Integration of the sessions WHERE RELEVANT / DON'T KNOW FROM LEAD

- How have you found integrating the pilot material into existing sessions?
  - ~ Did you have to drop other perinatal material to accommodate the pilot material?
  - ~ IF HAD TO DROP MATERIAL:
    - ~ How did you decide what to drop?
    - ~ Did you have to reach a compromise on what to keep and what to exclude?
    - ~ IF HAD TO REACH COMPROMISE: How happy are you with this compromise?

Reactions to the sessions

- How would you say parents react/engage with the sessions?
  - ~ To what extent do parents participate in the exercises/discussions and how?
  - ~ To what extent do parents appear interested or disinterested in the materials? How / in what ways?
  - ~ Have you had any comments or feedback on the materials?
- And how would you say Dads react/engage with the session in particular?

  IF NOT EMERGED:
  - ~ To what extent do Dads participate in the exercises/discussions and how?
  - ~ To what extent do Dads appear interested or disinterested in the materials? How / in what ways?
  - ~ Have you had any comments or feedback on the materials from Dads?

- What sections spark the most reaction? This can be either good or bad e.g. sections that spark the most conversation?
  - ~ Is there anything particular to a given type of parent e.g. Dads, teenage or younger parents, minority ethnic groups, those with severe disabilities etc?
- To what extent are parents willing to share information about their own relationships during the session?
  - ~ How honest do you think parents are during the session?
- To what extent are there opportunities to discuss parents' individual relationship problems/needs?
  - ~ What are your views on the extent of this opportunity (i.e. do they think there is enough focus or not enough focus on this?).
- Are there any sections / exercises that feel less relevant or important to parents?

INTERVIEWER TO EXPLORE SPECIFIC THOUGHTS ON EACH OF THE FOUR ONEPLUSONE OBJECTIVES AVOIDING REPETITION WITH EARLIER CONVERSATIONS.

INTERVIEWER TO BE FAMILIAR WITH THE EXERCISES UNDER EACH OBJECTIVE TO BE ABLE TO PROMPT AS NECESSARY; ALSO TO HAVE TRAINING PACK TO HAND.

- The OnePlusOne material spans four key objectives:
  - ~ Have you been able to use something from each of the following…? INTERVIEWER NOTE: take note of which sections they have used and then ask:
  - ~ What has worked well / less well?

1. **Me, you and Baby too** – *Objective: To raise parents' awareness of the impact a baby can have on their relationship*
2. **Why does it matter?** – *Objective: To raise parents' awareness of the impact their relationship with one another has on their baby*
3. **Changes and challenges** – *Objective: To prepare parents for the changes and challenges to their relationships: Physical, emotional, sexual, financial and practical.*
4. **Communicating and managing conflict** – *Objective: to help parents develop skills of communication and managing conflict*

- **Overall thoughts**
  - Can you think of any other successes or challenges in delivering the pilot that we have not already covered?
  - How confident are you in the future of the pilot / delivery (do you see it as something that should be implemented more widely?)
  - To what extent do you think relationship education is something that has been missing from perinatal provision?
  - Do you have any recommendations for the future of the delivery?
  - Do you have any other comments?

Logistics of pre-survey

- How do you feel about:
  - Handing out the pre-survey before your sessions?
  - Collecting the pre-survey back before your sessions?
  - Collecting the pre-survey back in at the end of your sessions and handing them on to a central contact (e.g. a colleague)?
- SHOW THEM COPY OF PRE-SURVEY:
  - Do you have any feedback?
  - Is there anything you don't understand / think parents will not understand?
- How do you feel about being on standby to help parents if they don't understand a particular word or questions?
- Is there any further guidance or support in terms of the pre-survey that would be helpful to you (in terms of the content or the logistics in handing them out and collecting them)?

I would just like to confirm that this survey has been carried out under IFF instructions and within the rules of the MRS Code of Conduct. Thank you very much for your help today.

SHOWCARD

- Fathers
- Teenage or younger parents
- Minority Ethnic Groups
- Refugees and asylum seekers
- Those who do not speak English as their first language
- Those experiencing domestic violence
- Those with mental health problems
- Those with severe disabilities
- Those who live in poverty, and those who are homeless or live in temporary housing
- Those from the travelling community

3 Site visits – Observation sheet

5520 site visit session observation sheet

- **My name is [name] from IFF Research, an independent research company.**
- **[Name of local NHS or LA area] is including relationship education in perinatal provision, as part of a Department for Work and Pensions (DWP) pilot study.**
- **On behalf of the Department for Work and Pensions, IFF Research and the Tavistock Institute are conducting some research into this pilot. The research will be used to understand effectiveness of this pilot and inform decisions about whether to include relationship education more widely within perinatal provision.**
- **We would like to observe pilot sessions today and to collect some information. We would like to collect information about attendance, how the session is delivered and parents' responses to the session.**
- **Your participation in this research is entirely voluntary and will not affect your future dealings with the department. You can withdraw from the research at any time.**
- **The information that we collect will be held in the strictest confidence and will be handled securely throughout the study in line with the requirements of the Data Protection Act (1998). The information that we collect will be used only for research purposes and the research findings will not identify you. You will not be identified in any published research reports.**
- **The study has not applied for approval under the MCA which means it can only include respondents who have the capacity to consent to their own participation.**
- **Do you consent to take part in this research?**
  - **Yes**
  - **No**
  - **Don't Know [Ask if they would like further information or time to consider]**

Class details

Detail	NOTE
Name of midwife / HV	
Role	
Type / objective of session e.g. Parent craft class	
Total class length	
Total amount of time devoted to OnePlusOne content	

Attendees

- **How many people attending**
- [IF REGISTRATION IN ADVANCE] **How many people were expected to attend?**
- **Who attending** (couples vs. just mothers, just fathers, any other friends / family members)
- Whether any same sex-parents / adoptive parents

Midwives / Health visitors

- **How many are delivering the session and who** (Health visitors vs. Midwives)

Overall views of the session and reactions to OnePlusOne content

IF ONEPLUSONE MATERIAL DID NOT TAKE UP THE WHOLE SESSION:

- **How and when was it introduced to parents?**
- **Was it woven in or introduced as a separate section?**
  - IF SEPARATELY: **How did they react? Did the idea of the training change the general atmosphere?**
    - ~ Did parents make any positive or negative comments in response to the introduction of relationship support content?
    - ~ Were any changes in body language as relationship support was introduced? (e.g. shifting in chairs, looking away vs leaning forward)
    - ~ Did parents appear to feel comfortable or uncomfortable at the idea / introduction of relationship support content?
    - ~ Did these reactions vary depending on the type of attendee (e.g. Mums vs. Dads)?
- **Record comments on parents' reaction to / engagement with the OnePlusOne content**
  - What was the reaction of the class and how did this change throughout the session (if at all)
  - IF ONEPLUSONE MATERIAL DID NOT TAKE UP THE WHOLE SESSION: Did the OnePlusOne content cause a particular lull / lift in atmosphere/engagement?
    - ~ Did parents make any positive or negative comments in response to the relationship support content?
    - ~ Did they participate more or less than during other parts of the session?
    - ~ Were there any changes in body language throughout the session? (e.g. nervous laughter, shifting in chairs, leaning forward)
    - ~ Were there opportunities for parents to ask questions and discuss individual relationship issues?
    - ~ Did parents appear to feel comfortable or uncomfortable discussing relationship issues?
- **Did the above depend on the type of attendee (e.g. Mums vs. Dads)**

- **Record comments on the interaction between health visitors/midwives and parents**

CONSIDER FACTORS SUCH AS:

THE BALANCE BETWEEN STAFF AND PARENTS TALKING,

PACE OF DELIVERY,

ANY DIFFICULTIES IN UNDERSTANDING,

LEVELS OF ATTENTION FROM PARENTS,

LEVELS OF PARENT PARTICIPATION,

RAPPORT

- **Record comments on how engaged with / comfortable midwives/health visitors seemed to be in delivering the OnePlusOne content**
  - How knowledgeable did they appear?
  - Did they appear confident in the material they were delivering?
  - Were they enthusiastic about the content?
  - How did they respond to any difficulties or issues raised during the session?

NOTE IF THIS VARIED BY

  - Type of content
  - Type of attendee they were addressing (e.g. Mums vs. Dads)
    - ~ Did they interact differently with Mums vs. Dads?
- **Any other general comments.**
- **Which activities / materials under each of the four objectives / sessions were used and how?**
  - Eg. Activity 1 ‘You, me and Baby too’, or any of the general ‘Activity for couples or individuals’, relationship insights, film clips, cartoons etc.
  - Examples of how used: Slides on a laptop/projector, handouts, flipchart, discussion only

Session	Activity / material used	How did parents react? Did it depend on the type of attendee e.g. Mums vs. Dad?
Session 1 Me, You and Baby too To raise parents' awareness of the impact a baby can have on their relationship.		
Session 2 Why does it matter? To raise parents' awareness of the impact their relationship with one another has on their baby.		
Session 3 Changes and Challenges To prepare parents for the changes and challenges to their relationship: physical, emotional, sexual, financial and practical.		
Session 4 Communicating and Managing Conflict: Used? To help parents develop skills of communication and managing conflict.		

- **How often was the 'Couple Relationship Wellbeing Plan: Me, You and Baby Too' referred to and used? How did parents respond to this?**

The pre-survey

- **How was the pre-survey introduced by the midwives / health visitors (practically and in terms of how encouraging they were)**
  - To what extent did midwives / health visitors explain the following principles of the research:
    - ~ That questionnaires should be completed anonymously and in private.
    - ~ That the information will be used for research purposes and the research findings will not identify individuals
  - Did midwives / health visitors explain when and where parents should complete the surveys?
    - ~ INTERVIEWER NOTE: It is important that surveys are conducted at a time **before the Perinatal Pilot education session when midwives/health visitors are present**, so that they are on hand to answer queries and see that surveys are completed in private.
  - When and where were the pre surveys actually completed?
  - How were the pre surveys collected? (e.g. in sealed envelopes posted into a box)

- **Was the midwife / health visitor on hand to answer queries?**
  - Did they have enough knowledge to answer queries?
  - Were they willing to assist?
  - What information / guidance did they provide? (Record examples)
- **How did parents react to the idea of the pre-survey?**

CONSIDER:

  - How and where did they complete it (e.g. in the classroom, or outside of the classroom)
  - Did it cause any concern?
  - Did it cause any friction between couples?
  - Did they generally fill it out on their own or discuss it with anyone?
  - Did anyone refuse to do it?
  - Did some types of attendees seem keener than others?
  - Did they raise any queries with the midwife/health visitor?

- **Did there seem to be any practical issues with dissemination and filling out (e.g. enough time, enough space in the room, anything causing confusion or annoyance etc.)**

- **Any other comments**

4 Site visits – Parents exit topic guide

5520 Parents Exit Topic Guide

Introduction to the research and consent

- **My name is [NAME] from IFF Research, an independent research company.**
- **[Name of local NHS or LA area] are including relationship education in perinatal provision, as part of a Department for Work and Pensions (DWP) pilot study.**
- **On behalf of the Department for Work and Pensions, IFF Research and the Tavistock Institute are conducting some research into this pilot. The research will be used to understand the effectiveness of this pilot and inform decisions about whether to include relationship education more widely within perinatal provision.**
- **We would like to ask you about how you found the relationship education session today and to collect some information. We would also like to ask you about the short survey that you were given at the start of the session; it doesn't matter whether you filled this in or not. The interview will take around 5 or 10 minutes.**
- **Your participation in this research is entirely voluntary and will not affect your future dealings with the department. Some people might find some of the questions difficult or upsetting to answer. If you agree to take part you do not have to answer all of the interview questions, and you can also choose to end the interview at any time. Please speak to a course facilitator if you would like any help or guidance about relationships after the interview.**
- **Any information you provide will be held in the strictest confidence and will be handled securely throughout the study in line with the requirements of the Data Protection Act (1998). The information you provide will be used only for research purposes and the research findings will not identify you. You will not be identified in any published research reports.**
- **The study has not applied for approval under the MCA which means it can only include respondents who have the capacity to consent to their own participation.**
- **Do you consent to take part in this research?**
  - Yes
  - No
  - Don't Know [Ask if they would like further information or time to consider]
- **With your permission, the interview will be audio recorded to ensure that we report all views as accurately as possible. The information recorded will be used for research purposes only and will be deleted once the research is completed. It is entirely up to you whether we record the interview and we can take notes if you'd prefer.**

- **Are you happy to be recorded during the interview?**
  - Yes
  - No
  - Don't Know [Ask if they would like further information or time to consider]

Thoughts on the session

MAKE CLEAR THAT TALKING ABOUT RELATIONSHIP PART OF SESSION (IF BROADER THAN ONEPLUSONE)

- What were your overall thoughts on the session?
  - Were there any parts you particularly liked? Why?
  - Were there any parts that you didn't like? Why?
  - *IF NO ACTIVITIES MENTIONED PROBE WITH ACTIVITIES COVERED:*
    ~ What did you think of this activity? Why?
- Any suggestions for possible improvements?

  - Do you think there was anything missing from the session [IF SESSION IS NOT WHOLLY ONEPLUSONE: in terms of relationship advice] that you would've found useful?
  - IF SESSIONS IS NOT WHOLLY ONEPLUSONE: How well did you think the relationship advice aspects of the session fit in with the other topics covered in session?

Learning from the session

- What would you say is the main thing you have learned from the session?
  - *INTERVIEWER NOTE: THE AIM HERE IS TO FIND OUT THEIR 'KEY TAKE OUT'*
    ~ What did you find most useful? ADD IF NECESSARY: What have you learnt?

Thoughts on the pre-survey questionnaire

- Did you fill in the pre-survey?

IF NOT:

- Why was this?

IF YES:

- Overall, how did you find filling in the questionnaire given out before the session?
- Were there any parts of the questionnaire you found difficult to answer?
- IF YES: Why did you find this difficult to answer?
  - PROBE:
    - ~ Sensitive topic (find out which questions)
- Unclear wording / codes (find out which questions)
- Did you feel you needed more guidance on how to complete the survey?
- Did you feel like you could approach the midwife / health visitor if you had any questions?
- Did you feel you were given enough time to complete the survey properly?
- Did you feel that you were given an opportunity to complete the survey in private?
- IF DID NOT HAVE THE OPTION TO GO TO ANOTHER ROOM / PART OF THE ROOM: Would you have liked the chance to fill the survey out in a more private setting? E.g. another room, a more secluded part of the room etc.
- Do you have anything else you would like to say about the session or the questionnaire?
- Are you happy for us to match your feedback here with your responses in the questionnaire?
  - *Interviewer note: take down relevant details*

I would just like to confirm that this survey has been carried out under IFF instructions and within the rules of the MRS Code of Conduct. Thank you very much for your help today.

5 Quantitative initial survey

Antenatal research

- [Name of local NHS or LA area] are including relationship education in antenatal provision, as part of a Department for Work and Pensions (DWP) pilot study. On behalf of the DWP, IFF Research and the Tavistock Institute are conducting research to understand the effectiveness of this relationship education.

How to take part?

- We would really appreciate it you could fill out this questionnaire before today's session begins and hand it back to the midwife or health visitor sealed in the envelope provided.
  - **If you are here today with your partner, please fill in your surveys separately as we are interested in knowing your individual views.**
- We are interested in **comparing parents' attitudes and behaviours before and after they have received the relationship education** and so we would also really like to **speak to you again by telephone after you have had your baby**. If you agree to provide your contact details, this means you may be invited to take part in a telephone interview in around 6 months' time. If you are re-contacted, you will still be able to decide you do not want to take part if you wish.

Confidentiality details

- Your participation in this research is entirely voluntary and will not affect your future dealings with the department. Some people might find some of the questions difficult or upsetting to answer. If you agree to take part you do not have to answer all of the questions, and you can also withdraw from the research at any time. Please speak to a course facilitator if you would like any help or guidance about relationships after filling out the questionnaire.
- Any information you provide will be held in the strictest confidence and will be handled securely throughout the study in line with the requirements of the Data Protection Act (1998). The information you provide will be used only for research purposes and the research findings will not identify you. You will not be identified in any published research reports.
- The study has not applied for approval under the MCA which means it can only include respondents who have the capacity to consent to their own participation.
- Further information about the research and how your contact details will be used is provided at the end of the questionnaire.
- By providing your contact details, you also confirm that you understand that:
  - Your contact details will only be shared for the purposes of contacting you about this research.
  - You can change your mind at any time and withdraw your consent by contacting [INSERT CONTACT DETAILS] and your contact details will be deleted from the contact records for this research.

Consent agreement:

I have read the information overleaf and agree to take part in this research.

Name _____

Signature _____

Date _____

Contact telephone number_____

Email address_____

Section 1: Getting started

Q1. What gender are you?

Male ☐

Female ☐

Q2. How many weeks pregnant are you / is your partner?

PLEASE WRITE IN_____weeks

Q3. What is your relationship situation at the moment?

Married	☐	⇨	Go to Q4
Living together (without being married)	☐	⇨	Go to Q4
Steady relationship without living together	☐	⇨	Go to Q4
Single	☐	⇨	Go to Q10
Other ***(please tick and write in)***	☐	⇨	Go to Q4

…….

Q4. Is your partner attending the session with you today?

Yes ☐

No ☐

Q5. Is the session a class / group or an individual appointment?

Antenatal class or other group session ☐

Individual appointment / home visit ☐

Section 2: Your relationship

Q6. Most people have disagreements in their relationships. Please indicate the approximate extent of *agreement or disagreement between you and your partner* for each item on the following list.

	Always agree	Almost always agree	Occasionally disagree	Frequently disagree	Almost always disagree	Always disagree
Philosophy of life (your approach to life)	☐	☐	☐	☐	☐	☐
Aims, goals and things you believe to be important	☐	☐	☐	☐	☐	☐
About the amount of time spent together	☐	☐	☐	☐	☐	☐

Q7. How often would you say the following events occur between you and your partner?

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often
Have a stimulating exchange of ideas	☐	☐	☐	☐	☐	☐
Calmly discuss something together	☐	☐	☐	☐	☐	☐
Work together on a project / plan something together	☐	☐	☐	☐	☐	☐

Q8. The following boxes represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships.

Please tick the box which best describes the degree of happiness, all things considered, of your relationship.

Extremely unhappy	Fairly unhappy	A little unhappy	Happy	Very happy	Extremely happy	Perfect
☐	☐	☐	☐	☐	☐	☐

Q9. How much do you agree or disagree with each of the following statements?

	Strongly agree	Moderately agree	Neither agree nor disagree	Moderately disagree	Strongly disagree
When we have a disagreement, we openly share our feelings and decide how to resolve our differences	☐	☐	☐	☐	☐
I am very satisfied with how my partner and I talk with each other	☐	☐	☐	☐	☐
When we are having a problem, my partner often gives me the silent treatment	☐	☐	☐	☐	☐
I do not always share negative feelings I have about my partner because I am afraid he/she will get angry	☐	☐	☐	☐	☐
I am aware of how my relationship with my partner might change after having a new baby	☐	☐	☐	☐	☐

Section 3: Use of services and relationship support in the future

Q10. How likely would you be to seek relationship support (for example, couple counselling services, online help or courses) if you had relationship problems?

Very unlikely	Quite unlikely	Slightly unlikely	Unsure	Slightly likely	Quite likely	Very likely
☐	☐	☐	☐	☐	☐	☐

6 Quantitative 6-month follow up survey

Perinatal Pilot Evaluation – Post Survey

Telephone

Screener

ASK PERSON WHO ANSWERS PHONE

S1 **Good morning / afternoon / evening. Please can I speak to [**NAME FROM SAMPLE**]?**

Respondent answers phone	1	CONTINUE
Transferred to respondent	2	
Hard appointment	3	MAKE APPOINTMENT
Soft Appointment	4	
Refused	5	THANK AND CLOSE
Respondent has died	6	THANK AND CLOSE
Baby is no longer with us	7	THANK AND CLOSE
Wrong number (respondent no longer lives / not known at address)	8	CONTINUE TO S3
Respondent wants reassurances	9	GO TO REASSURANCES

ASK ALL

S2 Good morning / afternoon/evening, my name is [NAME**], calling from IFF Research, an independent research company.**

As part of a Department for Work and Pensions (DWP) pilot study, [Name of local NHS or LA area] **are including relationship education in antenatal provision and IFF Research and the Tavistock Institute are conducting an evaluation of this provision on behalf of the DWP.**

Our records show that you attended [TEXT SUB: INSERT CLASS TYPE FROM SAMPLE**] administered by [**TEXT SUB: INSERT NHS AREA FROM SAMPLE**] on the [**TEXT SUB: DATE FROM SAMPLE**]. This session will have covered relationship advice and guidance for new parents.**

At the beginning of this session you completed a short paper questionnaire about your relationship and kindly provided your contact details so that we could ask you some follow-up questions. Would now be a good time to ask you these questions?

INTERVIEWER NOTE: THEY WILL HAVE ATTENDED THE SESSION SO DO USE ALL PROMPTS ABOUT DATE, TIME AND LOCATION TO JOG THEIR MEMORY.

Continue	1	GO TO S4
Hard appointment	2	MAKE APPOINTMENT
Soft Appointment	3	
Refused	4	THANK AND CLOSE
Refused – I did not agree to be contacted	5	
Respondent has died	6	
Baby is no longer with us	7	
Not available during fieldwork	8	
Respondent wants reassurances	9	GO TO REASSURANCES
Respondent wants reassurance email	10	COLLECT EMAIL AND ARRANGE APPOINTMENT DS: SEND AUTOMATIC EMAIL

ASK IF WRONG NUMBER (S1=6)

S3 Do you have a forwarding number for [NAME FROM SAMPLE**]?**

Yes (RECORD NEW NUMBER)	1	SEND RECORD TO A 'REFERRAL NUMBER' QUEUE
No	2	THANK AND CLOSE – OUTCOME = WRONG NUMBER AND NO FORWARDING NUMBER GIVEN
Respondent wants reassurances	3	SHOW REASSURANCES

S4 This call may be recorded for quality and training purposes only.

REASSURANCES TO USE IF NECESSARY

The interview will take around 15 minutes to complete.

[Name of local NHS or LA area] are including relationship education in antenatal provision, as part of a Department for Work and Pensions (DWP) pilot study. On behalf of the DWP, IFF Research and the Tavistock Institute are conducting research to understand the effectiveness of this relationship education. You kindly filled out a paper questionnaire during an antenatal session and agreed we could call you back to ask some follow-up questions.

Your participation in the research is entirely voluntary and will not affect your future dealings with the department. You can withdraw from the research at any time.

Any information you provide will be held in the strictest of confidence and will be handled securely throughout the study in line with the requirements of the Data Protection Act (1998). The information you provide will be used only for research purposes and the research findings will not identify you.

The study has not applied for approval under the MCA which means it can only include respondents who have the capacity to consent to their own participation. People such as relatives or carers [amend as appropriate] will not be able to reply on behalf of those without the capacity to give their consent to participation but may, where relevant, be invited to provide their own views.

All the information that you provide will be combined with those of other people and reported as anonymised statistics. Your answers will not be reported in any way that would allow you to be identified.

You supplied us with your name and contact details when you filled out the paper survey and agreed to be recontacted.

If respondent wishes to confirm validity of survey or get more information about aims and objectives, they can call:

- **INSERT CONTACT DETAILS HERE**

A Introduction / Background

ASK ALL

A1 **When you completed the paper survey, you/ your partner was pregnant. Have you/she had the baby now?**
SINGLECODE.

Yes	1	
No	2	
DO NOT READ OUT: Our baby is no longer with us	3	THANK AND CLOSE

ASK IF HAVEN'T HAD BABY (A1=2)

A1b How many weeks pregnant are you / your partner?

WRITE IN		
DO NOT READ OUT: Not pregnant	1	THANK AND CLOSE
DO NOT READ OUT: Refused	2	THANK AND CLOSE

ASK ALL

A1a And how many months old is your baby now?

INTERVIEWER NOTE: Ensure that the child is 4 months old or over before continuing, make appointment if the child is younger.

WRITE IN		
DO NOT READ OUT: Don't know	1	
DO NOT READ OUT: Refused	2	
DO NOT READ OUT: Child younger than 4 months	3	GO TO A1C THEN TO MAKE SOFT APPOINTMENT FOR APPROPRIATE TIME

IF DK / REF (A1A=1-2)

A1a1 Prompt with ranges

Under 4 months	1	GO TO A1C AND MAKE SOFT APPOINTMENT
Over 4 months	2	CONTINUE

ASK IF A1=2 OR A1A=3 OR A1A1=1

A1c Thank you, for these follow up questions, we are speaking to parents when their baby is around 4 months old so we shall call you back in a few months.

OK	1	MAKE SOFT APPOINTMENT FOR APPROPRIATE TIME
Would rather not be called back - Refused	2	THANK AND CLOSE – DS: MARK AS REFUSAL

ASK ALL

A2 **And in terms of the mother / father of this child, are you…..?**

SINGLECODE. READ OUT.

INTERVIEWER NOTE: WE ARE REFERRING HERE TO THE PARTNER THEY HAD THE CHILD THEY WERE PREGNANT WITH AT THE [INSERT DATE] CLASS / HOME VISIT.

INTERVIEWER NOTE: IF RESPONDENT SAYS THEY ARE NOT TOGETHER CLARIFY WHETHER THEY ARE DIVORCED OR WERE NEVER MARRIED.

Married	1	
Living together (without being married)	2	
In a steady relationship without living together	3	
Divorced	4	
Not together	5	
Other (please specify)	6	
DO NOT READ OUT: Refused	7	THANK AND CLOSE

ASK IF DIVORCED OR NOT TOGETHER (A2=4 OR 5)

A2a1 Are you co-parenting this child with their mother / father?

SINGLECODE. DO NO READ OUT.

Yes – Co-parenting	1	
No – we are not co-parenting	2	
Prefer not to say	3	THANK AND CLOSE

ASK IF DIVORCED OR NOT TOGETHER (A2=4 OR 5)

A2a **Were you in a relationship with the mother / father of this child at the time of the session on [**INSERT DATE**]?**

Yes	1	IF A2A1=1 CONTINUE; IF A2A1=2 ASK THE REST OF SECTION A THEN GO TO SECTION C
No	2	THANK AND CLOSE

ASK IF DIVORCED OR NOT TOGETHER (A2=4 OR 5)

A3 **How long were you in a relationship with the mother / father of this child?**
READ OUT. SINGLE CODE.

Less than a year	1	
1-2 years	2	
3-5 years	3	
6-10 years	4	
More than 10 years	5	
DO NOT READ OUT: Refused	6	
DO NOT READ OUT: Don’t know	7	

ASK IF STILL IN A RELATIONSHIP (A2 = 1-3 OR 6)

A4 **How long have you been in a relationship with your partner?**

READ OUT. SINGLE CODE.

Less than a year	1	
1-2 years	2	
3-5 years	3	
6-10 years	4	
More than 10 years	5	
DO NOT READ OUT: Refused	6	
DO NOT READ OUT: Don't know	7	

ASK ALL

A5 **How many children are currently under** [IF DIVORCED OR NOT TOGETHER A2=4-5**; your care;** IF IN A RELATIONSHIP A2=1-3 OR 6**: the care of you and your partner?**

INTERVIEWER NOTE: WE WANT TO UNDERSTAND HOW MANY CHILDREN THEY FEEL THEY HAVE A RESPONSIBILITY FOR, WHETHER OR NOT THEY LIVE WITH THEM. THIS COULD INCLUDE THEIR PARTNERS CHILDREN E.G. STEP CHILDREN AND ALSO ADOPTIVE CHILDREN.

WRITE IN		
Just the one child	1	
DO NOT READ OUT: Refused	2	

ASK IF MORE THAN ONE CHILD (A5≠1)

A6 **And of these [INSERT A5 ANSWER] what age is the oldest child?**

WRITE IN		
Under 1 year of age	1	
DO NOT READ OUT: Refused	2	

ASK ALL

A7 **How many children currently live in your household?**

WRITE IN		
DO NOT READ OUT: Refused	1	

ASK ALL

A8 **And what age is the oldest child living in your household?**

WRITE IN		
Under 1 year of age	1	
DO NOT READ OUT: Refused	2	

B Standardised measure DAS-7 scale / Your relationship

ASK ALL IN A RELATIONSHIP OR CO-PARENTING (ALL EXCEPT A2A1=2)

I'd now like to ask you some questions about your relationship with your partner.

INTERVIEWER NOTE: THE RESPONDENT MAY RECOGNISE THESE QUESTION FROM THE PRESURVEY. IF THIS IS THE CASE PLEASE JUST EXPLAIN WE ARE INTERESTED IN LOOKING AT ANSWERS OVER TIME.

B1 **Most people have disagreements in their relationships. Please can you tell me the approximate extent of agreement or disagreement between you and your partner – since the birth of your child - for each item on the following list.**

For each item please indicate whether you and your partner 'Always agree', 'Almost always agree', 'Occasionally disagree', 'Frequently disagree', 'Almost always disagree' and 'Always disagree'.

READ OUT. CODE ONE PER ROW.

	Always agree	Almost always agree	Occasionally disagree	Frequently disagree	Almost always disagree	Always disagree	DO NOT READ OUT: Don't know
Philosophy of life (your approach to life)	**1**	**2**	**3**	**4**	**5**	**6**	**99**
Aims, goals and things you believe to be important	**1**	**2**	**3**	**4**	**5**	**6**	**99**
About the amount of time spent together	**1**	**2**	**3**	**4**	**5**	**6**	**99**

ASK ALL IN A RELATIONSHIP OR CO-PARENTING (ALL EXCEPT A2A1=2)

B2 **How often - since the birth of your child - would you say the following events occur between you and your partner?**

For each event please indicate whether it 'Never' happens or whether it happens 'Less than once a month', 'Once or twice a month', 'Once or twice a week', 'Once a day' or 'More often'.

READ OUT. CODE ONE PER ROW.

	Never	Less than once a month	Once or twice a month	Once or twice a week	Once a day	More often	DO NOT READ OUT: Don't know
Have a stimulating exchange of ideas	**1**	**2**	**3**	**4**	**5**	**6**	**99**
Calmly discuss something together	**1**	**2**	**3**	**4**	**5**	**6**	**99**
Work together on a project / plan something together	**1**	**2**	**3**	**4**	**5**	**6**	**99**

ASK ALL IN A RELATIONSHIP OR CO-PARENTING (ALL EXCEPT A2A1=2)

B3 **I am going to read out some options that represent different degrees of happiness in your relationship. The middle option, 'happy', represents the degree of happiness of most relationships. Please tell me which of the following best describes the degree of happiness, all things considered, in your relationship.**

READ OUT. SINGLE CODE.

Extremely unhappy	1	
Fairly unhappy	2	
A little unhappy	3	
Happy	4	
Very happy	5	
Extremely happy	6	
Perfect	7	
DO NOT READ OUT: Don't know	8	

ASK ALL IN A RELATIONSHIP OR CO-PARENTING (ALL EXCEPT A2A1=2)

B4 How much do you agree or disagree with each of the following statements?

Please indicate whether you 'strongly agree', 'moderately agree', 'Neither agree nor disagree', 'Mostly disagree' or 'Strongly disagree'.

READ OUT. CODE ONE PER ROW.

	Strongly agree	Moderately agree	Neither agree nor disagree	Moderately disagree	Strongly disagree
Since the birth of our child... When we have a disagreement, we openly share our feelings and decide how to resolve our differences	**1**	**2**	**3**	**4**	**5**
Since the birth of our child...I am very satisfied with how my partner and I talk with each other	**1**	**2**	**3**	**4**	**5**
Since the birth of our child... When we are having a problem, my partner often gives me the silent treatment	**1**	**2**	**3**	**4**	**5**
Since the birth of our child...I do not always share negative feelings I have about my partner because I am afraid he/she will get angry	**1**	**2**	**3**	**4**	**5**

C Recall of the session

ASK ALL

C1 **As I mentioned at the beginning of the call, our records show that you attended [TEXT SUB:** INSERT CLASS TYPE FROM SAMPLE**] administered by [TEXT SUB:** INSERT NHS AREA FROM SAMPLE**] on the [TEXT SUB: DATE FROM SAMPLE]. This session will have covered relationship advice and guidance for new parents.**

IF 'HOME VISIT' ON SAMPLE: **For ease, I will refer to your home visit as a 'session' throughout this section.**

So, how well can you remember the relationship advice and guidance covered in this session?
READ OUT. SINGLE CODE.

Very well	1	
Quite well	2	
Not very well	3	
Not at all well	4	
DO NOT READ OUT: Don't know	5	
DO NOT READ OUT: Refused	6	

READ OUT TO ALL: **I'm now going to ask you about the specific relationship content you remember the session covering. This could be a video, cartoon or handout that you were shown, group/ couple activities or discussions you had or any other advice or guidance the midwife / health visitor gave to you.**

I'll ask you to focus first on the things you a good recollection of. After this we'll talk about anything you have more of a vague recollection of.

ASK ALL WITH A GOOD RECOLLECTION OF THE SESSION (C1=1 OR 2)

C2 **So, what relationship advice / guidance do you have a good recollection of?**
PROBE FULLY: WRITE IN AND THEN CODE ALL THAT APPLY TO THE OBJECTIVES LIST BELOW

WRITE IN		
DO NOT READ OUT: Don't know	1	
DO NOT READ OUT: Refused	2	

Raising awareness of the impact having a baby can have on parents' relationship.	1	
Raising awareness of the impact parents' relationship on their baby.	2	
Preparing parents for the changes and challenges to their relationship: physical, emotional, sexual, financial, and practical.	3	
Helping parents develop skills in communication and managing conflict.	4	
Other	5	
Don't know	6	

ASK ALL

C3 **Is there any relationship advice / guidance that you have a vague recollection of?**
PROBE FULLY: WRITE IN AND THEN CODE ALL THAT APPLY TO LIST BELOW

WRITE IN		
Don't know	1	
Refused	2	

Raising awareness of the impact having a baby can have on parents' relationship.	1	
Raising awareness of the impact parents' relationship on their baby.	2	
Preparing parents for the changes and challenges to their relationship: physical, emotional, sexual, financial, and practical.	3	
Helping parents develop skills in communication and managing conflict.	4	
Other	5	
Don't know	6	

ASK ALL

C4 **And overall, what is the one key message you took from the session?**
PROMPT AS NECESSARY.

WRITE IN		
DO NOT READ OUT: Don't know	1	
DO NOT READ OUT: Refused	2	

D Effectiveness of the session

ASK ALL

D1 **Please could you tell me whether the session raised your awareness of each of the following issues 'A great deal', 'A little' or 'Not at all'.**
READ OUT. CODE ONE PER ROW.

	A great deal	A little	Not at all	DO NOT READ OUT: DK	DO NOT READ OUT: Refused
The impact having a baby can have on your relationship generally. For example, why couples may become less close after having a baby.	**1**	**2**	**3**	**4**	**5**
The changes and challenges having a baby can bring to the physical aspect of your relationship. For example tiredness and exhaustion and how you might support each other through this	**1**	**2**	**3**	**4**	**5**
The changes and challenges having a baby can bring to the emotional aspect of your relationship. For example feeling neglected/ unsupported	**1**	**2**	**3**	**4**	**5**
The changes and challenges having a baby can bring to the sexual aspect of your relationship. For example what are some of the worries you may have about being sexually active, how does sleep affect your sex drive, how to maintain closeness and intimacy without intercourse, etc.	**1**	**2**	**3**	**4**	**5**
The changes and challenges having a baby can bring to the financial aspect of your relationship. For example, how disagreements about money may mask deeper issues that lie beneath the argument.	**1**	**2**	**3**	**4**	**5**
The changes and challenges having a baby can bring to the practical aspect of your relationship. For example the amount of spare time you have, making time for each other, conflicting advice from family and friends	**1**	**2**	**3**	**4**	**5**
The impact that your relationship can have on your baby. For example, babies can be affected by stress and discord.	**1**	**2**	**3**	**4**	**5**
Skills in communication and managing conflict. For example, how talking things through with each other in a calm and respectful way helps couples to stay close and prevents issues building up.	**1**	**2**	**3**	**4**	**5**

ASK IF PARTATTEND=3 'UNKNOWN' ON SAMPLE

D1a And did your partner attend the session with you?

Yes	1	
No	2	
DO NOT READ OUT: Don't know/ Refused	3	

ASK IF IN A RELATIONSHIP (A2=1-3 OR 6)

D2 **Did you discuss the things that were covered in the relationship session with your partner?**
READ OUT. SINGLE CODE.

Yes – A lot	1	
Yes – A little	2	
No	3	
DO NOT READ OUT: Don't know	5	
DO NOT READ OUT: Refused	6	

ASK ALL

D3 **Have you changed your behaviour as a result of anything you learned from the session? For example, what you do or how you behave in your relationship with your partner.**
READ OUT. SINGLE CODE.

Yes – definitely	1	
Yes – a little	2	
No	3	
DO NOT READ OUT: Don't know	4	
DO NOT READ OUT: Refused	5	

ASK IF HAVE CHANGED BEHAVIOUR (D4=1 OR 2)

D4 **What have you changed?**
PROBE FULLY.

WRITE IN		
DO NOT READ OUT: Don't know	1	
DO NOT READ OUT: Refused	2	

E Rating the session

READ OUT TO ALL: **Thank you for the information you have provided so far. We are now going to talk about what you thought of the session.**

ASK ALL

E1 **What did you think about the length of the relationship advice section of the session? Was it…?**
READ OUT. SINGLE CODE.

Too short	1	
Too long	2	
About right	3	
DO NOT READ OUT: Don't know	7	
DO NOT READ OUT: Refused	8	

ASK ALL

E2 **What did you think about the timing of the relationship advice in terms of the stage of pregnancy you were at? Do you think…?**
READ OUT. SINGLE CODE.

It was too early in the pregnancy	1	
It was too late in the pregnancy	2	
It was at the right stage of pregnancy	3	
It would have been better post-birth	4	
DO NOT READ OUT: Don't know	5	
DO NOT READ OUT: Refused	6	

ASK ALL

E3 **And overall, how would you rate the relationship session?**
READ OUT. SINGLE CODE.

Very useful	1	
Quite useful	2	
Not very useful	3	
Not at all useful	4	
DO NOT READ OUT: Don't know	5	
DO NOT READ OUT: Refused	6	

F Further information and signposting

ASK ALL

F1 **Did you receive any free materials from the session? For example the "Relationship Wellbeing Plan" or any other handouts, cartoons or activities?**
INTERVIEWER NOTE: THE RELATIONSHIP WELLBEING PLAN IS A BOOKLET PARENTS CAN USE TO RECORD THEIR IDEAS AND INSIGHTS GAINED FROM THE SESSIONS.

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	

ASK IF RECEIVED FREE MATERIALS (F1=1)

F2 **What did you receive?**
PROBE FULLY.

WRITE IN		
DO NOT READ OUT: Don't know	1	
DO NOT READ OUT: Refused	2	

ASK IF RECEIVED FREE MATERIALS (F1=1)

F3 **Did you read/use what you received?**
READ OUT. SINGLE CODE.

Yes	1	
Only dipped into it / briefly referred to it	2	
No	3	
DO NOT READ OUT: Don't know	4	
DO NOT READ OUT: Refused	5	

ASK IF MADE USE OF FREE MATERIALS (F3=1 OR 2)

F4 **And have you kept the materials you received?**

Yes	1	
No	2	
Don't know	3	

ASK ALL

F5 **And were you signposted to any further materials, agencies or services? For example online materials linked to the session or any other activities, courses or online materials more generally.**

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	

ASK IF SIGNPOSTED TO FURTHER MATERIALS (F5=1)

F6 **Did you access/make use of the further materials, agencies or services that you were signposted to?**
READ OUT. SINGLE CODE.

Yes	1	
Only dipped into it / briefly referred to it	2	
No	3	
DO NOT READ OUT: Don't know	4	
Refused	5	

ASK IF MADE USE OF MATERIALS (F6=1 OR 2)

F7 **What did you access / make use of?**
PROBE FULLY.

WRITE IN		
DO NOT READ OUT: Don't know	1	
DO NOT READ OUT: Refused	2	

ASK IF MADE USE OF MATERIALS (F6=1 OR 2)

F8 **How useful did you find the materials, agencies or services you made use of?**
READ OUT. SINGLE CODE.

Very useful	1	
Quite useful	2	
Not very useful	3	
Not at all useful	4	
DO NOT READ OUT: Don't know	5	
DO NOT READ OUT: Refused	6	

G Use of services and relationship support in the future

ASK ALL

G1 **Would you know where to go to for relationship support, for example, couple counselling services or online help or courses, if you needed it?**

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	

ASK IF AWARE OF WHERE TO GO FOR RELATIONSHIP SUPPORT (G1=1)

G2 **And did you know this before you attended the relationship session?**

Yes	1	
No	2	
DO NOT READ OUT: Don't know	3	

ASK ALL

G3 **How likely would you be to seek relationship support if you had relationship problems? Would you be…?**
READ OUT. SINGLE CODE.

Very unlikely	1	
Quite unlikely	2	
Slightly unlikely	3	
Unsure	4	
Slightly likely	5	
Quite likely	6	
Very likely	7	
DO NOT READ OUT: Don't know	8	
DO NOT READ OUT: Refused	9	

H Demographics

ASK ALL

Finally, I'd like to ask you a few questions that will help us to put your answers into context.

H1 **Which of the following best describes your housing situation?**
READ OUT. SINGLE CODE.

Owner occupier	1	
Council property	2	
Renting from private landlord	3	
Renting from Housing Association	4	
Living with others (i.e. not a homeowner or tenant)	5	
Other (please specify)	6	
DO NOT READ OUT: Don't know	7	

ASK ALL

H2 **What is your current age?**

WRITE IN		
Refused	1	

ASK IF REFUSED TO PROVIDE AN AGE (H2=1)

H3 **Please could you tell which of the following age bands you fall into?**
READ OUT. SINGLE CODE.

Below 18	1	
18-24	2	
25-34	3	
35-44	4	
45-54	5	
55 and over	6	
DO NOT READ OUT: Refused	7	

ASK ALL

H4 **How would you describe your ethnicity?**
PROBE AS NECESSARY. CODE TO LIST.

White UK	1	
White Irish	2	
White Other (Please specify)	3	
Asian/Asian British – Indian	4	
Asian/Asian British – Pakistani	5	
Asian/Asian British – Bangladeshi	6	
Asian/Asian British – Other (please specify)	7	
Black/Black British – Caribbean	8	
Black/Black British – African	9	
Black/Black British – Other (please specify)	10	
Mixed ethnicity - White and Black Caribbean	11	
Mixed ethnicity - White and Black African	12	
Mixed ethnicity - White and Asian	13	
Mixed ethnicity - Other (please specify)	14	
Other (please specify)	15	
Prefer not to say	16	

ASK ALL

H5 **What is the occupation of the chief income earner of your household?**
PROBE FOR

- Position, rank or grade
- Industry or type of company
- Type of qualifications, degrees, apprenticeships needed for job
- No. Of staff employed by the whole organisation

IF UNEMPLOYED / RETIRED – PROBE FOR DETAILS OF MOST RECENT JOB

WRITE IN: ALLOW REFUSED.

ASK ALL WHO ATTENDED THE SESSION WITH THEIR PARTNER OR DID NOT INDICATE WHETHER THEY HAD. FROM SAMPLE, ATTEND=1 OR 3

H6 **And what is the name of your partner?**

REASSURE AS NECESSARY: WE WILL NOT USE THIS INFORMATION TO IDENTIFY YOU OR YOUR PARTNER IN ANY WAY. WE WILL USE THE INFORMATION TO MONITOR HOW MANY INDIVIDUAL RELATIONSHIPS WE HAVE SPOKEN TO.

WRITE IN		
Refused	1	

ASK ALL

H7 **Occasionally it is necessary to call people back to clarify their answers. Would you be happy for us to call you back for this purpose?**

Yes	1	
No	2	

ASK ALL

H8 **We are also looking to conduct some more in-depth discussions with parents who have attended a relationship session. This will involve a telephone conversation lasting approximately 45 minutes in the next few weeks or so. We would give £20 as a thank you for your time. Does this sound like something you would be interested in?**

Yes - RECORD: Name _____ Telephone number_____ Email address _____	1	
No	2	

IF CONSENT TO QUAL (H8=1)

H9 **Thank you, we will send you an email to confirm this appointment in the next couple of days.**

ASK ALL

THANK RESPONDENT AND CLOSE INTERVIEW

Finally I would just like to confirm that this survey has been carried out under IFF instructions and within the rules of the MRS Code of Conduct. Thank you very much for your help today.

7 Qualitative follow up topic guide with parents

Provision of Perinatal Pilots Research Telephone Interview

Background for interviewer

Overall, the project aims to evaluate the success of a pilot scheme delivering relationship education in prenatal classes across 7 areas. The scheme aims to prepare prospective parents for the impact a baby will have on their relationship. It aims to provide couples with relationship and communication skills and to make them aware of further support available to them. The materials used in the pilot were developed by OnePlusOne, experts in relationship education. Officially the sessions are known as 'Me, You and Baby Too' sessions but respondents may not know the session as this so you can probe around a session that involved an element of relationship education.

Local Authority and NHS staff, health visitors and midwifes, have been trained to deliver the sessions to participants. The sessions have been integrated into existing prenatal classes and additional content will be made available to couples online. Specifically the aims of the programme are to:

- To raise parents' awareness of the impact a baby can have on their relationship
- To raise parents' awareness of the impact their relationship with one another has on their baby
- To prepare parents for the changes and challenges to their relationship: physical, emotional, sexual, financial and practical
- To help parents develop skills of communication and managing conflict

The aim of the evaluation is to understand how well the pilot scheme achieves the above aims and assess its suitability for national roll out. The evaluation will also seek to identify lessons learnt and best practice for delivering relationship education as part of perinatal programmes.

We are looking to speak to 40 participants in the pilot scheme about their experience and perceptions of impact. They will have already filled out a paper questionnaire at the relationship session and taken part in a 15 minute telephone conversation. The appointment date and time will have been prearranged with respondents at the end of this telephone conversation and followed-up with a confirmation email.

This document is a guide to the principal themes and issues to be covered. Questions can be modified and followed up in more detail where necessary.

A Introduction (2 min)

• **Interviewer and IFF introduction** – thank you for taking part • **Background to the research:** You have already participated in the quantitative element of the research – a paper survey and telephone interview regarding the piloting of a relationship education package known to some as 'You, Me and Baby Too', which is delivered as part of prenatal classes – and we'd like to explore certain aspects of your experience in more detail through a more in-depth and qualitative discussion. • **MRS Code of Conduct and Confidentiality:** IFF Research is an independent market research company, operating under the strict guidelines of the Market Research Society's Code of Conduct. This means that anything you tell us will be treated in the strictest confidence, and none of your answers will be attributed to you unless you give explicit permission for us to do so. • **Participation is voluntary -** there are no right or wrong answers, you can choose to not discuss any issue. • **ADD IF NECESSARY:** • [Name of local NHS or LA area] are including relationship education in antenatal provision, as part of a Department for Work and Pensions (DWP) pilot study. On behalf of the DWP, IFF Research and the Tavistock Institute are conducting research to understand the effectiveness of this relationship education. You kindly filled out a paper questionnaire during an antenatal session and took part in a follow-up conversation a few weeks ago. • Your participation in the research is entirely voluntary and will not affect your future dealings with the department. You can withdraw from the research at any time. • Any information you provide will be held in the strictest of confidence and will be handled securely throughout the study in line with the requirements of the Data Protection Act (1998). The information you provide will be used only for research purposes and the research findings will not identify you.	***PROCESS NOTES:*** *The purpose of this section is to explain what will be covered during the telephone discussion, explain how their answers will be used, provide assurances around anonymity and request permission to record*

• The study has not applied for approval under the MCA which means it can only include respondents who have the capacity to consent to their own participation. People such as relatives or carers [amend as appropriate] will not be able to reply on behalf of those without the capacity to give their consent to participation but may, where relevant, be invited to provide their own views. Data Use: The answers you provide will be analysed by the IFF research team and used to evaluate the pilot. We will be writing a report based on these findings but individuals' names' will not be included in the report and you will not be identifiable in any way. • **Permission to record:** We like to audio record all interviews of this nature so we don't have to take a lot of notes and also to accurately capture our discussion – the recording will only be used for analysis purposes. The recorder is encrypted and the recordings will be securely stored in folders that only the IFF research team will have access to. All recordings will be deleted at the end of the research. Ask for permission to start recording. **The interview will last around 45 minutes.**	

B Warm Up (5 min)

B1 **Can you first of all tell me a little bit about yourself, what do you do, where do you live etc?** B2 **And just to recap, how many children do you have?** • Do they all live at home with you? • What ages are they? • When you took part in the prenatal classes we will be discussing you were/your partner was pregnant. How old is your youngest child now? B3 **And again, just to recap, how would you describe your relationship status? (Married, domestic partner, in a relationship but not living together, single etc).** IF SINGLE: **This conversation will involve talking about what you remember about the session and how much you spoke to your partner about it.** **We understand that this might be difficult for you so just want to check whether you are happy to continue?**	*The purpose of this section is to warm the respondent up and to generally get to know their household and family status.*

C Experience (10 min)

I would now like to ask you a few questions about the relationship education session you attended.

C1 **When was this?**

- Did this take place in a group setting or an individual session with a midwife?
- Was this topic covered in one session or across several sessions?
- How long was the relationship part of / session?
- ASK MOTHERS ONLY AND IF NOT COLLECTED FROM THE PRESURVEY: Did your partner attend the session/s with you?
- Do you remember whether this session/s had a name? PROBE: You, Me and Baby Too, explain that this is the name of the package and that you will be referring to it by this name throughout the interview.

C2 **Overall, what do you remember about this session/s?**

- What sort of topics did you discuss as part of this session/s?
- Who was leading the session? What did you think of her/ him?

C3 **In your opinion, how well did this session fit within the overall prenatal class structure? Why is that?**

C4 ASK ALL FATHERS: **As a father, how included or excluded did you feel in the session?**

- Was there any information or discussion that you felt was particularly relevant to you as a father? If yes, what and why?
- Was there any information or discussion that you felt wasn't relevant to you as a father? If yes, what and why?
- Was there any particular activity or group that you liked or didn't like? What and why?
- **Was there anything you would have like to cover that wasn't covered or anything that wasn't covered enough? If yes, what and why?**

C1: The You, Me and Baby Too package can be delivered as part of group antenatal sessions or during work with individual couples, either in NHS facilities or during home visits.

The You, Me and Baby Too package is split into four modules which can be delivered as a whole during a one hour session or split and delivered over a longer period of time. It may be integrated into existing antenatal classes or as a standalone session.

The package may not have been referred to as You, Me and Baby Too to participants.

D Content (10-15 min)

I would now like to ask you a few questions about the sorts of topics that were covered in the session.

D1 **Firstly, what do you remember discussing in the session?**

D2-D5 – PROBE IF NOT EMERGED

D2 **Do you remember talking about how you and your partner's relationship might change after having a baby?**

- IF REMEMBER: What do you remember about this discussion?
- What key message/messages did you take from it PROMPT IF NECESSARY: e.g. the ways in which couples might become less close after having a baby?

D3 **During the session/s, do you remember talking about how parents' relationship with each other can affect the baby?**

- IF REMEMBER: What do you remember about this discussion?
- What key message/messages did you take from it PROMPT IF NECESSARY: e.g. for example, babies can be affected by stress and discord?

D4 **And do you remember talking about how you can prepare for the changes or challenges that may arise when you have a new baby?**

- What do you remember about this discussion? What kind of changes did you discuss? PROBE:
- PHYSICAL – For example tiredness and exhaustion and how you might support each other through this
- EMOTIONAL – For example feeling neglected/ unsupported
- SEXUAL – For example what are some of the worries you may have about being sexually active, how does sleep affect your sex drive, how to maintain closeness and intimacy without intercourse, etc
- FINANCIAL – For example, how disagreements about money m**ay mask deeper issues that lie beneath the argument**
- PRACTICAL – For example the amount of spare time you have, making time for each other, conflicting advice from family and friends

D5	**And finally, during the session/s, do you remember talking about ways in which parents can communicate with each other and manage potential conflicts?** • **IF REMEMBER: What do you remember about this discussion?** • **Any skills, ideas or key messages that stuck with you? E.g. communication skills and conflict management such as thinking about how talking things through with each other in a calm and respectful way helps couples to stay close and prevents issues building up?**	AT D6 AND D7 INTERVIEWER TO PROMPT RESPONDENT WITH THE FOUR TOPIC AREAS AS NEEDED: 1. How you and your partner's relationship might change after having a baby 2. How parent's relationship with each can affect the baby 3. How you can prepare for the changes or challenges that may arise when you have a new baby 4. Ways in which parents can communication with each other and manage potential conflicts
D6	**To what extent was the information you covered in these conversations new to you and to what extent did it cover information you were already aware of / had previously considered?** PROBE AS NECESSARY: • What information was new to you? • What information had you previously considered?	
D7	**How useful did you find these discussions? Why?** PROBE AS NECESSARY: • Which discussions did you find useful? • Which discussions did you find less useful?	
D8	**Did you and your partner talk about any of these issues after the session?** IF YES: **Which issues did you discuss and what did you discuss?** **Did you discuss anything that was covered in the session with anybody else?** IF YES: **Which issues did you discuss and what did you discuss? At what point did you discuss these** (e.g. straight after the session or after you'd had the baby)**? Who with?**	

RESOURCES

INTERVIEWER NOTE: FOCUS ON PROMPTING THESE IF THEY HAVE RECEIVED OR USED RESOURCES. CAN MOVE SWIFTLY TO D13 TO CAPTURE AWARENESS IF NOT.

D9 **Were you given a Me, You and Baby Too Couples Relationship Wellbeing Plan as part of the session/s?**

- IF YES: Did you use this?
- IF YES: How useful was this?
- IF NO: Do you think this would have been a useful tool?

D9: The Me, You and Baby Too Couples Relationship Wellbeing Plan can be used to encourage parents to record their ideas and insights gained from the sessions.

D10 **Did you watch any film clips as part of these sessions?**

- Do you remember what the film clips were about?
- What did you think of these film clips? Were they useful?

D10: The You, Me and Baby Too package included two films to be showed as part of the sessions: (a) 'John and Julie explore how stress affects communication and give couples an opportunity to explore their conflict style', (b) 'Danny and Jem demonstrate an argument going badly and then how the couple managed to argue in a way that is better for them and their children'.

D11 **Did you use any cartoons or handouts?**

- Do you remember any of these cartoons or handouts?
- What did you think of these? Were they useful?

D12 **Were you told about any free online materials you could access in your own time?**

- IF YES: Did you access any of these? (if no, ask if any particular reasons why, or anything that might have helped/made them more likely to access online materials)
- IF YES: How useful was this?

Content

D13 **Thinking about each issue in turn, do you think your awareness changed since attending the session?**

INTERVIEWER: ASK HOW / WHY?

1 How you and your partner's relationship might change after having a baby

2 How parents' relationship with each other can affect the baby

3 How you can prepare for the changes or challenges that may arise when you have a new baby

4 Ways in which parents can communicate with each other and manage potential conflicts

D14 **To what extent do you think the session impacted on your preparedness for changes/ challenges after having a baby? Why/ how?**

D15	**And do you think you have changed your behaviour as a result of anything you learned at the session/s?** • PROBE: Any examples or anecdotes of participants making use of ideas or skills introduced during the sessions, taking tips and putting them into practice.	

E Overall Satisfaction (5 min)

E1	**Overall, how would you rate the You, Me and Baby Too session/s?** • How useful was the session/s? What did you find most useful? And what did you find the least usefulWhat did you think of the way the information was presented? PROBE: person delivering the session, topics covered/not covered, materials, length of lesson etc. • Would you recommend taking part in similar sessions on relationships and having children to other people? Why/why not?	
E2	**Are there any ways in which it could be improved?** • What did you think about the timing of the relationship education? Do you think it is better to have relationship education before or after having a baby? • Are prenatal classes /[IF HOME VISIT: home visits] a good setting in which to deliver relationship education? • IF NO: Why is that? Where would you expect to see relationship education delivered? • IF YES: Why is that? Are there any other ways that you could deliver relationship education to expecting couples?	
E3	**If someone was planning to roll out these types of relationship education classes in other parts of the country, what would you tell them?**	
E4	**And finally, how likely would you say you would be to seek out help in the future if you were having relationship problems? Why is that?** • PROBE: Has your experience of the session changed your attitude towards relationship education? • Where would you go for help with relationship problems or to learn more about relationships, communication skills etc? Was this something you were aware of before the session or something the session drew your attention to? • What else would be helpful to support with your relationship?	

F Wrap Up

F1 **Is there anything related to this topic that we haven't covered and you would like to add?**

F2 **As a thank you for your time today, IFF is offering a £20 thank you by either PayPal transfer, Amazon e-voucher or personal cheque. How would you like to receive your incentive? I'll just need to confirm some details:**

THANK RESPONDENT AND CLOSE INTERVIEW

I declare that this survey has been carried out under IFF instructions and within the rules of the MRS Code of Conduct.		
Interviewer signature:	Date:	
Finish time:	Interview Length	Mins

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