INTERIM SECOND YEAR
RESEARCH EVALUATION OF
THE HEALTHY RELATIONSHIPS:
HEALTHY BABY PROGRAMME

EXECUTIVE SUMMARY

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Executive Summary

The Stefanou Foundation created the Healthy Relationships: Healthy Baby Programme and launched it in 2015 as two prototype projects. In June 2017, the programme was given a new name, For Baby’s Sake.

The Stefanou Foundation commissioned Kings College London and their partners to conduct an external research evaluation of the programme. The evaluation began in 2015 and is due to be completed in 2019. This document is the executive summary by Kings College London of their interim second year evaluation. This document refers to the programme as Healthy Relationships: Healthy Baby or HRHB, as this was the programme’s name throughout the period covered by the interim second year evaluation.

Domestic Violence and Abuse (DVA) is a major public health problem, with around 3%-30% of women reporting domestic violence during pregnancy. DVA in pregnancy is associated with antenatal and postnatal depression, obstetric complications and adverse foetal development. DVA in the perinatal period can also have profound negative consequences on the psychological well-being of children throughout childhood.

Pregnancy and childbirth are major milestones in the lives of many mothers and fathers and this period can be a significant motivator for change. Existing interventions, however, have generally focused on supporting the needs of victims/survivors alone, and few take a whole-family approach that seeks to reduce DVA and promote positive and healthy parenting for mothers and fathers. The Healthy Relationships: Healthy Baby (HRHB) programme seeks to address the limitations of existing interventions by using a whole-family approach that addresses the cycles of DVA (including the impact of parents’ own childhood experiences of abuse) and seeks to improve mental health and parent-child attachment outcomes for both mothers and fathers.

The HRHB programme is a manualised intervention with a structured therapeutic core component, delivered to mothers and fathers from the antenatal period up to when the infant(s) is 2 years of age. The programme incorporates individual- and, if appropriate, group-sessions. Regular comprehensive assessments of the needs, risks and progress of mothers, fathers, babies and any other children are undertaken throughout. The HRHB programme is being implemented within two areas: Hertfordshire Local Authority and the tri-borough area of Westminster, Hammersmith and Fulham and Kensington and Chelsea.

The Stefanou Foundation commissioned King’s College London and their partners to undertake an independent evaluation of the HRHB programme. The evaluation is collecting process-related data, data on the outcomes of families in the HRHB programme and data on the views and experiences of HRHB staff and stakeholders. Process-related data includes charting the characteristics of families taking part in the programme; establishing fidelity measures to map the balance and content of the HRHB therapeutic programme; charting HRHB staff capacity and skills to deliver the programme; and examining the success of the integration of the HRHB programme within the two localities. Interviews are being conducted with HRHB staff and key stakeholders at the start, middle and end of the evaluation to establish their views and experiences of the programme. Interviews are also being conducted
with families on the HRHB programme to chart their experiences and to measure their outcomes over time. This summary of the interim evaluation report, written by the evaluation team, covers the activities of the HRHB programme in the second year of the research evaluation period.

This interim evaluation highlights the success of the social marketing activities, and the work of the two HRHB teams, in engaging and encouraging participation from stakeholders and families. Indeed, many stakeholders report a good level of understanding about the programme and a confidence in describing it to service users. They are favourable to the approach and philosophy of the HRHB programme, and are hopeful about the positive impact that it may have on families. The evaluation findings indicate that stakeholders are engaging well, with some organisations requesting closer working arrangements with the HRHB teams. With regards to recruitment of families to the HRHB programme, both teams have high levels of engagement with families that meet the programme inclusion criteria, with similar participation rates reported among women and men. These findings are noteworthy, as it can be particularly challenging to engage groups that are experiencing violence and report multiple other health and social needs.

Examination of the experiences of HRHB staff and those families involved in the programme highlight the importance of developing trust and rapport, and providing consistent, supportive and non-judgemental support. The strength of the therapeutic model of the HRHB programme in supporting the needs of families was also highlighted. Indeed, families describe how the techniques that they have learnt in the programme to date have resulted in improvements for their own well-being and that of the relationship with their co-parent. HRHB staff can see the value of the whole-family approach in supporting changes among families and report a feeling of progress, both in terms of embedding the programme within the sites and also in terms of personal and professional development.

In relation to the successful implementation of the programme, stakeholders, staff and families spoke of key considerations in relation to the successful recruitment and engagement of families, and the sustainability of the programme in the longer term. Stakeholders described that the teams had successfully overcome many of the early barriers but described ongoing challenges with recruitment, due to the complex needs of the families targeted by the programme. HRHB staff noted the potential for differential engagement between male and female service users, as well as practical difficulties regarding finding appropriate times and locations to meet families. Stakeholders and families talked about the potential costs of the programme, with stakeholders highlighting the need to evidence outcomes in order to attract ongoing funding and service users calling for a wider remit so that more families with different needs in relation to domestic abuse could be supported. Despite these challenges, feedback about the programme to date was very positive and all those involved were hopeful that the HRHB programme had the potential to support sustainable change in the families who engaged.

Executive Summary - HRHB evaluation interim second year findings, June 2017
Background to Research Evaluation

There is increasing recognition that Domestic Violence and Abuse (DVA) is a public health problem, with around one in four women reporting abuse from a partner during their lifetime (1). DVA is particularly common in Accident and Emergency (A&E) attenders, primary care and mental health service users and accounts for more than 3% of the NHS budget. Prevalence estimates for DVA in pregnancy range from 3% to 30% (2). Pregnancy can be a time of particular vulnerability for DVA due to changes in the physical, emotional, social and economic demands and needs of mothers and fathers.

DVA is a strong risk factor for antenatal and postnatal depression and women with perinatal mental disorders report a high prevalence and increased likelihood of DVA over their lifetime and during pregnancy (3). Alongside increased psychiatric morbidity, a growing body of research has documented the risk of DVA in the perinatal period on maternal physical health problems, such as obstetric complications, and foetal development (4). DVA can also have profound consequences on the psychological well-being of children throughout childhood and adolescence (5-9), and evidence suggests that children living in a household with DVA are 30-60% more likely to experience child abuse (10, 11). Several studies have shown significant associations, independent of other risk factors, between children’s exposure to parental DVA and adjustment problems such as poor peer relationships, low academic attainment and engagement in risky health behaviours (9, 12). There is also evidence to suggest that exposure to DVA in childhood is associated with DVA victimisation and perpetration in adolescent relationships and during adulthood (13-15).

Pregnancy and birth are major milestones in the lives of many mothers and fathers and the transition to parenthood brings rewards and challenges for both parents (16). This period can be a significant motivator for change and presents an opportune time to intervene to prevent DVA and to promote healthy relationships between parents and children. Presently, however, existing interventions have generally focused on supporting the needs of victims/survivors alone, and few also seek to target DVA and its associated consequences in conjunction with perpetrators and children. A number of community-based interventions have shown some promise for reducing the frequency and severity of DVA and mental health problems (17, 18) among female victims/survivors, although these have not been thoroughly evaluated in light of impacts on children’s health or the specific needs and demands of pregnant women. A recent Cochrane review suggests that there is insufficient evidence of interventions for DVA on pregnancy outcomes and that there is a need for high-quality research studies -which are adequately powered -to examine the ability of interventions to prevent or reduce DVA during pregnancy and to improve maternal and neonatal mortality and morbidity outcomes (19). Existing programmes also largely fail to work with partners who have perpetrated DVA and to take a whole-family approach that seeks to reduce DVA and promote positive and healthy parenting, although some models of ‘whole family’ interventions in DVA are beginning to emerge (20). Finally, although adults experiencing or perpetrating DVA
have frequently experienced trauma in their own childhood, current DVA interventions often do not address the impact of trauma in parents’ own childhood.

The Healthy Relationships: Healthy Baby (HRHB) programme seeks to address the limitations of existing interventions by developing a whole-family approach that addresses the cycles of DVA (including the impact of parents’ own childhood experiences of abuse) and seeks to improve mental health and parent-child attachment outcomes.
Research Evaluation Outline

The Stefanou Foundation has commissioned King’s College London and its academic partners to undertake an evaluation of the HRHB programme. Our research evaluation team comprises UK and international consultant perinatal and child and adolescent psychiatrists, and professors of midwifery, social work and health economics (see appendix 1 for a list of the research evaluation team).

Study Aims

The evaluation aims to assess the following components of the HRHB programme:

- whether the programme operates as anticipated
- whether the programme delivers (or gives an early indication of delivering) a range of positive short-term outcomes which may also signal the likelihood of medium- and longer-term outcomes for families
- evidence that the benefits delivered would outweigh the costs of the programme in the short- to medium-term and to explore initial indications of cost-effectiveness
- whether the information gathered and benefits observed enable further development/piloting of the programme and support the case for funding

The process, outcome, and economic components of the above evaluation are similar to those that we have used to inform the evaluation of other complex domestic abuse interventions with vulnerable groups (21, 22). We have found that the collection of process data is of key importance in the evaluation of complex interventions, and our recent findings suggest that evaluation designs which utilise routine outcome data may be more appropriate in determining the feasibility and success of complex domestic violence interventions (22).

Quantitative and qualitative data gathered from the detailed process-related evaluation of the HRHB programme will inform its future operationalization (e.g. providing estimates for recruitment and follow-up rates, informing strategies to enhance recruitment and retention). These data can also assist the ongoing development of therapeutic interventions, through the utilisation of data on levels of compliance and preferred methods/modes of delivery, among others. In addition, the fidelity scale and checks that are developed will be essential in ensuring accurate interpretations of the study findings and can be used in the future development/piloting of the programme. The reporting of families’ outcomes collected from the evaluation, including both quantitative and qualitative data, can be used to facilitate the case for future funding.
Appendix 1 – The Research Evaluation Team

Professor Louise M. Howard - Institute of Psychiatry, Psychology & Neuroscience, King’s College London

Dr Louise M. Howard (PhD, MRCP, MRCPsych) is Professor of Women’s Mental Health and Consultant Perinatal Psychiatrist at the South London and Maudsley NHS Foundation Trust. Professor Howard’s research expertise is in perinatal mental health and domestic abuse; she currently leads a NIHR programme grant examining the effectiveness and cost-effectiveness of health services for pregnant women and mothers with mental illness, and has successfully led on several large health studies on domestic abuse and human trafficking. Professor Howard chaired the NICE Guideline Development Group on Antenatal and Postnatal Mental Health and was a member of the WHO and NICE guideline groups on Violence Against Women.

Professor Harriet MacMillan – McMaster University, Canada

Dr Harriet MacMillan (MD, MSc, FRCPC) is Professor of Psychiatry and Behavioural Neurosciences at McMaster University, Canada. Professor MacMillan is also a paediatrician and child psychiatrist with extensive research experience in family violence research, including trials of interventions aimed at the prevention of child maltreatment and domestic abuse, and was a member of the WHO guideline development group on responding to intimate partner violence and sexual violence against women.

Professor Paul Ramchandani – Imperial College London

Dr Paul Ramchandani (BM BCh, MSc, DPhil, MRCPsych) is Professor of Child and Adolescent Mental Health at Imperial College London. Dr Ramchandani is also a Consultant Child and Adolescent Psychiatrist within Central and Northwest London NHS foundation trust. His research investigates the link between parents’ and children’s health.

Professor Debra Bick – King’s College London

Dr Debra Bick (RM, BA, MMEdSci, PhD) is Professor of Midwifery at King’s College London. Professor Bick has research expertise in public health and epidemiology research. She has completed several UK wide studies of complex interventions to improve maternal physical and psychological health and well-being. Professor Bick was midwife adviser to the Children’s and Young People’s Health Outcomes Forum, clinical advisor to the NICE postnatal care guideline and Chair of the NICE postnatal quality standards group.
Dr Nicky Stanley (BA, MA, MSc and CQSW) is Professor of Social Work and a co-director of University of Central Lancashire’s Connect Centre for international research on interpersonal abuse and harm. She has considerable experience of research on domestic abuse, child protection and maternal mental health and has undertaken reviews of the evidence on interventions for children and victims of domestic abuse. She led the evaluation of the Strength to Change service for perpetrators of domestic abuse as well as undertaking the formative research on the social marketing campaign that preceded the service. She was Principal Investigator on a Government commissioned study of innovative approaches in social work with looked after children conducted across 11 sites.

Professor Byford has extensive experience of utilising a range of economic methodologies to accurately evaluate the costs and economic implications of complex interventions, including health-based interventions for domestic abuse and interventions in early childhood and adolescence. She has been a member of the NICE/SCIE programme development groups for looked after children and for preventing and reducing domestic violence.

Dr Margaret Heslin is an experienced epidemiologist and health economist who works fellow at the Institute of Psychiatry, Psychology & Neuroscience, King’s College London. Dr Heslin conducts economic assessments of a number of complex interventions, including Professor Howard’s study on the effectiveness and cost-effectiveness of services for mothers with mental illness.

Dr Kylee Trevillion is a mixed-methods research fellow at the Institute of Psychiatry, Psychology & Neuroscience, King’s College London. Dr Trevillion’s primary research interests are on the practice and policy responses to violence against women and perinatal mental disorders. She has successfully completed several domestic abuse research studies and conducted her PhD thesis on mental health service responses to domestic abuse. Dr Trevillion is currently programme manager on a National Institute for Health Research funded grant examining the effectiveness and cost-effectiveness of perinatal psychiatry services.
Dr Jill Domoney is a Research Clinical Psychologist in the Section of Women’s Mental Health, specialising in perinatal and infant mental health. Her research interests include developing and evaluating psychosocial perinatal interventions, paternal mental health and father-inclusive practice. Jill was recently awarded a Churchill Travelling Fellowship to explore evidence-based practice in perinatal mental health services in Australia. She is also a member of the pPOD research group and the South London Clinical Network for Perinatal Mental Health.
References


Executive Summary - HRHB evaluation interim second year findings, June 2017


