Joint submission from The Tavistock Centre for Couple Relationships and Relate to the Mental Health Taskforce regarding the Five Year Strategy for Mental Health (2015-2020)

Relate and the Tavistock Centre for Couple Relationships – charities which are primarily concerned with the provision of relationship support – have long recognised the bi-directional links between relationship quality and mental health. Recognition of these links and a desire that they be more widely acknowledged and acted upon underpin our respective memberships of the We Need to Talk Coalition, as well as our work together to advocate for relationships in mental health policy and practice (see our policy briefing *Couple Relationships and Mental Health* with the Relationships Alliance).

We are pleased to see that a process has been devised for the development of a new mental health strategy for the next Parliament, and for the opportunity to respond to the six questions posed by Paul Farmer below.

We would like to preface our responses with the general observation that we would like to see the relational aspects of mental health care explicitly acknowledged in the proposed Five Year Strategy for Mental Health. For while it was important that *No health without mental health* (Department of Health, 2011) acknowledged at its outset the link between mental health and strong relationships – "Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential" – it was regrettable that the strategy was much less clear on the impact of poor relationships on mental health. And yet, it is this link between relationship quality and mental health, particularly depression and anxiety, which needs to be more widely acknowledged in policy circles if mental healthcare practice is to adopt a truly 'person centred' approach, enabling and supporting people to achieve the outcomes that are important to them, which so often revolve around relationships.

Question: What are the 3 priority outcomes i.e. overarching ambitions for change you want to see in the way that the NHS provides mental health support – and why?

- Over the lifetime of the Five Year Mental Health Strategy, we would like to see a sea-change in our approach to mental health care such that the identification and treatment of relationship distress is seen as a basic element of effective mental health care. Workforce training – of GPs, psychiatrists, psychologists, health visitors, social workers and others involved in mental health care (such as Psychological Wellbeing Practitioners in IAPT) – will be key to achieving this.

- We would also like to see the Department of Health set a clear policy ambition outlining the level of meaningful choice that should be available to clients through the IAPT programme, going beyond increasing the number of clients who are able to make a choice, to consider

whether this is a fully-informed choice from a diverse range of options, including couple therapy for depression. In particular, full choice requires that the NICE-approved treatment for depression – couple therapy for depression – becomes available in 100% of IAPT services by the end of the five year period covered by the strategy; and that the delivery of this intervention matches the level of identified need in the population.

In order to deliver this, clear guidance and training for commissioners with the support of their local Strategic Clinical Network will be key to ensure that they understand the benefits of the full range of NICE-recommended IAPT therapies, including couple therapy for depression, and the importance of meaningful choice. Furthermore, it is imperative that psychological wellbeing practitioners in IAPT services actively assess whether a patient's relationship with their partner is a factor in that patient's depression (see question 2 below). Improved information and brokerage support should also be provided directly to people accessing IAPT services to ensure that fully-informed choice is possible.

- We would like to see a focus on relationships in public health embedded as a core part of a prevention strategy. In particular, in recognition of the links between relationships and long-term health conditions - and the evidence that good-quality relationships can protect against deterioration, aid recovery and even prevent us from becoming ill in the first place, while poor-quality relationships are health risks (Relate/NPC, 2015) - we would like to see the NHS providing preventative mental health and wellbeing support to people living with long-term conditions – those with the conditions, their carers/partners, and families.

- In terms of why we are calling for the Five Year Mental Health Strategy to lay the foundations for this change in approach, this is because the research evidence so clearly demonstrates how relationship quality and mental health are interlinked – for example:

    - 71% of clients coming for couple therapy at TCCR are suffering from mild, moderate or severe depression (Beck Depression Inventory scores);
    - people who live in distressed and troubled relationships are three times as likely to suffer from mood disorders (e.g. depression), and two and a half times as likely to suffer from anxiety disorders, as people who do not experience such relationship distress (Whisman and Uebelacker, 2003).
    - adults in the lowest-quality relationships are twice as likely to develop depression as those in the highest quality relationships (Teo, 2013)
    - the treatment of relationship distress has the potential alleviate up to 30% of cases of major depression, according to research (Whisman, 2001)
    - interventions which aim to treat mental health issues in the context of relationship distress are only minimally available under the NHS (the NICE-approved treatment for depression, couple therapy for depression, accounts for just 1 in every 250 sessions delivered in IAPT (HSCIC, 2014)
    - unresolved and poorly managed conflict between parents can create long-term emotional and behavioural problems in children (TCCR, 2012) (Coleman and Glenn, 2009).

Question: What, specifically, would need to be different by 2020, particularly for different age groups and to address inequalities?

- Babies and young children:

The impact of relationship conflict and distress on babies and young children is incontestable (TCCR, 2013; Coleman and Glenn, 2009). The transition to parenthood – acknowledged to be a particularly stressful time for couples - therefore presents a key opportunity where support can help to reduce the likelihood of relationship difficulties becoming entrenched. Research shows that such workforce training is effective at helping frontline professionals, such as health visitors, to screen for relationship problems during the postnatal period and to provide support or signpost to specialist support when required in a way that is valued by mothers (Simons, 2003). Research also suggests that building in a couple focus to existing parenting support services may be effective at reducing postnatal depression in mothers and improving couple relationship quality (Clulow and Donaghy, 2010).

- Older children and young people:

Relational working in children and young people's mental health services has the potential to reduce psychological distress and improve wellbeing. Access to counselling for young people is important to reduce mental health problems. One in ten children and young people live with a diagnosable mental health condition – around three in every school classroom (Green et al, 2004). It is estimated that two-thirds of young people attending school-based counselling are experiencing difficulties at 'abnormal' or 'borderline' levels, and have problems which have been present for a year or longer (Cooper, 2013). A substantial body of research has found that children's and young people's counselling can be effective at reducing depression, anxiety, and a range of other mental health problems. For example, a meta-analysis of 30 UK studies on counselling in UK secondary schools, found that counselling was associated with large improvements in mental health (Cooper, 2009).

However, a relational approach to young people's mental health and wellbeing is required, given the links between mental health and relationships. It is important to note that many of the problems children present with in counselling are symptoms of relational problems at home: in a recent survey of over 4,500 children seen by CAMHS services, 'Family Relationships Problems' were the biggest presenting problem (Wolpert and Martin, 2015). We believe that greater emphasis should be placed by CAMH services on workforce development such that practitioners feel better equipped to recognise, and address, the parental relationship issues which lie at the heart of much child mental ill health. In addition, we would like to see the Department of Health by 2020 establishing targets stipulating that all children and young people who need it can access support for mental health problems, including counselling at school, in order to support them to better understand and navigate their relationships, with benefits for their mental health (this is obviously an area with cross-over with the Children and Young People's Mental Health and Wellbeing Task Force.)

- Adults:

The Implementation Framework for *No health without mental health* stated that: "*We now need to go further, ensuring a choice of NICE approved therapies are commissioned and provided in all areas of the country, and that they are accessible to all, including older people and people from BME communities."*

The fact that couple therapy for depression accounts for just 1 in every 250 sessions delivered in IAPT (HSCIC, 2014), and that 50% of IAPT services do not offer this intervention at all (FOI request to CCGs, submitted by Action for Choice in Therapy, 2015) suggests that this laudable ambition has not been realised in respect to couple therapy for depression (the only relational intervention which the NHS delivers).

In order for the provision of couple therapy for depression to reflect population need, Health Education England would need to put in place a robust workforce plan (see point below). In addition, the Department of Health would need to issue its booklet, 'Which talking therapy for depression?', to all clinical commissioning groups. Furthermore, there should be a requirement placed on all IAPT providers such that they must provide the full range of NICE approved therapies for the treatment of depression. Lastly, IAPT services should be required to assess patients against the Z63 category of ICD-10 when using the IAPT problem descriptor to assess patients. We know that services which do not offer couple therapy for depression are unlikely to fill out this descriptor (which relates to "Other problems related to primary support group, including family circumstances"). Since "Problems in relationship with spouse or partner" is one of the items on this list, the fact that services do not assess against this problem descriptor means that vital data – which could help identify the true level of need for this relational approach to treating depression – is lost.

- Older people:

Widening the uptake of relationship support services by people of working age and in later life has the potential to reduce the numbers of elderly people living alone. Given the links between loneliness and depression, it makes sense to invest in relationship support services for this age group as a preventative approach to tackling depression (TCCR, 2012). By 2020 we would like to see the NHS establishing targets for the numbers of people living with a long-term health condition having access to support for their relationships as a part of person-centred care.

Question: What does each priority outcome mean for different groups?

- Groups affected by inequality of access and outcome e.g. BME
- Pregnant women, children, young people, adults, older people, black and minority ethnic groups and people with multiple needs.

Developing the ability of frontline professionals such as health visitors to respond to relationship distress will be of obvious benefit to pregnant women, children and adults, as the research findings above indicate. It will also be of particular help to minority ethnic groups who are less likely to seek relationship support than other groups.

- Whole population (prevention), "one in four" (mild or moderate mental health problems), "one in fifty" (severe mental illness), "when needs collide" (long term conditions and disability"), "complex" (intensive and ongoing"

Early intervention to reduce relationship distress through services such as health visiting has the potential to reduce incidence of mental health problems (such as depression and anxiety) in adults as well as mental health problems, and behavioural difficulties, in children.

Workforce training around the relational aspects of mental health - for professionals such as GPs, psychiatrists, psychologists involved in delivering mental health care – has the potential to reduce the incidence, and alleviate the severity, of mental health problems such as depression and anxiety in the 'one in four' of the population suffering from mild or moderate mental health problems.

Such training also has the potential to benefit those living with long-term conditions, such as depression (Relate, 2015) (Relationships Alliance, 2013); it also has the potential to reduce mental health problems such as depression experienced by those dealing with relationship problems as a result of long-term conditions such as cancer and cardiovascular disease (Relate, 2015) (Relationships Alliance, 2013).

Question: What is achievable in each year? In this context, this is practical milestones, year-on-year, which would help achieve priority outcomes by 2020. This includes leadership, quality, integrated approaches to care, workforce development, data, commissioning, co-production, payment and pricing, research, digital, monitoring and reporting.

We would like to see the Five Year Mental Health Strategy call on Health Education England – the body responsible, under its Mandate from the NHS, for 'ensuring sufficient therapists and other staff with the right skills to deliver the IAPT programme' – to develop a workforce plan in the first year of the Five Year Strategy which will set out what steps it intends to take in partnership with clinical commissioning groups to increase the numbers of practitioners trained to deliver couple therapy for depression in order that there is sufficient availability of this intervention in IAPT services to meet need.

We would also like to see the Five Year Mental Health Strategy call for a working party to be set up in its first year to scope how the Royal Colleges and other relevant training bodies can devise and implement training in the relational aspects of (mental) health, with an ambition that, by the end of the five year period, trainings for GPs, psychiatrists, psychologists and other relevant professionals, include a mandatory element on this aspect of mental health care.

Finally, we would like to see the Department of Health establish an inquiry to review the NHS Outcomes Framework and NHS Mandate to make recommendations on how relationships should be included in these frameworks.

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