



The Best Medicine?

The importance of relationships for health and wellbeing

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Foreword: Ruth Sutherland, Relate

Good quality relationships with partners, families, friends and wider social networks bring health benefits as well as happiness, and provide meaning to our lives. They can help prevent illness, help us recover more quickly or prevent deterioration, and minimise the impact of ill health. Our relationships are all the more important as we consider the challenges ahead – an ageing population; rising costs of social care; financial pressures, including an estimated funding gap of £30 billion a year¹; an NHS struggling to adjust away from treatment and prevention of infectious disease towards managing long term conditions; rising prevalence of cancer, diabetes, cardiovascular disease and dementia.

The protective effect of relationships is increasingly recognised, as policy-makers face the growing problem of loneliness across all ages, but particularly in later life. Similarly, there's increasing attention being paid to the conditions in which people are born, grow, live, work and age, and which account for inequalities in our health. Our relationships with families, friends and neighbours are fundamental social determinants of our health: when we're well-connected in strong, positive, nurturing relationships, we're not only happier but also more resilient; more likely to live healthier and longer lives.

However, we also know there are common strains on relationships, including major life transitions such as the onset of a long term condition. These can be life-changing, and – when we need them the most – the impact on our relationships with partners, families and friends can be profound. We know this from Relate's experiences of working with couples, individuals and families each year. Over a million people every year access our information, support and counselling but many more could benefit.

This is why we partnered with NPC to produce this report, and why we're launching our 'The Best Medicine' campaign to raise awareness of the link between relationships and health. Strong relationships with partners, family and friends are the latent assets which can improve outcomes and save money in the long term. We're social beings; yet in focusing on treating the individual patient, our health system doesn't always draw on the social basis of our health. Our relationships are crucial resources, and supporting them may help to protect people from deterioration, aid recovery or adjustment – and ultimately reduce the costs associated with responding to long term conditions.

In recognition of the importance of relationships for health and wellbeing, and of the impact of long term conditions on these relationships, Relate is piloting a number of support services for people living with long term health conditions and their families – for example providing free relationship support to people with dementia and cancer and to carers in different parts of the country.

Support is out there, but too few people get access to it. We're calling on local and national government to put relationships at the heart of the NHS. Broadening the way in which we understand health and wellbeing by considering people not just as individuals, but as entwined in relationships with others, could be the key to unlock public health benefits, tackle the drivers of health demand, and help us live longer, healthier lives.

Foreword: Dan Corry, NPC

Across the developed world the health of our peoples and our ability to continue to finance our health systems is rising fast up the agenda. In the UK we see a lot of focus on the older end of the population - we are an ageing nation, experiencing increased loneliness, and 15 million of us are living with a long term health condition. But worries about both physical and mental health issues extend right through people's lives, from babies and young children, through adolescence and early adulthood and on to the difficult and stressed years of middle age. Keeping up with these demands in the context of tight public finances, whilst staying true to the NHS's long standing mission to *ensure high quality care for all*, can seem an insurmountable task.

Increasingly, the realisation that a purely medical fix to all these issues is neither sufficient nor desirable is taking hold and being replaced by an understanding that prevention and a focus on wellbeing must be key to the future. NHS England's Chief Executive Simon Stevens' Five Year Forward View was the most recent public pronouncement to that effect.

Key to preventing poor health and wellbeing are the personal and social relationships we have within our communities, schools, workplaces and families. Perhaps the idea that good, fulfilling relationships are linked to health outcomes is not that surprising - but the strength of the evidence that this report, carried out for Relate by NPC, reveals is surely an eye opener.

Those of us with strong relationships are 50% more likely to survive life-threatening illness than people with weaker ones. Our relationships are as important to our health as our diet or whether we smoke, if not more so. They impact positively on our likelihood of encountering long term health conditions and other illnesses but also on how well and quickly we recover. This reinforces previous research we have carried out for Relate, which found that good quality relationships contribute to fulfilling lives for those in older age and help prevent the challenges that ageing brings². It also links to work we have done recently around finding new and innovative ways of helping tackle the increasing pressures on the health and social care systems, where the more personal, holistic approach can pay dividends³.

The great challenge now is to think what interventions, approaches and general societal changes can help to improve and sustain personal relationships so that we can reap the benefits that the evidence so clearly points to. If we can integrate our relationships into a holistic healthcare model, we should be able to reduce the likelihood of so many of us requiring costly treatment and care. And if we can create a society that brings people together, rather than isolating them, then we will not only have a happier society but one with less health costs to meet. The urgency of this task should be apparent and I hope that this report helps us on our way.

Executive Summary

The NHS is a very different institution to the one established in 1948. The service has endured various waves of structural reforms since it was formed, and the environment in which it operates has changed considerably. The architects of the NHS believed that the costs of healthcare would reduce as the new health service addressed health needs; clearly, this has not turned out to be the case. Demand is increasing, and the biggest driver is no longer infectious disease, but long term health conditions and the costs associated with them. We are living longer lives, but we are doing so with long term health conditions, with incidences of cancer, diabetes, cardiovascular disease and dementia all rising⁴.

In an era of fiscal constraint, efficiency drives, and increasing costs of advanced health care, the cost of meeting these needs outstrips the current NHS budget by an estimated £30 billion⁵. The system is under unprecedented pressure, and as long term health conditions are the primary drivers of increasing cost, we need to find new and different ways to prevent, treat and care for those living with long term conditions.

Relationships may hold some of the answers to improving our health and wellbeing. Relationships with friends, families and partners are fundamental to our wellbeing and the quality of these relationships has a major impact on our health. Evidence shows that our relationships can protect us from the effects of long term health conditions, aid recovery, and even prevent us from becoming ill in the first place. On the other hand, poor quality relationships can also be a risk factor, increasing the chance of us acquiring a long term health condition and reducing our likelihood of recovery. With all this in mind, there is an opportunity to address public health demands differently, by considering people in the context of their relationships.

This agenda is gaining greater currency in debates about public health with recognition of social factors of health increasingly appearing in policy. Professor Sir Michael Marmot's (2010) review of the social determinants of our health influenced a shift from a purely medical model to one which includes influences such as the conditions in which we are born, live, learn and work. For example, the *Health and Social Care Act 2012* promotes a holistic approach to healthcare and the Public Health White Paper (2010) specifically refers to targeting social determinants to improve our health. The *Five Year Forward View*, presented by Simon Stevens, Chief Executive of NHS England in 2014, placed a welcome emphasis on prevention. However the *View* focuses on the behavioural pathway of health, with less attention to social factors as the underlying causes of behaviour. In all of these policy papers, the specific role that relationships play is given little attention. Furthermore, relationships (and in particular couple and family relationships) are not incorporated into national policy frameworks such as the *NHS Outcomes Framework*, *Public Health Outcomes Framework* or the *Adult Social Care Outcomes Framework* or NICE guidelines.

The evidence demonstrates that relationships are important for our individual and collective health outcomes; however they may also come under strain during times of ill

health. Not all relationships offer these health benefits – it is the quality of the relationship that matters, with poor quality relationships having a negative impact on health and wellbeing. Given that good quality relationships can prevent, delay or minimise the deterioration of long term health conditions, we must ensure our relationships are robust and resilient in order to both prevent us from becoming ill in the first place, or if we do, to protect us from deterioration and promote recovery. It makes sense that policy should reflect this, by giving due attention to the importance of relationships. We can then expand our current health model to consider the person in the context of their couple, family and social relationships; we can draw on these relationships as an asset to our health and wellbeing. Putting them at the heart of our healthcare plans will support us to prevent, delay or minimise the costs of responding to long term health conditions, improve recovery rates, and ultimately contribute to a more effective and efficient health system.

To move towards a more ‘relational’ health system, we recommend that:

1. The UK Secretary of State for Health becomes Secretary of State for Health and Wellbeing
2. Couple, family and social relationships become a core part of the work of local Health and Wellbeing Boards
3. Government establishes an inquiry into how relationships can be included in health policy frameworks, including outcomes frameworks
4. The What Works Centre for Wellbeing commissions research into long term health conditions and relationships
5. Public Health England establishes a National Health and Relationships Intelligence Network
6. Directors of Public Health consider the best ways to gather data on the quality and stability of relationships to inform local authorities and commissioners
7. Clinical Commissioning Groups and local authorities have a duty to undertake a ‘Family Test’ when considering new local policies and in the commissioning cycle
8. Relationship support and impairment-specific charities partner to provide support
9. Public Health England supports local authorities to embed plans to strengthen relationships and incorporate relationships into Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies
10. The Department for Work and Pensions pilots a local ‘family offer’ with a focus on health and wellbeing, particularly on the couple, family and social relationships of people with long term health conditions.

Background to the report

This report is a result of the combined expertise and efforts of New Philanthropy Capital (NPC) and Relate. NPC was keen to do this research, particularly in light of our previous collaboration with Relate where we explored the importance of couple, family and social relationships in the context of ageing, and argued that good relationships are an essential pillar of older age⁶. Furthermore, NPC has an existing interest in the health arena, and we are working on a project which considers ways the NHS can be supported to meet increasing demands under the efficiency drive, and the best ways of influencing change within the system⁷. We therefore welcomed the opportunity to examine whether relationships can impact positively on our health, and in particular long term health conditions.

For this report, NPC conducted a literature review of the research around relationships and health, and contributed findings from our recent work around how to support and strengthen the health system^{8 9}. Relate – experts in relationship practice and policy – led the policy review and formulation of recommendations.

Report outline

The first section, “The current context”, considers the specific economic and social context that this report strives to respond to. It outlines the increasing prevalence of long term health conditions, and argues that in the midst of a gloomy economic landscape, we must take heed of the robust evidence that social factors, and in particular relationships, are fundamental pillars of good health.

The second section, “Relationships and health: the evidence”, looks at the link between long term health and relationships. It presents evidence of the impact good quality relationships have on health outcomes, including their preventative and healing benefits, and identifies wellbeing as an important pathway by which relationships and health are interlinked. We then look at the effect long term health conditions can have on relationships, including common emotional, cognitive and physical challenges that arise.

“Relationships in health policy: current status”, the third section, reflects on the extent to which relationships feature in existing policy frameworks and identifies the barriers to the progression of this agenda.

The fourth section, “Opportunities in policy and practice”, then identifies opportunities for furthering a relational approach to health and some of the key actors.

This leads to “New landscape for health: a relational approach”, the fifth section, which gives some examples of where a relational approach to health has reaped some significant benefits. We consider the success of Men’s Sheds, Family Nurse Partnership and approaches to counselling people with long term health conditions.

The final section of the report presents a series of recommendations, based on the research, interviews and roundtable discussions undertaken as part of the development of this report.

Throughout this report we draw on evidence and discussion about all types of relationships, recognising they are complex and come in many forms. In this report we see relationships as encompassing couple, family and social ties. Couple relationships refers to a loving relationship between two people; family relationships reflect relationships between families and those who are related; and social relationships are those between friends, neighbours, community and society. More detailed definitions can be found in the Appendix.

Thanks

We would like to thank Chris Sherwood, Helen Undy and Sarah Milsom of Relate for their contribution to this report.

We would also like to thank the following for contributing their knowledge and experience during the research process:

Tim Beanland (Alzheimer's Society)

Dr Noriko Cable (UCL)

Mel Harakis (Mind)

Gregor Henderson (Public Health England)

David Hewison (The Tavistock Centre for Couple Relationships)

Simone Milani (DWP)

Jan Mitcheson (OnePlusOne)

Fiona Paine (Relate Mid Thames & Buckinghamshire)

Stuart Reid (Mind)

Julia Slay (New Economics Foundation)

Luen Thompson (The Carers Trust)

Prof Jan Walker (Newcastle University)

1. The current context

With the population ageing and long term health conditions increasing, the NHS is struggling to meet these challenges. It is itself going through significant structural transformation against a backdrop of economic austerity. At the same time, our knowledge of what makes us healthy is advancing, including recognition of the social determinants of health and the importance of wellbeing. This presents an opportunity to meet our growing public health needs holistically. Given relationships are the foundation of social capital and of our wellbeing, integrating relationships into a new approach to healthcare could help to meet the challenges of this demanding landscape.

1.1. Rising health demands

In an era of fiscal constraint, the cost of rising health demands is outstripping resources, putting our health system under extensive pressure. The health demands of the population are increasing without a parallel increase in the NHS budget. We are living longer lives, with 17.4% of the population over 65 – a 17.3% increase in the last decade¹⁰. Alongside our ageing population, there has been an increase in the absolute number of people experiencing loneliness¹¹. Loneliness, or a lack of social networks, is a significant risk to our health¹². Our ageing society is also contributing to the 15 million of us living with long term health conditions¹³. This is a challenge the NHS was not set up to deal with. Its original mission – to tackle infectious diseases – is less relevant, and nowadays it is chronic, long term conditions that are taking centre stage, with nearly two thirds of people dying from cancer and cardiovascular diseases¹⁴.

1.2. The NHS today

Our NHS is cherished and continues to rank as one of the top concerns of voters in the UK¹⁵. Across all of the main political parties, there is a commitment to ensuring that the National Health Service continues to provide high quality universal care that is free at the point of delivery. The challenge is to meet this vision in the climate of rising demand and financial constraint. The 15 million people living with a long term health condition in England are putting a huge strain on the NHS: 70% of the current health and social care budget is spent on people with long term health conditions and this group also takes up 50% of all GP appointments¹⁶. In the 1990s the government recognised that inpatient stay tended to be from people with long term health conditions. Various National Service Frameworks were created to respond to this, and in 2004 there was a growing emphasis on empowering patients and promoting care in the community¹⁷.

The NHS began an ambitious programme of reform from 2010 – a programme so big ‘you could see it from space’¹⁸. This has altered beyond recognition the power structures in the NHS, decentralising power and delegating the majority of commissioning decisions down to local Clinical Commissioning Groups (CCGs), and making it harder to influence practice and resource allocation through national decision-making and lobbying. In 2011, the NHS was tasked with the “Nicholson Challenge” of making £20 billion worth of efficiency

savings by 2015¹⁹. The hope was that helping people to manage their own conditions would contribute to this efficiency drive²⁰. Meanwhile, and despite the continued emphasis on patients and community care, 70% of all inpatient bed days today are occupied by people with long term health conditions²¹.

These challenges continue to be recognised by government. The latest NHS plan, *Five Year Forward View*, criticises the current “factory model of care and repair” and calls for a “radical upgrade in prevention”, in order to improve healthy life expectancy and reduce heavy use of expensive treatment services²². The traditional medical model of health, though largely still practiced, is increasingly challenged by one of a social emphasis, which stipulates that health is influenced by determinants such as our communities, work, early environment and education²³. *Five Year Forward View* calls for new models of care including greater flexibility, a patient-focused agenda, power to communities, and a renewed focus on prevention²⁴. In response, the Coalition Government has committed an extra £2 billion to the NHS in 2015; however, *Five Year Forward View* estimates the real gap between resources and patient need to be £30 billion a year. In order to close this gap and in times of austerity, we need to find innovative, scalable, and sustainable ways to prevent, delay, or minimise the demands long term health conditions are putting on the system.

1.3. Carers

One implication of the current environment, including social care cuts, is that families are increasingly stepping into the gap to pick up care responsibilities. With seven million unpaid carers in the UK, millions of partners, families, and friends are deeply involved with the management or care of people with long term health conditions²⁶. Over the next 30 years, the numbers will increase by 3.4 million to over 10 million²⁷. Becoming a carer affects one’s health, particularly for those with long term caring responsibilities: full time carers are twice as likely to report ill health and up to 92% report that their new responsibility had a negative effect on their mental health²⁸.

“Most people who end up being a carer do so because they have an emotional tie to the person who is unwell. Ultimately, the quality of the relationship is critical to the delivery of care.”

Luen Thompson, Carers Trust²⁵

The Carers Strategy recognises the burden of care on the carer, but with no emphasis on challenges to the personal relationships care can bring. It is increasingly important to consider the implications of the rising numbers of unpaid carers both from a public health perspective and for individual health outcomes. Conversely, the impact of poor quality relationships on families’ capability to provide such care is also significant: the annual cost of relationship breakdown in the UK is estimated to be £47 billion, with £15 billion of this bill going to health and social care²⁹.

1.4. A new model of healthcare?

The medical model of health is increasingly challenged, and a holistic approach to health is cited often by public health specialists, sociologists and psychologists. The World Health Organization (WHO), for example, has highlighted that how people experience social relationships influences health inequities³⁰. In 2010, Professor Sir Michael Marmot was commissioned by the government to collate evidence on the social determinants of health, sparking mainstream debate on the links between our social environments and our health outcomes³¹. Marmot, concerned with the stark facts that those enjoying a more comfortable socioeconomic position also enjoy better health outcomes, identified the early years, education, work, income, and community as key influences on our health.

Marmot's challenge to the traditional model of health has positively influenced policy to move beyond the medical approach. The 2010 Public Health White Paper *Healthy Lives, Healthy People* responded to Marmot by proposing a strategy that prioritised a social model of healthcare, and talked of a "life course framework for tackling the wider social determinants of health"³². The *Health and Social Care Act 2012* promotes a holistic approach to healthcare and nods to Marmot's social emphasis.

Marmot's review and the subsequent legislation represent positive steps towards a social model of healthcare, and provide a solid foundation to build upon. Marmot's fifth determinant – the role of communities – includes a focus on the ways in which social networks influence mortality, cognitive decline, and wellbeing. Marmot also acknowledges that there is strong evidence that social relationships can reduce the risk of depression, and that family factors have more of an influence on educational attainment than schools. Developing this idea further, in this review, NPC has found strong evidence that our social, couple and family relationships play a significant part in our health outcomes. Indeed, relationships are relevant to all of Marmot's social determinants. For example, the relationships we hold in the early years, at school, and work are fundamental to our health outcomes as well as our wellbeing³³. Furthermore, recent guidance from Public Health England on community-centred approaches to health and wellbeing also emphasises that "Good social relationships and engagement in community life are necessary for good mental health, and may offer protection in adversity or where there is exposure to stressors"³⁴.

However, the extent to which this growing social approach to health has translated into practice is not clear. For example, the current model of health treats high blood pressure and attempts to prevent risk of heart disease by recommending behavioural changes in terms of diet, exercise, and smoking cessation, alongside medication such as calcium channel blockers³⁵. Given the evidence that social determinants, including relationships, have a fundamental influence on health, it is pertinent to include these social factors in health intervention, prevention and treatment of long term health conditions.

1.5. Wellbeing

The counterpart to this momentum towards a more holistic, social model of health is an increasing recognition of government's role in promoting our wellbeing. Wellbeing is understood as how satisfied we are with our lives, and the extent to which we feel they are meaningful³⁶.

The significance of wellbeing is increasingly recognised by government. The Prime Minister launched the National Wellbeing Programme to measure the quality of life in 2010, and the Office for National Statistics (ONS) began development of indicators of national wellbeing³⁸, and now produces annual statistics on the wellbeing of the UK. The recently established "What Works Centre for Wellbeing" also aims to understand how best to improve wellbeing and communicate this to support implementation across stakeholders³⁹.

Health and wellbeing are intimately linked. It is now accepted that our health service has a responsibility not only to treat disease, but to promote wellbeing⁴⁰. The WHO defines health as "a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being."⁴¹ This is reflected in the development of local Health and Wellbeing Boards and Health and Wellbeing Strategies as part of the re-structure of the health system.

"Social connections, including marriage, of course, but not limited to that, are among the most robust correlates of subjective wellbeing. People who have close friends and confidants, friendly neighbours and supportive co-workers are less likely to experience sadness, loneliness, low self-esteem and problems with eating and sleeping [...] subjective wellbeing is best predicted by the breadth and depth of one's social connections."

Helliwell & Putnam, 2004³⁷

This policy focus on the social factors which influence health and the close connection between health and wellbeing opens up a clear space for addressing relationships as a core component of health and wellbeing. Top of the nation's list of things that matter most to our wellbeing, joint with health, is our relationships with friends and family (89%)⁴².

The 2008 Commission on the Measurement of Economic Performance and Social Progress (the 'Stiglitz Commission') counted social connections and relationships among its eight recommended core components for measuring national wellbeing. The ONS similarly identifies relationships as a domain which influences subjective wellbeing⁴³ and includes satisfaction with family life, social life, and the extent to which people have a spouse, family member, or friend to rely on in its national wellbeing measures⁴⁴.

The 2014 Commission on Wellbeing and Policy headed by Sir Gus O'Donnell also recognised the role of relationships in wellbeing, noting that across the world, the quality of home life – which is ultimately based on family relationships – is a universal ingredient

of life satisfaction⁴⁵. The relationships we hold within our communities are another key factor of wellbeing⁴⁶, and social capital – our relationships, networks and shared values that enable our society to function – is recognised to be a key influence on our wellbeing⁴⁷. Given that wellbeing matters to our health, relationships could take a lead role in tackling rising health demands.

Conclusions

Relationships, as part of a social model of health and wellbeing, could offer valuable solutions to the challenges presented by the current health and economic environment. This chimes well with the *Five Year Forward View*'s focus on innovative and preventative interventions.

2. Relationships and health: the evidence

Our health and our relationships do not exist in isolation from each other. They are fundamentally linked and influence and interplay with each other, with factors such as wellbeing playing a key part in binding them together. Professor Mel Bartley et al⁴⁸ concluded that strong and supportive relationships can help to protect individuals' health against the damages from poverty and other forms of social disadvantage. Furthermore, there is good evidence that social factors such as isolation and the quality of relationships can predict health as much as, if not more than, medical factors⁴⁹. If we can incorporate this knowledge into our current approach to public health and healthcare, and consider the person in the context of their relationships, we may have a better chance of meeting the prevention priorities, and empowering people to manage conditions independently, without heavy reliance on our health system.

This section presents the evidence that the quality of relationships significantly impact on health, and considers the implications that poor health can have on our relationships.

2.1. Impact of relationships on health: quality matters

Good quality relationships have a significant influence on our health. They can prevent the onset of poor health, aid recovery, improve prognosis, and promote a good quality of life. If these things can be achieved, it is likely that reliance on health and care services will be reduced. Not any relationship will do, though; it is the quality of the relationship that matters. Poor quality relationships can put our health at risk, increasing use of costly treatment and care facilities.

2.1.1. Prevention of health problems

Good quality friendships and social networks can protect against illness and improve prognosis. Having good quality relationships also makes us healthier and happier; with researchers estimating that 14% of adults who have very poor quality social relationships will experience depression later in life, compared to seven per cent of adults with high quality relationships⁵⁰. People in good quality marriages also have lower blood pressure compared to those in poorer quality marriages⁵¹, and men in opposite sex relationships are also more likely to seek help for health problems than single men because their female partners encourage them to seek help⁵². The evidence also shows that the preventative health benefits of good quality relationships extend to family members: the relationship between couples directly affects the wellbeing of their children, and children living with married parents are less likely to suffer from asthma or become overweight⁵³.

2.1.2. Recovery and quality of life

Relationships can also help us to recover from or manage illness. Close couple relationships can act as a buffer against cognitive deterioration by slowing the rate of decline in people with dementia⁵⁴, and even delay admission to hospital or care homes⁵⁵. There is also evidence that a lack of positive interaction between couple carers and people with dementia predicted how long the patient survived, with those experiencing less positive interaction more likely to die earlier⁵⁶.

For people living with cancer, the support of a partner is an important determinant of their future general health, pain, physical function, and mental health⁵⁸. Research has found that the extent to which breast cancer patients feel they have a strong network of friends is strongly related to survival rates⁵⁹. Survival rates after heart surgery

People with strong social relationships are 50% more likely to survive life-threatening illness than people with weaker ones.

Holt-Lunstad et al, 2010⁵⁷

seem to be affected by marriage – in one study, patients who were married had better long term survival rates than their unmarried counterparts⁶⁰. Furthermore, when researchers reviewed a group of studies to understand the extent to which social relationships influence risk of mortality, they were able to conclude that, on average, people with strong social relationships are 50% more likely to survive life-threatening illness than people with weaker ones⁶¹.

Research has also found that whilst stroke impacts on quality of life because of the physical changes it creates and the disabilities it can cause, the changes in social functions exert a greater influence⁶². The quality of our social relationships seems to be the most important influence on post-stroke quality of life, both for patients and their carers. The length of time somebody survives heart disease depends on a number of factors, the severity of the disease being one of the obvious influences. It is also apparent that the quality of relationships seems to play a greater role for women. Researchers looked at male and female heart disease patients who differed in the severity of illness, comparing the extent to which marital quality and severity of illness predicted survival in heart disease patients. For men, both quality and severity were equally important in influencing mortality, and for female patients, quality of marriage had a greater influence than disease severity⁶³. These differences require further research to inform future practice.

2.1.3. Health risks of poor relationships

Just as good quality relationships can protect our health, so the reverse is true: poor quality relationships can present a health risk. In one study, social risk factors including parental marital status were as much of a risk factor on health outcomes of babies as biological factors. Furthermore, social risk factors were more common, meaning they played an even bigger role in the later health of newborns⁶⁴.

Domestic violence and abuse is at the most harmful end of the spectrum of poor quality relationships, with costs to services, including health, amounting to £3.8 billion a year⁶⁵. Poor quality relationships can also lead to an increase in risky health behaviours, such as

smoking and substance abuse, as well as driving emotional distress such as depression and anxiety⁶⁶. Loneliness also affects our health. It is fundamentally associated with relationships as it occurs when we miss a particular person, be it a friend, partner or family member, or when there is a lack of a social network⁶⁷. When we are lonely, our risk of poor health increases, with estimates that it is as harmful to our health as smoking 15 cigarettes a day⁶⁸.

Individuals in poor quality couple relationships have worse health than those in happier ones⁷⁰, and those who are unhappily married are at greater risk of poor health than divorced people⁷¹. Some research has found that single, divorced, and widowed women have higher survival rates than breast cancer patients who were married⁷², and though further research is needed to confirm this, the authors speculate that this finding could be reflecting the idea that poor quality marriage negatively affects health outcomes. Single people have lower blood pressure than people who are unhappily married⁷³, and poorer quality relationships have been shown to be risk factors for depression⁷⁴.

When we are lonely, our risk of poor health increases, with estimates that it is as harmful to our health as smoking 15 cigarettes a day.

Holt-Lunstad et al, 2010⁶⁹

There are differences amongst people of different ages and genders that need to be explored further. Once again, quality of relationships seems to be more important to women than men, with one study finding that poorer quality marriages put women at risk of heart disease more so than men⁷⁵. The same study found that the effects of marriage are more pronounced in older couples. This is true both for the protective benefits it can bring, and the negative influences stemming from poor quality marriages. These differences need to be explored further; however the finding stands strong that the quality of the relationship is central to health.

Although the evidence is clear that quality matters, it is not conclusive as to whether long term health conditions lead to increased incidence of relationship breakdown: couple relationship break up rates in people with long term health conditions have varied in the literature between 15% and 78%⁷⁶. As divorce is often used as an indicator of relationship breakdown, thereby excluding couple breakdown outside of marriage, the picture is far from clear. What we do know is that quality is important, with those unhappily married being at greater risk of poor health than divorced people⁷⁷.

2.1.4. Wellbeing

Wellbeing plays a key part in our health, and can influence our recovery, promote survival, and influence risk factors. The Department of Health notes that a policy focus on wellbeing will improve health, and is subsequently likely to reduce burden on health services⁷⁸. Public Health England also identifies wellbeing as a key driver of public health⁷⁹.

Wellbeing has been associated with reduced rates of mortality in both healthy populations and in those with long term health conditions⁸⁰. Those with higher levels of wellbeing are more likely to recover from serious illness than those with low scores⁸¹. A

review of quantitative studies concluded that high levels of wellbeing protected healthy populations, and promoted survival in those with long term conditions. Specifically, the researchers found a 19% reduction in mortality in healthy populations, and a 23% reduction in mortality in those with renal failure⁸². How we feel also affects our health. Positive emotions can speed up recovery, whilst negative ones can increase cardiovascular risk factors⁸³. Similarly, more negative emotional styles have been associated with poorer immune functioning and greater health risk than those who have a more positive emotional approach⁸⁴.

Strong relationships are fundamental to wellbeing⁸⁵: 89% of people cite personal relationships as a key component of wellbeing⁸⁶. Data from Office for National Statistics indicates that people who are married or in a civil partnership have significantly higher life satisfaction than those who are single, divorced or separated⁸⁷, although data published by Relate in 2014 showed that people who described their relationship as average, bad, or very bad were more likely to report lower wellbeing than single people⁸⁸. In a previous collaboration, Relate and NPC found a correlation between the number of close relationships a person has and their self-reported wellbeing, with higher wellbeing associated with an increased number of social relationships⁸⁹. Research also shows that adults with no friends have very poor psychological outcomes, and wellbeing has been found to be affected by the relationships we have with neighbours⁹⁰. One expert says that relationships are the most important cause of happiness⁹¹, and research has shown that that satisfaction with marriage and family relationships is the most important predictor of life satisfaction⁹².

Given the strong links between relationships and wellbeing, and subsequently between wellbeing and health outcomes, there is significant merit in considering relationship as a source of preventing long term health conditions and helping us to recover from them.

2.2. The impact of long term health conditions on relationships matters

Long term health conditions can present physical, cognitive, and emotional challenges to our relationships. Coping with a long term health condition, for both the patient and those around them, can be a challenge, and one that goes beyond diagnosis and other traditional transition points supported by professionals. Not only can a long term health condition affect someone physically, there can be emotional, psychological and social consequences that accompany it. There can be repercussions for partners and family members, and for the relationships the patient holds. Recent research indicates that nearly half of stroke survivors experience relationship strain, and two thirds of carers undergo relationship difficulties⁹³.

These detrimental effects on relationships matter because, as we have seen, poor quality relationships put us at further health risk, which drives increased use of health services. A relationship that has been damaged by the effects of a long term condition is unlikely to provide the protection that a good quality relationship can offer. We are less likely to be able to manage our condition independently, and therefore more likely to need the support of the health and social care system. Whilst health services operate on the basis

of need, and are free of charge at the point of access to everyone regardless of individual wealth, social care is means tested. Only those with low incomes and limited assets have access to free social care. Furthermore, over 87% of local authorities are limiting care to those with critical or substantial need⁹⁴. So significant numbers of individuals do not qualify for free social care because they do not have high enough needs or because they hold assets, such as owning the house they live in, or savings. It is likely that individuals with unmet social care needs will then enter the health system to get the care they require, putting further pressure on the NHS.

If we can keep relationships healthy, however, those living with long term health conditions will be more likely to survive and recover from serious illness, and less likely to need to rely on costly treatment or care services. If our relationships are healthy enough in the first place to help us when we do face life transitions such as the onset and development of illness, we will be well equipped to deal with them, and improve our chances of recovery. In time, this may reduce the demand on health and care services and could free up resources and help to meet public health needs.

Below we look in more detail at the specific physical, emotional, and cognitive effects that long term health conditions can have on relationships. This is important to consider in order to help widen the approach to healthcare to a more holistic one that views individuals in the context of their relationships.

2.2.1. Physical

Many long term health conditions cause physical changes and impairments. These can impact the person's relationships firstly through limited mobility and capability⁹⁵ and secondly through changing relationship roles⁹⁶. Reduced mobility and increased fatigue as a result of illness or treatment may change the usual lifestyle of an individual and those around them, and people who experience mobility problems often suffer from more restricted social lives⁹⁷. Long term health conditions can also put a strain on sexual relationships. In many couple relationships, sex is an important part of expressing and affirming intimacy and love, and physical conditions such as spinal cord injury that make sex difficult can have a negative effect on the quality of the relationship⁹⁸. Physical changes due to a long term health condition can make a person dependent on his or her partner for personal care. This can have a range of emotional impacts for both partners which then, in turn, affect the relationship.

2.2.2. Emotional

The emotional effects of physical changes and disabilities are central for understanding the impact of long term health conditions on relationships. The Stroke Association has shown that the emotional impact of stroke can be as significant as the physical effects⁹⁹. When someone suffers a stroke or is diagnosed with another long term health condition, they are often faced with complex and difficult emotions, including grief for the life they previously had, anxiety about the future, and anger towards the illness¹⁰⁰. These feelings can develop into depression – studies of stroke survivors show that this is a common consequence of the illness¹⁰¹. Often it can be difficult to separate the illness from the

individual, and grief and anger can be directed at the partner¹⁰². If communication between the partners breaks down as a result, it can be hugely damaging to the relationship, and require intervention when it reaches crisis point. Indeed, 84% of Relate's clients identify communication as the reason for accessing couple counselling¹⁰³, whilst 62% of Relate and Relationship Scotland counsellors identify not understanding each other and communication problems as the number one strain on couple relationships¹⁰⁴.

Emotional impacts also come about when a partner becomes a carer. Taking on a care role can be new and unfamiliar, and studies show that it is common for carers to feel that because of the intensive support they provide, the relationship becomes imbalanced, with the carer experiencing a lack of benefits. This feeling of inequality is particularly pronounced amongst those who already regarded their relationship negatively¹⁰⁵. Carers need their own feelings attended to by ill partners, without which their emotional resources suffer. Studies show that partner carers have a significantly increased risk of mental health problems, which in turn can affect the relationship¹⁰⁶. One partner being dependent on the other for care can also impact sexual relations, as many couples find it difficult to switch from the carer-patient dynamic to being physically intimate¹⁰⁷.

2.2.3. Cognitive

Intellectual fit is an important factor when choosing our partner or friend. Cognitive decline, such as in dementia, can mean intellectual intimacy changes within a relationship¹⁰⁸. A couple may not be able to communicate and share their aspirations and hopes as they used to, and in addition, illness can sometimes highlight personality weakness and reveal previously hidden problematic personality traits. The couple can feel alienated from each other, leading to a vicious cycle of avoidance and poor communication¹⁰⁹. Cognitive changes can also negatively impact social relationships. One expert told us that for dementia patients, the illness can mean a devastating loss of friends for people who have previously enjoyed active social lives¹¹⁰. With our social networks being a fundamental part of our wellbeing, loss of these can further increase the risk of our health deteriorating, increasing the demand further on our health services.

Conclusions

The quality of relationships drives our health, but equally, our relationships are placed at risk by ill health, at just the time people need to draw on them as an asset. Therefore, nurturing good quality relationships, and framing this in policy and practice, could reap significant public health benefits.

3. Relationships in health policy: current status

The evidence is clear that relationships and our health and wellbeing outcomes are closely intertwined. The question is to what extent this is recognised in policy. The move to a new health system under the Coalition Government, including the transfer of public health to local government, brings both opportunities for health to become more relational, and also challenges, including national fewer policy levers being available. In order to examine the ways in which health policy could be more relational, it is important to consider the current policy landscape and identify the key actors.

3.1. What is happening in policy?

Despite the strong evidence that relationships and health are inextricably linked, policy has not yet caught up. As discussed earlier, the Marmot Review, the White Paper *Healthy Lives, Healthy People*, and the *Five Year Forward View* all go some way towards a more social model which pays attention to the social factors which influence health outcomes (including relationships). Yet despite the positive rhetoric, health policy has not reflected the significance of our relationships for our health and wellbeing.

There has been increasing recognition of the importance of relationships by government and across the political spectrum. The government has acknowledged the significance of strong and stable relationships and has made commitments to supporting family relationships within the Social Justice Strategy, with a focus on preventing family breakdown¹¹¹. Around £30 million was invested in relationship support over 2011-15, and the 'Troubled Families' programme was devised with a whole-family focus, highlighting the importance of relationships between families and agencies¹¹². Health secretary Jeremy Hunt and health minister Norman Lamb have also highlighted the impact of loneliness on Britain's older population. Furthermore, at the Relationships Summit in August 2014, the prime minister announced an extension of the Troubled Families programme, a doubling of the budget for relationship support, piloting relationship support within antenatal classes and new guidance for Health Visitors¹¹³. The Department for Work and Pensions (DWP) has also begun work on piloting a local joined-up 'family offer', working with innovative Early Intervention Pioneering Place¹¹⁴ local authorities to take a comprehensive life-course approach to family and relationships support, integrate services, see what works locally, and showcase and spread best practice. Finally, the Family Test, introduced in October 2014, requires all new policies across Whitehall to consider the impact they might have on the family and couple, family and social relationships¹¹⁵.

However, it is notable that what impetus there is at present in putting relationships onto the mainstream policy agenda derives largely not from the Department of Health (DoH), but from DWP, which has now assumed responsibility from the Department for Education (DfE) for relationship support funding. Even recent policy announcements which directly

address health professionals have come from DWP rather than DoH. DWP announced in November 2014 pilots of relationship support as part of antenatal classes to prepare couples for the transition to parenthood and encourage fathers' involvement, and new guidance for Health Visitors¹¹⁶.

3.1.1. Relationships are missing from national outcomes frameworks

It is surprising – given the evidence around the importance of relationships for health and wellbeing – that relationships are currently largely absent from national health outcomes frameworks, which set the landscape within which local health strategies and commissioning take place. The *Public Health Outcomes Framework*, for instance, sets out a range of indicators for public health to help inform priorities locally, from which it is for local authorities in partnership with Health and Wellbeing Boards to identify indicators that best reflect local needs. It is something of a missed opportunity, therefore, that while the framework implicitly recognises the significance of social relationships as determinants of health, couple and family relationships are missing. Similarly, the *Adult Social Care Outcomes Framework* includes some references to social relationships and includes a focus on carers as well as people who receive care, yet does not address couple or family relationships between them. Correspondingly, while some National Institute for Health and Care Excellence (NICE) guidelines do include references to relationships, there is no over-arching guidance around the role of relationships in promoting health and wellbeing. The table below provides a few indicative examples of where relationships feature in national health frameworks.

Table 1: Where relationships feature in the main policy outcomes frameworks across both health and social care.

Framework	Where relationships feature
NHS Outcomes Framework	<ul style="list-style-type: none"> Domain 2 ('Enhancing quality of life for people with long term conditions') includes indicators of health-related quality of life for people with long term conditions as well as quality of life of carers, but there is no specific reference to or indicator of relationships as a constituent of this.
Public Health Outcomes Framework	<ul style="list-style-type: none"> Domain One ('Improving the wider determinants of health') includes social isolation and domestic violence as indicators – both of which clearly have pertinence to the quality of relationships, referring to the absence of good social relationships, and the most insidious and harmful end of the spectrum of poor quality relationships.
Adult Social Care Outcomes Framework	<ul style="list-style-type: none"> Domain One ('Enhancing the quality of life for people with care and support needs') includes social participation as a measure of social care-related quality of life and carer-reported quality of life. It also includes a measure of social contact ("Proportion of people who use services and their carers, who reported that they had as much social contact as they would like"). The framework recognises that respecting carers as equal partners improves outcomes both for the person cared for and the carer, and includes a measure of the extent to which carers feel that they are respected as equal partners in service design for those individuals for whom they care throughout the care process (3C), although this does not address the couple or family relationship between carer and person cared for.

NICE guidelines	<ul style="list-style-type: none"> • NICE public health guidance 40 <i>Social and emotional wellbeing: early years</i>¹¹⁷ is clear that a child's relationship with their mother (or main carer) has a major impact on social and emotional development, and stipulates that antenatal and postnatal home visiting for vulnerable children and their families should aim to achieve specified goals in relation to child-mother and child-father relationships. • NICE guidance 50 <i>Mental wellbeing of older people in care homes</i> notes that “Relationships, including those with family, carers and friends, are an important aspect of a person's identity and can have a significant impact on mental wellbeing”¹¹⁸. • NICE quality standard QS30 <i>Quality standard for supporting people to live well with dementia</i> includes a quality statement that “People with dementia are enabled, with the involvement of their carers, to maintain and develop relationships”, and underlines the importance of maintaining and developing personal and social relationships for people’s wellbeing, recommending that people with dementia continue to have opportunities to engage with friends and family, and to develop new relationships¹¹⁹. • NICE guidance CG162 <i>Stroke rehabilitation: Long term rehabilitation after stroke</i> recommends supporting social roles, for example, work, education, volunteering, leisure, family and sexual relationships¹²⁰.
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Given the predominance of localism in the government’s overhaul of the health service, national health policy frameworks now have limited ability to *direct*, but they do help to *orientate* local policy and take a national *lead*. National health outcomes frameworks are a major policy lever, which together set the landscape within which local health and wellbeing strategies are developed and implemented, and in which the funds which central government and NHS England transfers to Clinical Commissioning Groups are allocated. This underscores the importance of such frameworks reflecting the evidence above that relationships are key determinants of health and wellbeing.

A possible consequence of the absence of relationships-focused health policy is the very low take-up of couple therapy for depression, which is the only NICE-recommended talking therapy which focuses on the couple¹²¹. Despite the fact that it is currently in principle available through the NHS, funded by Improving Access to Psychological Therapies (IAPT), and that the Tavistock Centre for Couple Relationships (TCCR) has achieved recovery rates of 56.5% across their clinical services (compared to 46% in IAPT nationally, and 41% in IAPT London¹²²), provision of couple therapy for depression is very patchy. Research by TCCR in 2013 revealed only 0.62% of all sessions – one in every 161 – delivered at the high intensity level in IAPT services were for couple therapy for depression¹²³. Their ‘mystery shopper’ exercise also indicated very low levels of knowledge among IAPT staff of the full range of NICE-recommended treatments and inappropriate signposting, with 80% of advisors making no mention of couple therapy. This is perhaps unsurprising, considering the status of relationships in health policy.

Couple therapy for depression

Relate North East delivers couple therapy for depression, having been commissioned in a one year pilot initiative. Since November 2012, over 150 referrals have been made. Most people access the service after being referred from their GP for an initial IAPT assessment, where a consideration is made as to whether their relationship could be a cause of their mental health issues, and whether they are diagnosed as having depression. This is an important step in assessing whether people are ready for couple counselling for depression.

Many of the people seeking couple therapy for depression had not previously identified that problems in the relationship itself may be one of the root causes of their depression. As one counsellor put it, “these are problems that they’ve swept under the carpet for ages.” Counsellors identify couple therapy for depression delivered through IAPT as being innovative as it takes a holistic view of their depression – a holistic view of illness that improves their chance of recovery. It is also a service that objectively explores problems in the relationship – for some this means that couples will part and for those that do, the person who has depression is referred back to the IAPT service to assess whether further intervention is necessary. Early results are positive in signifying that the intervention successfully treated depression.

3.2. Why is policy lagging behind?

If the evidence is clear that relationships matter, and the policy agenda is moving towards a more social model of health and wellbeing, it is important to examine the reasons why health policy has not yet caught up and directly addressed the ways in which relationships are key to health and wellbeing. Identifying the barriers will help to pave the way for a more relational approach.

3.2.1. Fragmented policy

First, the fragmentation of responsibility for relationships across government leads to policy making around relationships in distinct ‘silos’, lacking a coherent strategy. Although the primary impetus currently comes from DWP, responsibility for relationships is currently dispersed across government. Responsibility for mediation and family justice, for instance, sit with the Ministry of Justice (MoJ), while responsibility for domestic violence and abuse resides in the Home Office. The Troubled Families Programme sits with the Department for Communities and Local Government (DCLG), driven as it is by local authorities. Responsibility for adoption and fostering remains with DfE, as does Children’s Services and Early Years, while children’s and young people’s mental health sits within DoH. Maternity Services and Health Visiting – including Family Nurse Partnerships (see page 31) – also sit with DoH. These policy silos make it challenging to apply knowledge and share best practice across different policy areas, and the effect of this dispersion across different departments is that relationships often fall through the gaps. It

is perhaps unsurprising, then, that the importance of good quality relationships for health and wellbeing is currently absent from national health policy frameworks.

3.2.2. Limited policy levers to effect change

Second, following the shake-up to the health system, with control over the majority of spending devolved to the local level, the policy ‘levers’ available to influence practice are now severely reduced. Upper-tier local authorities now assume responsibility for public health and wellbeing. Directors of Public Health, appointed jointly by the local authority and the Secretary of State for Health, have responsibility for delivering public health and wellbeing outcomes locally. Health and Wellbeing Boards (HWBs) bring together key health and social care commissioners with local Healthwatch representatives and are intended to improve the health and wellbeing of people locally, reduce health inequalities, and promote service integration. It is for local authorities, in partnership with Clinical Commissioning Groups (CCGs) and through HWBs, to identify which indicators from national outcomes frameworks best reflect local needs. These local needs will be set out in their Joint Strategic Needs Assessments (JSNAs), which are assessments of current and future health and social care needs of the local community. Based on these findings, the HWBs must develop a Joint Health and Wellbeing Strategy (JHWS) which sets out joint priorities for commissioning to meet local needs as identified in the JSNAs. In the spirit of localism, the DoH guidance is clear that the Adult Social Care Outcomes Framework, the NHS Outcomes Framework and the Public Health Outcomes Framework are intended to be useful to inform joint priorities locally, but not overshadow local evidence. This underscores the importance of such frameworks reflecting the importance of relationships for health and wellbeing.

JSNAs and JHWSs are an integral part of local authority and CCG commissioning. Consequently, as local communities’ relationship support needs are predominantly not being fed into JSNAs nor JHWSs, neither are they finding their way into commissioning cycles. In part, this is due to a lack of available local data on relationships. DWP’s Family Stability Indicator gathers limited data on family stability at the national level, measuring the proportions of all children not living with both birth parents, children in low-income households not living with both birth parents compared with children in middle- to higher-income households, and the proportion of children living with both birth parents where the parents report happiness or unhappiness in their relationship. However, there is no *local* data on the *quality* of people’s couple, family and social relationships to inform local policy-making and commissioning.

3.2.3. Under-developed evidence base

Third, while there is no shortage of evidence of *need*, we lack a clear and accessible evidence base on *what works*, for *whom*, and in what *circumstances*. The need for evidence is particularly important given the high threshold for entry to health commissioning. The ‘gold standard’ for clinical trials is a Randomised Controlled Trial (RCT), which randomly assigns patients to either receive the intervention being evaluated or an alternative, and is therefore amenable to conclusions which attribute any difference

in outcomes to the intervention. However, whilst often being the best way of attributing change to a specific intervention, RCTs are often expensive and are unsuitable for many projects, meaning that interventions which are successful at improving relationship quality – and thereby health and wellbeing – but are not amenable to RCT often miss out.

There is good evidence that some interventions that support relationships can be effective, with outcomes such as improved relationship quality, satisfaction, conflict resolution skills, as well as wellbeing and mental health¹²⁴. An evaluation for the DfE in 2014 showed that that adult relationship counselling significantly improved relationship quality, communication and wellbeing¹²⁵. The evaluation also demonstrated significant savings to the public purse of government investment, finding the overall cost-benefit ratio to be 11.4, meaning that for every £1 invested, £11.40 benefits accrue.

However, much of the research around relationship support suffers from limitations, including the representativeness of samples and how effectiveness is measured. Less is known about long term impacts than short term impacts¹²⁶ and there is little evidence of the relative effectiveness of different approaches¹²⁷. Further research is needed around what works best for whom, and into the cost-effectiveness of interventions.

Similarly, the UK suffers from a lack of evidence-based *programmes* to commission. The Allen Review into evidence-based Early Intervention programmes¹²⁸ lists 25 best-evidenced interventions for pre-school-, primary-school- and secondary-school-aged children, few of which include a direct focus on relationships as part of their design (e.g. Family Nurse Partnership). While several programmes exist internationally, there is as yet an absence of ready-built, already-validated programmes available for health commissioners to pick ‘off-the-shelf’ in the UK.

3.2.4. Cultural attitudes

There also exists significant cultural reticence around talking about relationships. Relationships are still seen as private spaces, with people expected to address any issues in their relationship themselves¹²⁹. We tend not to prioritise the ‘health’ of our relationship in the way that we do other things like housing or careers, until problems emerge. Research indicates a belief that talking about relationship difficulties is not the ‘done thing’¹³⁰ and it is often held to signify failure and disloyalty¹³¹. Evidence shows that negative views about counselling, and perceptions that it is an American import can also deter people from accessing support¹³². There is also increasing demand for online services rather than traditional face-to-face services from certain audiences because of the anonymity they offer¹³³. Such cultural barriers result in people delaying accessing support until their relationships have reached a crisis point or electing to not access any support at all. This cultural stigma associated with seeking help is therefore a significant barrier to greater focus on relationship support within wider health services.

3.2.5. Systemic barriers

Systemic barriers also exist, which inhibit those who are often in the frontline of dealing with the effects of relationship distress, such as employers and public services, from signposting people to support. Relationships are vulnerable at key transition points in people's lives (e.g. the transition to parenthood, retirement, the onset of a long term health condition), where people are more likely to be in contact with these agencies. Yet evidence shows that employers and public service professionals often do not know what services are available or who to refer people on to, but could play a critical role in signposting people to support if this knowledge gap was overcome¹³⁴.

Frontline health and social care professionals have the potential to both influence commissioners in this area and also initiate discussion about relationships with service users. If frontline staff see the value of integrating relationships into our health, they can champion investment from commissioners. If professionals are supported to initiate discussions with services users about their relationships, risks and difficulties could be identified early on. In addition however, these discussions could provide an opportunity to use relationships as an asset to help manage the condition.

"I think that the person who has the cancer gets information and support. But at no time did anyone speak to my husband. Maybe it would have helped, and we may have even stayed together."

Cancer survivor, cited in *Worried Sick*¹³⁵

However, challenges remain in understanding what works in broaching relationship issues with service users, and the extent to which practitioners currently engage with service users on this topic. Evidence indicates that health practitioners are not widely supported to talk to patients about their relationships, and given increasing pressures on time as well as the lack of profile relationships have in policy, relationships are not prioritised. Participants in research in 2010, for example, talked about the lack of support available to address relationship problems when common medical issues had caused stresses in the relationship, which had been particularly stressful for partners who were struggling to manage a medical condition and had realised that their relationship was suffering¹³⁶. Macmillan's research *Worried Sick* similarly highlighted that support for people with cancer doesn't always address their relationships and their loved ones¹³⁷.

Conclusions

We know that relationships are important to our health, and the good practice examples we have drawn on show how different support interventions show great promise in promoting good relationships, nurturing them and protecting them against health crises. So much of the policy conundrum revolves around how best to make the case for relationships to local commissioners so that viewing health through a relationship lens is seen as advantageous. Professionals and service providers who implement practice are an asset to this. If they see the value, they are more likely to argue for it to commissioners.

4. Opportunities in policy and practice

Despite some barriers, there are opportunities within both current policy and practice that can support a move towards incorporating relationships in our approach to health. Below we outline the importance of the local health and wellbeing infrastructure, and of the space occupied by health charities.

4.1. Local health and wellbeing infrastructure

In the new health and wellbeing policy landscape, Health and Wellbeing Boards are key levers of change and their position presents an opportunity to bring forward a model of health that has relationships at its heart. The Campaign to End Loneliness, for example, has reviewed all the Joint Health and Wellbeing Strategies (JHWSs) in England, and found that half (51%) of Health and Wellbeing Boards (HWBs) have now included some reference to loneliness or isolation in their strategies¹³⁸. Furthermore, while HWBs generally lack local data on relationships to inform their Joint Strategic Needs Assessments (JSNAs), there are some good examples to draw upon. There are initiatives to obtain local data on social relationships, given the evidence on how isolation impacts on health, particularly for older people. The Campaign to End Loneliness has championed local data collection on isolation to inform JSNAs, and some local authorities are leading the way. Essex County Council, for instance, has developed an 'Isolation Index', using commercial demographic data to determine which communities are most affected by loneliness¹³⁹. The Royal Borough of Kensington and Chelsea Older Persons' Partnership Board has developed an online tool to identify isolated older people, which can be used by anyone including professionals, community groups, and family members¹⁴⁰.

Some local authorities have also combined existing data sets with information about risk factors to identify populations most at risk from loneliness. Springboard Cheshire is a partnership between Age UK Cheshire and Cheshire Fire and Rescue Services (CFRS), supported by both Cheshire West and Cheshire's adult social care directorates, which uses a unique data sharing arrangement between CFRS and the local NHS, overlaid with demographic data, deprivation measures, and other datasets, to produce a sophisticated understanding of the local older population to identify older people who may be particularly vulnerable and in need of early intervention¹⁴¹.

Directors of Public Health also provide an under-used opportunity for addressing the local community's relationships and support needs in their annual reports on the health of the local population¹⁴². These reports are intended to contribute to improving the health and wellbeing of the local population, reduce health inequalities, promote action for better health and assist with planning of local services. They should also contain a statement about the health of the local community based on epidemiological evidence – including information on health and wellbeing, healthy lifestyles, access to services and health outcomes, and, importantly, *social, economic and environmental factors which influence*

wellbeing. In light of the evidence above that relationships are precisely such factors, there is a need for relationships to feature in these reports.

4.2. Health charities

The charitable sector occupies a unique space and can provide a lifeline beyond that of specialist medical treatment for people with long term health conditions. The *Five Year Forward View* identifies stronger partnerships with the charitable sector as key to improving health and wellbeing, noting charities can reach people that the health system may struggle to, and can provide advice and support to commissioners. It also commits to creating new options for health-related volunteering and designing easier ways for voluntary organisations to work alongside the NHS to achieve wider health goals.¹⁴³

“When funding is tight, NHS, local authority and central government support for charities and voluntary organisations is put under pressure. However these voluntary organisations often have an impact well beyond what statutory services alone can achieve. Too often the NHS conflates the voluntary sector with the idea of volunteering, whereas these organisations provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff. Often they are better able to reach underserved groups, and are a source of advice for commissioners on particular needs.”

Five Year Forward View¹⁴⁴

Health charities support people throughout their illness, not just at the traditional transitions such as diagnosis. Our discussions found that stress points are not cut and dry, and there is not a clear journey through a health condition¹⁴⁵. Diagnosis and other transitions such as beginning treatment do not always have clear beginnings and ends and the journey can be ongoing and confusing. This is not always reflected in the support provided by the health system, and charities can help to support people once the specialist medical provision is complete.

A cancer or diabetes diagnosis might prompt an individual to contact a condition specific charity for advice, information and support. The patient – likely overwhelmed with concerns and feelings about their diagnosis and condition – may be unlikely to recognise that supporting their relationships may help them with managing their condition. In NPC’s experience of working with over 40 health charities, these organisations rarely have the specialism to offer people with long term conditions relationship support. Some relationship and health charities are beginning to work together on pilot projects to plug this gap however, and we draw on some examples of this in the next section.

The *Five Year Forward View*’s ambitions around prevention and integrated care, and the desire to work more with charities and other partners, presents an opportunity to influence change. Recent research by NPC provides some useful insights into what to consider when influencing change in large institutions such as the NHS¹⁴⁶. We must be mindful of working within such a diffuse system, and ensure we target those who are both willing and able to implement change. Furthermore, it is important to strike a balance between the top-down policy influence and the bottom-up mobilisation, in order to achieve a flexible but strategic approach to implementation in the local environment. Due

consideration of these challenges will be key in taking up the opportunities *Five Year Forward View* offers for implementing a relational view of health.

4.3. Carers

The *Five Year Forward View* also emphasises the need for better support for carers. Carers are fundamental to the health of our nation, and are increasingly recognised by the government, with the 2010 Carers Strategy prioritising the importance of supporting carers by providing information and respite and involving them in patient decisions and supporting their own health¹⁴⁷. This growing recognition of the need to support carers may present an opportunity to bring a more relational focus into health. The challenge is to ensure that the relationship needs of carers are supported. In care situations, illness and relationships are inextricably linked, and the care relies on the quality of the relationships.

Conclusions

There are real opportunities for stakeholders to work together, whilst working within existing structures locally. By pooling knowledge and resources whilst drawing on specialist expertise, it is possible to expand our current model of healthcare to include relationships. This will be valuable to both our public health and our public purse.

5. A new landscape for health: a relational approach

The evidence is clear that the quality of relationships plays an important role across the spectrum of public health, from promoting health and wellbeing, through to preventing disease and managing long term health conditions. It is estimated, for example, that 75% of indicators in the 2011 public health framework are influenced by the quality of our couple relationships¹⁴⁹. Accordingly, broadening the way in which we understand health and wellbeing, extending the current model of person-centred care by considering people not only as individuals, but in context of their relationships with partners, friends and family, could reap significant public health benefits, tackle health inflation, and ultimately reduce the costs associated with responding to long term health conditions.

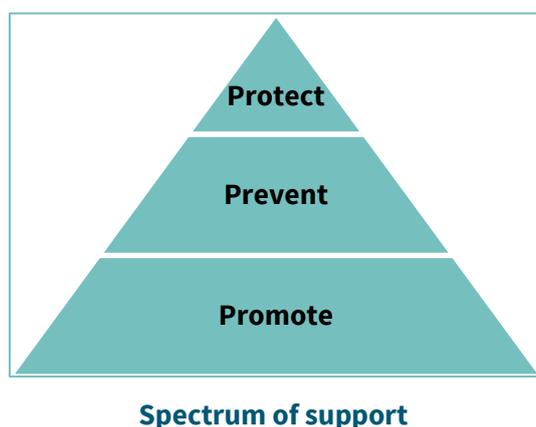
“As social beings, people rarely recover or deal with problems on their own.”

Gregor Henderson, Public Health England¹⁴⁸

5.1. A spectrum of support

The social model of health which pays attention to the social factors which influence our health and wellbeing paves the way for a relational approach, since the evidence is clear that the quality of our couple, family and social relationships are key social determinants of health and wellbeing. We can draw on our relationships as a resource which is fundamental to health and wellbeing and as an asset in our approach to healthcare.

Figure 1: The spectrum of support



Relationships can be supported in a variety of ways, and it is important to do more than provide support only once they are at risk of breaking down and need crisis intervention¹⁵⁰. What is required is a relational model of health and wellbeing which includes a *spectrum* of support, recognising that supporting relationships to improve health and wellbeing is not all about relationship counselling for people with long term health conditions. We need

to **promote** people’s *relational capability* – their capability to form and nurture healthy, flourishing relationships with friends, colleagues, at school, with family, neighbours and communities, and with partners. This is a universal-level approach. Secondly, we need to **prevent** as far as possible people’s relationships from falling into difficulties, particularly during times of transition such as when a family member is diagnosed with a long term health condition. Finally, at the most targeted end of the spectrum where needs are most acute, we need to **protect** people at times of crisis such as relationship breakdown or

when their relationships are under most strain in order to better support people's health and wellbeing.

Given the evidence we present in this report, health and social care support for people with long term health conditions provides an opportunity to include a focus on the ways in which such conditions may impact on people's relationships with friends, families, and partners, and the ways in which, in turn, supporting these relationships may help to protect people from deterioration and aid recovery or adjustment. Viewing individuals not as isolated beings but as social beings with social needs; seeing people in the context of their couple, family, and social relationships, and supporting their relationships to thrive across the spectrum of support and across the life course, could help to reduce the burden on the health service. As well as improving health outcomes, approaches that focus on relationships as a means to achieving good health are often very cost effective too. The Kings Fund (2014) estimates that for every £1 spent on befriending services, £3.75 is saved on mental health service spending and health improvements¹⁵¹.

Expanding on the growing social model of health to include such a relational focus as key in promoting good health outcomes, reducing risk and focusing on prevention, has already been shown to be beneficial within health interventions. We give some examples of what a relational approach might look like below.

5.2. A relational approach in practice: illustrations

There are a range of interventions that improve health by promoting relationship capability, preventing difficulties and supporting during crisis. All types of relationships can support our health, and we need to be mindful of this in policy and practice. This is about more than focusing on the relationships between service users and service providers, although we advocate this as important to healthcare. Social ventures such as Men's Sheds have shown that a lot can be done via mutual aid – that is, by supporting relationships between service users, in order to achieve good health outcomes. The Family Nurse Partnership has had positive health outcomes because of its focus on the relationships within families, and TCCR's intervention focusing on couples where one partner has dementia has been shown to delay hospital admission and improve health and wellbeing outcomes. Whilst this research has not comprehensively reviewed all interventions, we present some case study examples, at different points on the spectrum of support above (from promotion, to prevention, to protection), of where a relational approach is promoting positive health outcomes.

5.2.1. Men's Sheds: promoting health and wellbeing

Originating in Australia, Men's Sheds are community initiatives which provide a space for men to meet others and socialise and participate in a range of activities. Men – who are less likely to seek out health services and make friends in later life as much as women – come together and participate in a range of activities¹⁵². The success of Men's Sheds is fundamentally based on the relationships between the men who participate. They are not

promoted to men as targeting health, and the approach is very much about mutual social support that evolves rather than being actively promoted. The Australian government has invested significant funding into them and cite them in their male health policy as reducing social isolation, in turn impacting on health and wellbeing¹⁵³.

Whilst early evidence is somewhat anecdotal, there are some encouraging signs of positive health benefits of Men's Sheds in the UK.

Qualitative interviews with members of Men's Sheds indicated that men attributed lower levels of stress, improved mental health and reduced blood pressure to participating in the initiative¹⁵⁵.

Participants commented that informal conversations with other men about health issues prompted people to seek health advice. This is an example of where good quality social relationships initiate positive health behaviour, presenting an exciting opportunity to adopt this further into public health practice.

"You start to see these guys struggling with a bad shoulder, something else – and you say 'Have you had a test lately?' and it seems to click in their minds that 'mmm I ought to do that'. And that's what it's all about."

Men's Shed participant, Milligan et al, 2012¹⁵⁴

5.2.2. Family Nurse Partnership: promoting health and wellbeing

Family Nurse Partnership (FNP) is a community-based approach grounded in the importance of long term relationships, both between the service provider and the service user, and between family members. Nurses build strong, therapeutic relationships with young pregnant women and new mothers and fathers by visiting them at home. This helps to build up strong relationships between the mother and child, and between the mother and her partner. Services users build good quality relationships with others, very much modelled on the relationship built between them and the family nurse¹⁵⁶.

FNP is based on the US Nurse Family Partnership, which has been shown to have some strikingly successful health outcomes in both parents and children. For example, trials have found that the partnership leads to reduced smoking in pregnancy and fewer pregnancy related infections¹⁵⁷. Child health outcomes have also been shown to improve, with a 28% reduction in contact with health professionals in the first two years of life¹⁵⁸. Financial returns are significant, with estimates ranging between \$17,000 and \$34,000 of saving by the time infants reach adulthood¹⁵⁹.

In the UK, there is also good evidence that the FNP model leads to more stable relationships between parents, and also to positive child health outcomes, including lower obesity rates and improved pre-natal health¹⁶⁰. Fundamental to the success of the programme is the quality of the relationships built between nurses and families and within the families themselves.

5.2.3. Living together with dementia: preventing distress at transitions

The Tavistock Centre for Couple Relationships (TCCR) is running an intervention specifically for couples living with dementia¹⁶¹. This programme targets both the person

diagnosed with dementia and their partners, and focuses on the relationship between them. Preserving and nurturing the couple relationship is thought to reduce couple stress and improve the health and wellbeing of both individuals. This is a pilot programme running until 2015, and so evaluation is pending; however, TCCR draws on evidence that closer couple relationships reduce cognitive decline, and that the most effective interventions focus on both the patients and the caregiver¹⁶². This programme draws on the relationship as an asset to both partner's health and wellbeing, helping couples to live healthier lives at home.

5.2.4. Relationship support to people living with cancer: protecting people at times of relationship distress

A cancer diagnosis can have a major impact on relationships – Macmillan's research found one third of people with cancer said that their relationships were put under 'enormous' strain, and a quarter experienced difficulties with their partner as a result of diagnosis¹⁶³. Four-in-ten people living with cancer also said that their sex life suffered as a result. Relate and Macmillan Cancer Support are working together to offer free specialist relationship counselling, including psychosexual counselling and telephone counselling, to people affected by cancer – including people with cancer, their families and carers. The service aims to help individuals, couples and families make relationships work better; help people talk to each other; help them to develop coping strategies and get 'back to normal' when cancer treatment is finished; and provide help with sexual problems resulting from surgery, treatment, altered body image, tiredness, or anxiety.

Anne is 45 years old and is married to Bob who is 59. They initially self-referred to Relate for couple counselling to work on sexual issues. Having had an assessment, they were then referred onto the Macmillan service because Bob had been diagnosed with prostate cancer two years ago and this had been the main impact on their sexual relationship. Anne was suffering with panic attacks and anxiety, and she was worried about Bob's health and felt their roles had changed. They had not been intimate for over two years and prior to the cancer had always had a good sexual relationship.

The couple counselling has enabled Anne to talk about her fears, something she hadn't been able to do before. Normalising how she felt took a lot of pressure off how she was feeling. After six sessions the couple were reassessed for psychosexual therapy they then continued into the psychosexual therapy program. The impact of the work has allowed Anne and Bob to regain intimacy and closeness again and to give them back what was for them a very important part of their relationship.

Case study from Relate Cymru (names have been changed)

Relate has been working with their clinical team, trustees and Macmillan to develop measures to evaluate the service and to note the changes people experience as a result of counselling. The results look promising: in Greater Manchester, for example, 73% of service users said it had a positive impact on their relationships and 76% said they were better able to cope with relationship difficulties¹⁶⁴.

5.3. Moving forwards: principles for a relational approach

We have drawn on just a handful of examples to illustrate ways to take forwards a relational approach to health and wellbeing. These interventions show how couple, family and social relationships can be latent assets which may be harnessed to promote health and wellbeing, prevent deterioration or crises, and protect people during difficult times.

In order to embed a relational approach more securely and widely, we need to:

- Understand what works, with whom, how it would be delivered, and under what circumstances. A comprehensive review of interventions, their effectiveness and value is necessary to make a case for a relational approach to health. This will also provide a practical menu of credible options for commissioners, service providers and professionals.
- Develop a strategy for getting good practice and good interventions into general use. Understanding who makes commissioning decisions and who influences these decisions will be key to achieving this.

The models of change that recent discussion at an NPC roundtable with the major health charities¹⁶⁵ identified fell into four main categories:

- Working with professionals, through professional development, practical support, influencing clinicians or developing ‘communities of interest’.
- Working with patients/service users—so that their voice is heard and they demand the services they need and services that work.
- Working on service delivery, improving commissioning, designing pathways and systems, relieving pressure points
- Changing the frameworks within which people operate, so that they are supportive – e.g. lobbying to include intervention in NICE guidelines, or national policy frameworks such as health outcomes frameworks and standards.

Conclusions

These interventions provide just a few examples of where social, family and couple relationships are proving to be assets in promoting health seeking behaviour, preventing decline and reducing cost to the public purse through reduced reliance on state health and care services. If we can look at scaling up these interventions, or draw lessons from them to invest in innovative programmes that extend the patient-centred approach to view the individual in the context of their relationships, we will be increasingly likely to serve the health needs of our population in a cost effective manner.

6. Recommendations

In order to further a relational approach to health and wellbeing, we recommend that:

1. Following Scotland's example – which since 2007 has had a Cabinet Secretary for Health and Wellbeing (now titled Secretary for Health, Wellbeing and Sport) – the UK Secretary of State for Health becomes **Secretary of State for Health and Wellbeing**. Underneath the Secretary of State for Health and Wellbeing should be a junior minister who explicitly has relationships and quality of life for carers and people with health and care needs in their portfolio.
2. **Couple, family and social relationships become a core part of the work of local Health and Wellbeing Boards. The Department of Health should issue guidance**, encouraging Health and Wellbeing Boards to evaluate the quality of relationships and support relationships as core social determinants of health and wellbeing. In addition, local couple, family and social relationships should be addressed in Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.
3. **Relationships are inserted into national health policy frameworks, including outcomes frameworks.** In order to review existing frameworks and ensure relationships are given the place they deserve, we recommend that the **government establishes an inquiry into relationships in health policy to make recommendations on how relationships should be included in policy frameworks**, including Public Health Outcomes Framework, Adult Social Care Outcomes Framework, NHS Mandate, NHS Outcomes Framework, and NICE guidelines.
4. The **What Works Centre for Wellbeing commissions research into long term health conditions and relationships**, including research on the impacts on relationships across conditions and the impact that different interventions and services have.
5. **Public Health England establishes a National Health and Relationships Intelligence Network**, modelled on the National Cancer Intelligence Network, to collect data in one place and inform service delivery and design.
6. **Directors of Public Health** consider the best way to **gather data on the quality and stability of relationships**, in order to inform decisions made by local authorities and commissioners
7. **Clinical Commissioning Groups and local authorities have a duty to undertake a 'Family Test'** when considering new local policies and in the commissioning cycle, similar to that which is now required to be undertaken by all central departments as part of the impact assessment of all new domestic policy. Since so many health, wellbeing and social care decisions are now made locally, they currently by-pass the family test. This test should be included as a new statutory duty on CCGs and local authorities.

8. **Relationship support charities and impairment-specific charities look for further opportunities to partner** in order to provide support for people with long term health conditions.
9. **Public Health England** uses its regional public health staff in its 15 local centres to **support local authorities to embed plans to strengthen relationships** and incorporate relationships into JSNAs and JHWSs.
10. **The DWP pilots a local ‘family offer’** working with innovative local authorities to adopt a comprehensive, life-course approach to family and relationships support, focusing on key transitions, and joining up local services around families and people’s relationships, **with a focus on health and wellbeing, particularly on the couple, family and social relationships of people with long term health conditions.**

Relate's campaign on relationships and long term health conditions

The findings in this report are a result of a literature review of the research into the links between relationships and long term health conditions, conducted by New Philanthropy Capital (NPC). Based on this research, Relate has made recommendations that sit alongside its wider campaign on the importance of the links between relationships and long term health conditions. The campaign, *The Best Medicine*, aims to:

- increase awareness of the importance of relationships for frontline practitioners in services supporting people with long term health conditions;
- increase awareness of the issues around long term health conditions and relationships amongst relationship support practitioners;
- explore relationship needs and experiences of people with long term health conditions, promoting their positive contributions, and
- ensure that people are able to access support for their relationship if they need it.

Relate believes that good quality relationships are an integral part of the public health agenda, and central determinants to the health and wellbeing of people with, and at risk of developing, long term health conditions.

For further information, please visit www.relate.org.uk/thebestmedicine

Appendix

Definitions

The table below shows some definitions of common terms we use throughout this report.

Term	Definition
Carer	A carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support (Carers Trust ¹⁶⁶).
Couple relationship	Loving relationship between two people. Includes: spouse, partner, civil partnership, cohabiting couples.
Family relationship	Relationships between those that are 'related' and/or considered to be in a family. Includes: parents including lone parents, foster/adoptive parents, children, siblings, family-in-law, stepfamily, kinship carers, extended families and grandparents.
Social relationship	Wider social, community and society relationships. Includes: friends, colleagues, neighbours, GPs, nurses, shop keepers.
Long term health condition	A health problem that can't be cured but can be controlled by medication or other therapies (Department of Health, 2013 ¹⁶⁷).
Relationship support	The provision of information, education, support, counselling, and therapy intended to strengthen or improve couple, family, and social relationships. This includes support from friends, family, and peers, as well as from more structured services and activities that promote relational capability, prevent relationship distress at key transitions, and support people at times of identified relationship distress. This support extends to people not currently in a relationship and to the quality of the co-parenting relationship between those who are separated (Relationship Alliance, 2014 ¹⁶⁸).

Methodology, scope and limitations

The research aimed to explore the effects of relationships on health, and of long term health conditions on relationships. In particular, we wanted to pursue the idea that relationships can be drivers of health, and the implications of this for policy-makers, commissioners and health and relationship support practitioners.

The research included:

- a literature and policy review;
- interviews with figures in government, charities, service providers and academics; and
- a roundtable discussion with experts to review findings and develop recommendations.

We reviewed over 70 papers that referenced relationships and health, which collectively held valuable insights. Individual studies varied in quality and rigour, including in sample sizes, control factors and timelines, and at times findings contradicted each other in parts. We have highlighted studies which provided the most interesting insights or were the most well designed, and other studies are more lightly touched upon. We had hoped to find authoritative statistics on particular risk factors or benefits to health. However, in reality, when the findings are all compiled, though we can draw general conclusions and hypotheses in which we have strong confidence, we were unable, within the scope of this research, to aggregate numbers into rigorous statistics.

It should be noted that whilst many of the studies we draw on here use marital status – often for practical reasons – to define their samples, we cannot draw any conclusions here on whether it is marital status per se or other background ‘selection’ effects which account for any differences in outcomes between samples¹⁶⁹. Our purpose is to examine the ways in which relationship quality – not marital status – impacts on and is affected by health.

Much of the research in this area focuses on three of the biggest non-communicable diseases: cancer, dementia and cardiovascular disease, and therefore a lot of the evidence and examples we draw on are focused on these conditions. On this occasion, the links between relationships and mental illness have been out of scope, however we recognise that there are strong associations between long term physical and mental health conditions, and between relationships and mental health, and recommend that this is an area for exploration. Many of our conclusions and recommendations will be relevant to mental illness, as they will to other physical conditions.

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About NPC

NPC is a charity think tank and consultancy which occupies a unique position at the nexus between charities and funders, helping them achieve the greatest impact. We are driven by the values and mission of the charity sector, to which we bring the rigour, clarity and analysis needed to better achieve the outcomes we all seek. We also share the motivations and passion of funders, to which we bring our expertise, experience and track record of success. We help charities and funders find solutions to the challenges they face—by helping them use their resources more effectively, inspiring new thinking and prioritising impact, we are transforming the sector.

- Increasing the impact of charities: NPC exists to make charities and social enterprises more successful in achieving their missions. Through rigorous analysis, practical advice and innovative thinking, we make charities' money and energy go further, and help them to achieve the greatest impact.
- Increasing the impact of funders: NPC's role is to make funders more successful too. We share the passion funders have for helping charities and changing people's lives. We understand their motivations and their objectives, and we know that giving is more rewarding if it achieves the greatest impact it can.
- Strengthening the partnership between charities and funders: NPC's mission is also to bring the two sides of the funding equation together, improving understanding and enhancing their combined impact. We can help funders and those they fund to connect and transform the way they work together to achieve their vision.

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Relate is the UK's leading relationship support organisation, serving more than one million people each year through information, support, and counselling. Our vision is a world where strong and healthy relationships are actively promoted as the heart of a thriving society and our mission is to develop and support healthy relationships by:

- Helping couples, families and individuals to make relationships work better
- Delivering inclusive, high-quality services that are relevant at every stage of life
- Helping both the public and policymakers improve their understanding of relationships and what makes them flourish.

Everyone can access Relate services through a growing range of channels: face-to-face, online, on the phone and via email.

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