Department for Work & Pensions

Research Summary

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Evaluation of perinatal pilots for delivery of Relationship advice

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Introduction

Previous research suggests that the normal pattern for relationships is for relationship quality to decline over time[1]. Such declines are most severe at particular stress points – such as becoming a parent, which, on average, has been shown to have a negative effect on relationship quality for both mothers and fathers[2]. Against this backdrop, the perinatal pilots 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[3] 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.
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

There were two key evaluation aims:

1. To measure the extent to which the pilots met the objectives in terms of the 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.

[1] Twenge *et al.* (2003).

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

[3] OnePlusOne are specialists in the area of relationship support and provided NHS Trusts with the session materials used in the pilots.

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The evaluation consisted of a mixture of qualitative and quantitative methods involving:

- **Scoping interviews:** Eight qualitative telephone interviews were conducted with delivery leads in the early stages of pilot delivery;
- **Site visits:** Four visits involving session observations, in-depth qualitative interviews with practitioners (nurses and midwives responsible for delivering the relationship support) and short exit interviews with parents;
- **Initial quantitative self-completion survey:** This involved a paper survey, filled out by parents at the start of the relationship education session. A total of 335 parents completed this initial survey;
- **Follow-up quantitative telephone survey:** Follow-up quantitative telephone interviews were conducted with initial survey participants. A total of 124 parents completed this phase of the evaluation; and
- **Qualitative follow-up survey:** 40 in-depth discussions were conducted with quantitative participants.

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 with this methodology which means results on the impact of the pilots should be treated with some caution. 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.

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.

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 it was often described by practitioners as interactive, enjoyable and informative.

How confident did National Health Service (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.

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 extensive resource easier to navigate.
- 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 resource pack to make it easier to digest and retain.

What delivery models did different NHS Trusts adopt?

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.

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.

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.

Pilots typically targeted parents that were around 30 weeks pregnant 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.

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[4] were not always represented.

Was the education training optimally designed?

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.

Suggestions for more effective implementation of relationship education sessions included:

- 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: If areas had been asked to report monthly attendance figures to the Department for Work and Pensions (DWP) then this might have been beneficial to sustaining momentum.
- 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.

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 around relationship quality and communication:

1. The DAS-7 – Relationship quality.
2. ENRICH Marital Satisfaction Scale – Communication.

A comparison of the responses to these questions at the initial survey with responses at the follow-up survey (conducted around six months after attending the relationship education sessions) 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 sub-scale then the mean score would have been 4 and if they had all given the highest possible response then the mean score would have been

[4] 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.

20. This difference in mean scores equates to an effect size of 0.37[5], 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[6]. Consequently, it is positive that the findings indicate that involvement within the pilots has led to no change in relationship quality and a small improvement in communication.

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 ($p<0.001$)[7] 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 1 to 7 where 1 is very unlikely to seek advice and 7 is very likely to seek advice).

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 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).

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

From the follow-up survey 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 'Not very well' and 11 per cent 'Not at all well').

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), roughly a third (35 per cent) said they used them and a further 45 per cent explained that only dipped into them briefly.

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.** 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).

[5] 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.

[6] Twenge *et al.* (2003).

[7] Hypothesis tests use a *p*-value to weigh the strength of the evidence. The *p*-value is a number between 0 and 1. A small *p*-value (typically ≤ 0.05) indicates strong evidence against the null hypothesis (in this case, the null hypothesis is that there is no impact on willingness to seek relationship support).

- **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).

Other implications for best practice were:

- 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).
- Ideally, relationship education sessions should involve **both partners** (fathers were sometimes the most positive about the provision).
- **Interactive** exercises worked well to stimulate debate.
- A follow-up or **refresher session** (possibly after the birth of the baby) could help to cement some of the learning.

- **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. 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 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.

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