Relationships: the missing link in public health

A report by the Relationships Alliance in association with the All Party Parliamentary Group for Strengthening Couple Relationships

The Relationships Alliance

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Foreword

Why should those charged with improving the nation's public health take an interest in the quality of the couple, family and social relationships of the populations they serve? Why, when there is ample work to be done on the traditional elements of public health such as immunisation, should directors of public health and allied professionals concern themselves with such an aspect of people's lives?

The reasons for doing so are various, as not only this report sets out but also the All Party Parliamentary Group on Strengthening Couple Relationships heard when I chaired a meeting on this topic in November last year. However, I would like to alight on two in particular which seem to me to encompass this field of endeavour.

First, because if we choose to re-focus our priorities and acknowledge the fundamental impact that the quality of our relationships has on our health and wellbeing throughout the life-course, we can successfully 'immunise' our population against much of the physical and mental ill-health which causes so much distress; the consequences of which we, as a society, increasingly struggle to afford. And second, because if we reframe our thinking and our frontline practice so that concern for the quality of people's relationships is seen as part and parcel of our everyday work, we can make significant improvements across a range of public health areas in which outcomes have long been poor.

Given that local authorities will be held to account against a range of indicators contained in the Public Health Outcomes Framework, it makes sense for those charged with public health improvement to pay particular attention to the approach, principles and case studies set out in this report. *Relationships – the missing link in public health* provides the most comprehensive attempt to date to spell out what a fully relational approach to public health means and, as such, I recommend it to everyone who is far-sighted enough to take its messages to heart and bold enough to implement its recommendations.

Andrew Selous MP

Chair of the All Party Parliamentary Group for Strengthening Couple Relationships

Executive summary

Evidence shows that the quality of our couple and family relationships is linked directly to specific areas of public health concern. Such areas include cardiovascular disease, child poverty, alcohol/substance misuse, depression and mental health, obesity/child obesity, children's mental health/ cognitive development, and infant attachment; all of which relate to specific indicators contained in the Public Health Outcomes Framework, against which local authorities and others charged with making improvements to public health will be held to account.

Independent of its relationship to those factors listed above, the quality of people's social relationships has been found to have a direct effect on mortality, with research showing that people with stronger social relationships are 50 per cent more likely to survive than those whose social relationships are weaker; and that the influence of social relationships on the risk of death are comparable with well-established risk factors for mortality such as smoking and alcohol consumption and exceed the influence of other risk factors such as physical inactivity and obesity.

Commissioners and providers wishing to adopt a relationships-focused approach to public health should do so in accordance with these key principles:

a) The quality of relationships is key to health, rather than family type or structure; healthy family stability and good relationships between partners result in positive outcomes for families.

b) Prevention and early intervention services have a key role as part of a wider package of relationship support provision.

c) Relationship support is the responsibility of all public service professionals; as such, the 'relationship support sector' should encompass health, public health and social care services and the range of professionals who work within these.

Any concerted and serious approach to public health which acknowledges the impact which poor relationship quality has on a number of areas of public health concern must be underpinned by a spectrum of support services. Such a spectrum will include relationship education and marriage preparation services; support for relationships through frontline staff such as health visitors, children's centre workers and GPs who see this as a core part of their work including relationship-focused parenting programmes; and relationship counselling and therapy for couples experiencing difficulties and distress.

Examples of services and interventions across this spectrum include ones relating to: approaches to child obesity which recognise the role of parenting to be just as important as nutrition; relationships-focused approaches to improving social connectedness; GP and primary care practice in which enquiry into the quality of the patients' relationships is seen as a central element; support services to parents of babies which have as a core element a focus on the quality of the parental couple relationship; dementia care which attaches rightful importance to the relationship between the person with dementia and their partner; counselling services which provide support for the relationships of all family members affected by cancer diagnosis and subsequent treatment; and couple-oriented psychological interventions for the treatment of depression.

1 While this report is not a systematic review of evidence, the most robust evidence has nevertheless been sought where possible.
2 For example, the Office for National Statistics wellbeing survey, Measuring National Well-being: Life in the UK (ONS, 2012) found that overall satisfaction with life and personal relationships are related. Of those who reported a medium/high satisfaction with life (7 to 10 out of 10), 92.3% also reported a medium/high satisfaction with their personal relationships (Figure 18).
3 Because of its legal status, data on married relationships and status are more widely used than other relationships, although it is likely that similar associations are evident in other relationships, such as cohabiting partnerships

Introduction

Now that responsibility for public health has moved to local authority control, and Public Health England, the new public body responsible for national oversight and guidance in this area has come into being, it is time for relationship health to take its rightful place as a central element of public health policy.

Why? In short, because the growing evidence base[1] showing relationship distress to be linked to key areas of public health concern such as cardiovascular disease, alcohol misuse, obesity and child poverty, signals a need for relationship health to be acknowledged as a key determinant of health and wellbeing[2]. This report calls for the development of a strategic vision to replace the piecemeal approach which it currently enjoys.

This view is wholly congruent with the Government's rationale for reforms to public health which it set out in the Public Health White Paper: "The Government is returning responsibility for improving public health to local government for several reasons, namely their population focus, ability to shape services to meet local needs, ability to influence wider social determinants of health, ability to tackle health inequalities" (Department of Health, 2010). As this report sets out, relationship health now needs to be acknowledged as an important determinant of health, and the policies and strategies which support and improve it must be aimed at a population-wide level, while being tailored to local needs.

With the costs of cardiovascular disease estimated at £19bn annually (BHF, 2013), alcohol abuse estimated at £25bn (Alcohol Concern, 2011), and depression £11bn (NHS Information Centre, 2011), it is clear that the £5.2bn public health budget (of which £2.2bn goes to local authorities) needs to be spent wisely if it is to make an impact.

As this report illustrates, high relationship quality is associated with better health and wellbeing, while the failure to foster and develop people's ability to sustain strong and stable relationships has deleterious consequences for their health later in life. Taking the decision to invest earlier in the life course has the clear potential to reduce the burden of disease which the UK currently faces, for example through reducing rates of cardiovascular disease, reducing alcohol misuse and reducing child obesity.

Embarking on such an approach fits neatly with the way in which progress on improving the nation's public health will be judged. If we acknowledge relationship health as a key social determinant of public health, and reflect this in local authority public health strategies, this would help local authorities improve performance in relation to many of the indicators contained in the Public Health Outcomes Framework against which they will be held to account.

Why do relationships matter to public health?

The quality of our couple and family relationships is linked directly to specific areas of public health concern or else to lifestyle factors which in turn have negative health effects. While this report does not amount to an exhaustive review of the evidence base, such areas include the following:

Cardiovascular disease

Relevant Public Health Outcomes Framework Indicator(s): Mortality from all cardiovascular diseases (including heart disease and stroke).

Numerous studies have linked marital and relationship dissatisfaction with increased incidence of cardiovascular disease (Kiecolt-Glaser, 2001). For example, marital stress may increase the risk of recurrent coronary events (Orth-Gomer, 2000), while marital quality predicts patient survival among patients with chronic heart failure (Coyne, 2001). The quality of couple relationships also has a remarkable impact on survival rates after bypass surgery, with married people being 2.5 times more likely to be alive 15 years after coronary artery bypass grafting (CABG) than those who are not married, and those in high-satisfaction marriages being 3.2 times more likely to be alive 15 years after CABG compared with those reporting low marital satisfaction (King, 2012).

In relation to blood pressure, people with mild hypertension who report higher levels of marital satisfaction exhibit decreased left ventricle mass and lower diastolic blood pressure after three years than people with lower levels of marital satisfaction (Baker, 2003). In addition, relationship quality is a better predictor of daily blood pressure than whether one is married, or in a partnership or not, with high relationship quality being linked to lower blood pressure (Grewen, 2005). Similarly, high marital quality is associated with lower ambulatory blood pressure, lower stress, less depression and higher satisfaction with life. On the other hand, single individuals have lower ambulatory blood pressure than their unhappily married counterparts (Holt-Lunstad et al., 2008).

In relation to atherosclerosis (thickening of the artery wall), research has found that women in satisfying marriages have significantly less hardening of the arteries than women in low-satisfying marriages (Gallo, 2003).

Child poverty

Relevant Public Health Outcomes Framework Indicator(s): Children in poverty.

Chronic and poorly resolved conflict is harmful to children, and the actual breakdown of the parental relationship often does not resolve this as many parents remain in conflict post-separation. It must also be acknowledged that relationship breakdown in and of itself significantly increases the chances of a child falling into poverty (HoC, 2003).

A review of evidence conducted in 2009 reported that 'evidence from extensive reviews of studies and vast longitudinal datasets largely in the US and UK has reported associations between couple relationship breakdown and poor child outcomes. These include associations with poverty, behavioural problems including conduct disorder and anti-social behaviour, distress and unhappiness, educational achievement, substance misuse, and physical and emotional health problems.' Notably, the report goes on to say: 'Of these child outcomes, the impact on socio-economic disadvantage or poverty appears to be the most prominent and may potentially extend into adulthood' (Coleman & Glenn, 2009).

And while, as a report from the Joseph Rowntree Foundation points out, 'public policy cannot legislate for better personal relationships [...] there is undoubtedly more that could be done to make support available to couples at times of stress and to limit the economic and other socially excluding effects of relationship breakdown on children' (Work and Pensions Committee, 2003).

Alcohol/substance misuse

Relevant Public Health Outcomes Framework Indicator(s): Mortality from cancer; Alcohol-related admissions to hospital.

Alcohol consumption in the UK has doubled in the past forty years. During this period, according to the Faculty of Public Health, the death rate from liver cirrhosis has more than quadrupled. In addition to a number of cancers, alcohol misuse can be a significant contributory factor to conditions such as obesity, high blood pressure, coronary heart disease and pancreatitis, as well as mental health problems such as depression and alcohol dependency (Faculty of Public Health, 2008).

Given the public health implications of alcohol use (see, for example, Wilkins, 2013, for further information showing how poor quality relationships have an effect on men's risk taking behaviour including alcohol and substance misuse), it is perhaps surprising that there are so few studies on the impact of relationship difficulties on alcohol consumption (as opposed to a plethora of studies which investigate the impact of alcohol consumption on marital and relationship satisfaction).

However, those studies which have been done point to a clear link between relationship dissatisfaction and alcohol misuse. One study, for example, found that women tend to drink more than men in response to relationship difficulties and low levels of intimacy from their partner (Levitt, 2010). This finding corroborated those from earlier studies which indicated that women whose relationships lacked intimacy reported increased drinking problems over time compared to women with more intimate relationships (Wilsnack, 1984). A longitudinal study however – which followed couples over a period of nine years – found that husbands rather than wives tend to drink more heavily in response to marital problems (Romelsjo, Lazarus, Kaplan, & Cohen, 1991).

The thrust of these findings is supported by two studies conducted in 2006. The first of these demonstrated a greater likelihood of people abusing alcohol one year after scoring highly on a rating of marital dissatisfaction, leading the authors of the study to observe that "if marital dissatisfaction is related to the course of alcohol use disorders, then reducing marital dissatisfaction should reduce the likelihood of onset or recurrence of alcohol use disorders" (Whisman, 2006); while the second, of nearly 5,000 adults aged 18 to 64, showed that the marital discord underlying a divorce (rather than the divorce itself) to be associated with the onset of alcohol abuse, social phobia and chronic low mood (Overbeek, 2006).

A randomised controlled trial conducted in 2005 to examine the clinical efficacy and cost-effectiveness of brief relationship therapy with alcoholic male patients and their non-substance-abusing female partners found that, at 12-month follow-up, heavy drinking and dyadic adjustment outcomes for patients who received brief relationship therapy were superior to those of patients who received individual-based treatment or a psycho-educational approach (Fals-Stewart, 2005).

Depression and mental health

Relevant Public Health Outcomes Framework Indicator(s): Self-reported well-being; Suicide rate.

Depression in adults is recognised as a major health, social and economic problem in the UK and across the world, and is estimated to become the world's second highest cause of disability by 2020. It affects individuals, families, children, employers, and the state. It is the major risk factor in suicide (NICE, 2009) (Wylie, 2012).

Studies (e.g. Teo, 2013) have indicated that relationship distress and depression are linked – in fact it is estimated that 60% of those with depression attribute relationship problems as the main cause for their illness ((Whisman, 2001; O'Leary, Riso & Beach, 1990; Rounsaville et al., 1979) – and that couple therapy is an effective way of treating depression.

Indeed, couple therapy for depression (see Relationship support: a broader approach below) is a NICE-recommended treatment for depression (NICE, 2009); an additional benefit of this approach is that it also treats the couple relationship which helps prevent relapse of depression as well as improving the family circumstances for any children and reducing their chance of having depression in later life.

Obesity/child obesity

Relevant Public Health Outcomes Framework Indicator(s): Breastfeeding initiation; Breastfeeding prevalence at 6-8 weeks after birth; Excess weight in 4-5 and 10-11 year olds

The impact of the quality of the couple relationship has been highlighted by research into parental behaviour during children's eating activities which suggests that "the emotional climate created by these behaviours can significantly impact the eating behaviours of the developing child in a positive or a negative way depending upon the feeding style of the parent" (Hughes, 2011). Another study found that "mothers of obese youth reported significantly greater psychological distress, higher family conflict, and more mealtime challenges" (Zeller, 2007).

Furthermore, children raised by parents who have an authoritative parenting style - characterised by a firm but warm and accepting approach - eat more healthily, are more physically active and have lower BMI levels compared to children raised with other styles. i.e. authoritarian (strict disciplinarian), permissive/indulgent, uninvolved/neglectful (Sleddens, 2011); while indulgent (Olvera, 2009) and authoritarian (Rhee, 2006) parenting predicts overweight in children.

In her 2009 review of evidence to the Department of Health, Tackling Obesity through the Healthy Child Programme: A Framework for Action (Rudolf, 2009), Professor Mary Rudolf stated: "Parents strongly influence their children's lifestyle. This goes beyond the food they provide for their children and the activities they encourage them to do. They influence them through the way they feed them, the way they present themselves as role models, the foods and activities they make available and accessible in the home,

and the parenting style they adopt". Given the links between parental behaviour and parental relationship quality – for example, permissive and authoritarian parenting styles are associated with lower marital satisfaction (Devito, 2001) and marital dissatisfaction results in more authoritarian and less authoritative parenting (Cowan, 1992) – it behoves us to pay attention to the relational factors which have a bearing on the development of childhood obesity.

Children's mental health/cognitive development

Relevant Public Health Outcomes Framework Indicator(s): Child development at 2-2.5 years; School readiness; Pupil absence.

Children's socio-emotional and cognitive development is significantly influenced by the quality of the parental couple relationship. Exposure to couple conflict – whether frequent and intense, or unexpressed and non-violent – can affect children of all ages (including babies) and can manifest itself as increased anxiety, depression, aggression, hostility, anti-social behaviour and criminality as well as deficits in academic attainment (Harold and Leve, 2012).

Relationship conflict and disagreements are inevitable in any relationship, and research also shows that it is the manner in which couple conflict is expressed, managed and resolved – as well as the extent to which children feel at fault for, or threatened by, their parent's relationship arguments – that is key to the impact couple conflict has on child outcomes (Harold and Leve, 2012).

Infant attachment

Relevant Public Health Outcomes Framework Indicator(s): Child development at 2-2.5 years.

Children who develop an insecure or disorganised attachment to their parents or caregivers are more likely, across the life-course, to experience difficulty sustaining close personal relationships, suffer more from low self-esteem and are more likely to break down under stress.

Research which looks at the impact of couple relationship quality on the formation of infant attachment demonstrates the following: secure child-mother and child-father attachments are more likely to occur in families in which husbands and wives are highly satisfied with their marriages, whereas insecure child-parent attachments are most likely to occur when marital adjustment is poor (Goldberg, 1984); for mothers, high satisfaction, low conflict and high communication quality are related to child security of attachment and sociability; whereas for fathers, higher levels of premarital conflict and lower levels of communication quality are linked to having children who are overly-dependent (Howes, 1989). These findings suggest that in the face of marital distress, fathers may withdraw from their children in a way that negatively affects the child's development of autonomy. The children of insecure mothers whose relationships are of relatively high quality are significantly more secure than those whose mothers have lower quality relationships (Das Eiden, 1995).

Social relationships have an impact on mortality independent of other factors

Relevant Public Health Outcomes Framework Indicator(s): Social connectedness.

Independent of its relationship to those factors listed above, the quality of people's social relationships has been found to have a direct effect on mortality.

For example, a meta-analytic review carried out in 2010 of 148 research studies – many of which statistically adjusted for standard risk factors such as alcohol misuse and CVD – found that people with stronger social relationships are 50 per cent more likely to survive than those whose social relationships are weaker (Holt-Lunstad, 2010).

Moreover, the influence of social relationships on the risk of death are, this analysis concluded, comparable with well-established risk factors for mortality such as smoking and alcohol consumption and exceed the influence of other risk factors such as physical inactivity and obesity.

These findings, the authors stress, are likely to be an underestimate of the true impact of stronger social relationships on longevity, in part due to the fact that most measures of social relations did not take into account the quality of the social relationships, thereby assuming that all relationships are positive. However, research suggests this is not the case, with negative social relationships linked to greater risk of mortality (Friedman, 1995) (Tucker, 1995) (Coyne, 2001) (Eaker, 2007).

What might a relationships-focused approach to public health look like?

Having set out the evidence base, what might a relationships-focused approach to public health look like in practice?

We will begin by outlining the overarching model of relationship support advocated by the Relationships Alliance. Such a model amounts to a significant re-conceptualisation of public health; and making it a reality will require a considerable refocusing of priorities. This section then goes into more detail by briefly describing examples of good and emerging practice that exemplify some of the key principles of a relationship-focused approach to public health which we outline later in the report.

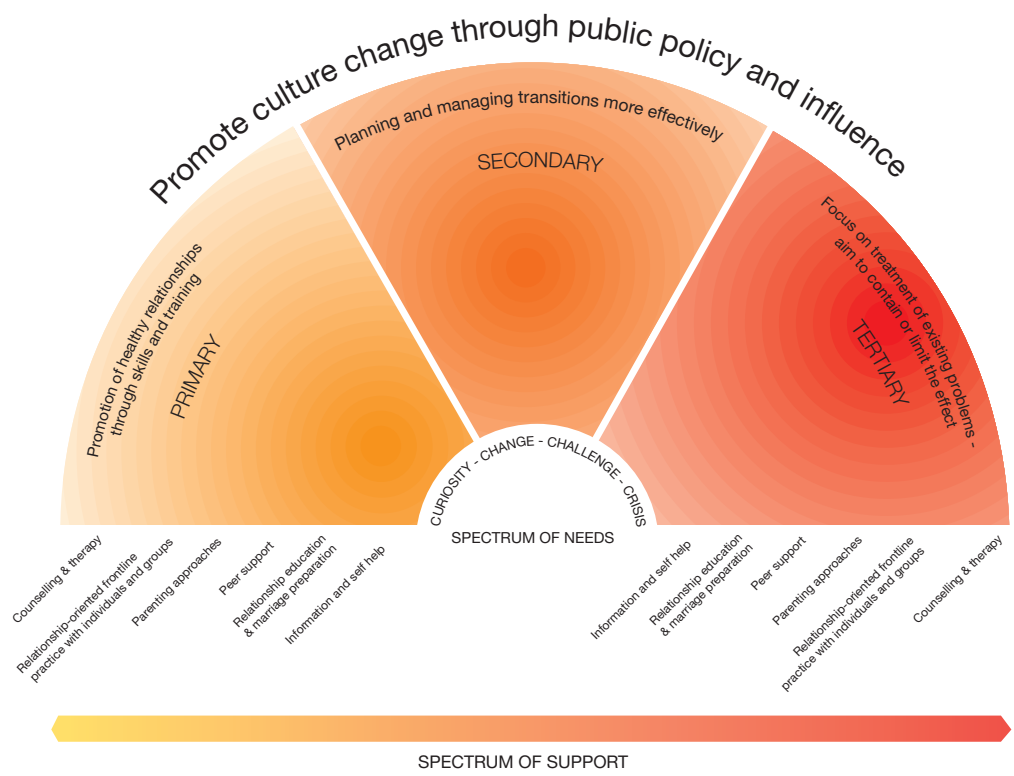
Relationship support: a broader approach

Any concerted and serious approach to public health which acknowledges the impact which poor relationship quality has on a number of areas of public health concern must be underpinned by a spectrum of support services. While this broad spectrum will be described in detail in a forthcoming publication, and is illustrated in Figure 1, it will include the following:

- Relationship education and marriage preparation services
- Support for relationships through frontline staff such as health visitors, children's centre workers and GPs who see this as a core part of their work including relationship-focused parenting programmes
- Relationship counselling and therapy for couples experiencing difficulties and distress

(N.B. all these services should be available to couples and families whatever their relationship status: married, living together, or separated or divorced)

Fig 1. Relationship support: A spectrum of approaches to meet a spectrum of needs



However, this kind of approach must also include a commitment by those working in health, social care and public health to reduce the knock-on impact which relationship distress has on the many areas outlined in this report. This is a significant shift in focus and will require clear advice and guidance from government agencies, together with training for those delivering and commissioning services.

Examples of primary support

Child obesity

In relation to action to prevent and tackle child obesity, a relational approach to public health would ensure that work in this area acknowledges the impact of the parental couple relationship and parenting style. An exemplar of good practice in this area is the HENRY programme, an approach which recognises the role of parenting to be just as important as nutrition in the prevention and management of child obesity (Willis, 2012). The Relationships Alliance does not believe that public health strategies which simply focus on increasing physical activity and improving diet for children are sufficient to tackle this issue.

Co-production

Co-production has been defined as "delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change" (Nesta, 2012).

One of the six key principles of co-production relates to mutuality; that is, "offering people a range of incentives to engage with, enabling them to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations". The co-production of services is therefore complementary to a relational approach to public health, and a recent report from Nesta contains numerous case studies of such services (Nesta, 2012).

Social connectedness

While this area of social and relationships practice is very much a new and developing area, promising and innovative approaches include:

- online support services (e.g. Tyze, an online service which helps to bridge the gap between formal and informal support, and allows users of health services to structure their relationships (see tyze.com));
- relationships-focused approaches to improving social connectedness (e.g. Circle, an approach which involves paid and unpaid helpers contributing to social events which benefit often isolated older people (see http://www.participle.net/), and
- time-banking (e.g. Paxton Green, one of the largest practices in south east London, uses time-banking, a mutual volunteering approach which enables people to swap skills with one another, using an equal currency of time. Time-banking enables people who live in the same area, whether or not they are actually patients at the practice, to get involved in a range of activities including befriending, visiting, lifts, art, creative writing, meditation and walking, the key aim being the provision of mutual support as all these services are delivered and exchanged by other members of the time bank (http://www.pgtimebank.org/)).

Examples of secondary support

Primary Care

GPs and other primary care should, be routinely asking patients with long-term health conditions such as cardiovascular disease or depression about their relationships and be willing to commission appropriate relationship support services where necessary.

Similarly, GPs should, as a matter of course, enquire about the quality of the relationships of those in their care with substance misuse and alcohol problems and, again, commission appropriate support services where necessary. Such an approach is congruent with that set out in an online course for general practitioners – Supporting Couple Relationships in General Practice - devised by One Plus One (http://www.rcgp.org.uk/courses-and-events/online-learning/ole/supporting-couple-relationships-in-general-practice.aspx).

However, given its potential to prevent ill health, such an approach should be a fundamental part of all general practice. For example, research shows that over half of people who have had a stroke have experienced difficulties in their couple relationship and, of these, nearly one in 10 had broken up with their partner or were considering doing so (Stroke Association, 2013). In addition, mental health issues place more strain on relationships than others such as financial hardship and employment problems (MIND/Relate, 2013).

As part of the spectrum of services mentioned above, a relationships-focused approach to public health would ensure that all those who are becoming parents, and parents of babies and young children, have access to relationship support services. This would help minimise the likelihood of relationship difficulties between parents having a negative effect on the development of attachment security between mother and baby, or father and baby.

The Family Nurse Partnership

The Family Nurse Partnership (recently extended by the Department of Health) offers mothers of babies under two, through her relationship with a dedicated family nurse who visits on a weekly or fortnightly basis until the child's second birthday, the opportunity to better understand and manage her relationships with others (including her own parents and the baby's father) so that they are supportive of the mother and child's needs.

The Relationships Alliance takes the view that approaches such as the Family Nurse Partnership need to place more focus than they currently do on the parental relationships involved. Notwithstanding this caveat, the Relationships Alliance believes that such interventions should be seen an important element in any locality's strategy not only because their potential to reduce child poverty but also – as with all services which provide support to parents – their potential to reduce the incidence of children's mental health problems, and improve children's cognitive development and academic attainment (TCCR, 2013).

Dementia

A relational approach to public health would ensure that care of those with dementia attaches rightful importance to the couple's relationship since this has been shown – for example in the 'Living Together with Dementia programme' (http://tccr.ac.uk/services/2012-03-20-14-49-08/living-together-with-dementia) – to increase shared activity, emotional contact and understanding between the partners.

Cancer care

In 2006, a Macmillan research paper (Worried Sick – the Emotional Impact of Cancer" (Opinion Leader Research April 2006)) showed that a quarter of people with cancer believe that the illness had affected their relationships and that the relationships of a similar proportion had broken down as a result of being diagnosed with the disease.

In response, Relate and MacMillan set up a counselling service in Greater Manchester in 2010 to provide support for the relationships of all family members affected by cancer diagnosis and subsequent treatment (Macmillan/Relate Greater Manchester, 2012).

Examples of tertiary support

Couple therapy for depression

In relation to adult mental health issues such as depression, a relationships-focused approach to public health would ensure that couple therapy for depression was available throughout primary care; this NICE-recommended approach is the treatment of choice where there is a distressed couple relationship that appears to be a factor in instigating, maintaining, or re-precipitating the depressive symptoms in one partner. It is also the intervention of choice where a close relationship might be a necessary support for treatment adherence (Hewison, 2011). In terms of wider social relationships, the Relationships Alliance also supports the use of befriending schemes for lower levels of depression, given the evidence showing a modest effect on depressive symptoms and emotional distress in varied patient groups (Mead, 2010).

Key principles of a relationships-focused approach to public health

Commissioners and providers wishing to adopt a relationships-focused approach to public health should do so in accordance with these key principles:

a) The quality of relationships is key to health, rather than family type or structure; healthy family stability and good relationships between partners result in positive outcomes for families.

b) Prevention and early intervention services have a key role as part of a wider package of relationship support provision.

c) Relationship support is the responsibility of all public service professionals; as such, the 'relationship support sector' should encompass health, public health and social care services and the range of professionals who work within these.

d) The relationship support sector has a duty to combat the stigma around asking for help with relationships and to normalise relationship support-seeking behaviour among all ages of society.

Conclusion and recommendations

This report sets out an evidence-based argument for why all those who commission and provide services should, and can, be doing more to improve relationship health within the populations they cater for.

If we introduce a relational approach to public health, we have the potential to improve our population's capacity to sustain strong and stable relationships, and thereby improve our mental and physical health and well-being.

If we fail to effect this change of approach, we can be sure that relationship distress will continue to have a negative impact on adult's and children's lives, for example through depression, anxiety, increased alcohol misuse and poorer cardiovascular health.

The approach, principles and case studies set out in this report, the Relationships Alliance believes, have the potential strengthen individuals' and family's own resources, as well as reducing health inequalities, the incidence of chronic conditions and over-reliance on health and social care professionals. Such an approach also has the potential to reduce public expenditure in a range of areas (for example through reduction in healthcare service usage and improved outcomes for children) (nef, 2012).

The Relationships Alliance urges all those charged with shaping our approach to public health in the coming years to adopt a relational approach to the field. Achieving this will best be accomplished by implementation of the following set of recommendations:

1. Public Health England should appoint a lead for relationship health in order to provide top-level expertise and guidance to local authorities on how to improve relationship health locally; local authorities should also appoint a lead for relationship health charged with ensuring that the fundamental importance of relationship health is acknowledged and reflected in the authority's public health strategy.

2. Directors of public health should collect data on relationship breakdown and relationship quality in their communities – and report such data in their public health annual reports – in order that the data informs the work of Health and Wellbeing Boards and joint strategic needs assessments.

3. Local authorities, clinical commissioning groups and other bodies delivering services aimed at improving public health should invest in training for all frontline staff delivering these services to increase awareness and skills of the profound impact which relationship health – including couple relationship quality – has on a wide range of specific public health issues; and that Public Health England should facilitate development in this area by setting out national standards and competencies.

4. Healthwatch England should ensure that relationship health forms part of the work of the emerging Healthwatch Groups.

5. Relationship health should be an integral part of commissioning strategies that are being developed by CCGs and linked to health and wellbeing strategies, and mental health strategies.

6. Each local authority should commission and carry out an audit of its approach to public health in order to:

• establish the degree to which their approach to improving public health reflects the profound impact which relationship health – including couple relationship quality – has on a wide range of specific public health issues

• plan how local authority approaches could better support and enhance relationship health before problems become entrenched

• identify the range of support services available to support and enhance adult couple and other relationships.

7. Relationship support providers in each local authority area should work together to ensure that their voice is represented on their local health and wellbeing board.

8. Relationship support providers in each local authority area should build up relationships with commissioners in local clinical commissioning groups to ensure that CCGs are aware of evidence between relationship health and aspects of healthcare which have a bearing on the public health of the local population; and that CCGs commission their services as a result (see the Relationships Alliance's forthcoming Toolkit on reforms to the NHS for local relationship support providers).

9. When running parenting classes, local authorities should explicitly acknowledge the evidence-based link between parenting and the quality of the parents' relationship (whether parents are still together or separated) and commission parenting support which recognises this[4].

10. Local authorities and Public Health England should be prepared to decommission approaches to improving public health where a more relationally-focused approach would result in improved performance against Public Health Outcomes Framework indicators (e.g. approaches seeking to improve parenting and maternal-infant attachment which work exclusively with mothers when a focus on the parental relationship would be more effective).

4 Evidence suggests that parent education programmes are more effective with parents in conflict if they include a couple relationship component compared to those which deal only with parenting issues (Webster-Stratton and Reid, 2003; Cowan et al., 2011).

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The Relationships Alliance, a corsortium comprising Relate, Marriage Care, One Plus One and the Tavistock Centre for Couple Relationships, exists to ensure that good quality personal and social relationships are more widely acknowledged as central to our health and wellbeing.

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