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	Which area of the review are you responding to? (please mark X)
Prevention strand	x
Review of disabled children	
Strategy for youth services	
Review of high cost, high harm families	x

**Comprehensive Spending Review 2007 – DfES/HMT Joint Policy Review on
Children & Young People**
A Response from Relate

About Relate: Relate is the largest provider of relationship counselling and support in the UK, with 150,000 clients being seen at over 600 locations around the country each year. We provide couple, family, individual, and young people's counselling, through both self-referral (subsidised for those on low incomes), and contracting with partners such as local authorities, PCTs, schools, and prisons. This year, we have opened the Relate Institute – a faculty of Doncaster College – which will train 400 counsellors and therapists a year, who will go on to work in the public, private, and voluntary sectors.

What should be the role of universal services in providing access to protective and preventative support, risk assessment, and referral?

Universal services – particularly those that are actually used by all groups – should act as triage for protective, and preventative, support. They are the services best placed to do at least initial risk assessment and referral. GPs are a good example of a service that already refers a percentage of patients in particular need to specific services (for example, many GP surgeries hold referral contracts with local Relate services. Clients typically reduce their visits to the GP by 40% after a Relate intervention).

However, there is much more GPs could do, particularly around early years' services. During pregnancy, GPs could refer pregnant women assessed at being at risk of poor outcomes to home visiting programmes, peer or counsellor support, or even residential care (all of which have evidence from the UK and abroad to suggest they are effective). These programmes can be organised in a variety of ways, but there is plenty of evidence that they can have a positive effect in reducing low birth weight, increasing breastfeeding, and reducing maternal depression.

The corollary of intensive services is that fewer services may be available to all universally (e.g. the average number of visits to a GP or midwife that a low-risk pregnant woman makes should be reduced from thirteen, to allow greater resources for the preventive service). But this is inevitable if progressive universalism is to become a reality, and is highly unlikely to make a difference to the health outcomes of those currently at low-risk. If they should move into a high-risk category, targeted and intensive services would be more easily available than they are now.

Teachers should also be able to refer children, and possibly parents, to intensive services, although it is unclear as to what powers of compulsion they could or should have. In some examples, these could be provided under the aegis of extended schools – for example, family or young people's counselling could take

place after school. The advantage of using universal services as a 'triage,' for targeted ones is that stigmatisation could be avoided. Professionals who see children and families regularly are the best people to decide when an intervention is needed, and are less likely to wait until it reached crisis. However, these professionals – particularly teachers – need to feel confident that the services they refer to will be appropriate and available. They also need the confidence and skills to raise what may be personal and difficult issues with families. Health visitors, teachers, GPs, childcare workers, and midwives might all benefit from this training.

What would be the impact of more preventative services and early intervention on the life chances of children and young people, and on the value for money of public spending on children, young people and families?

Preventative services cost less than crisis intervention – not only are they usually less costly to deliver but they avoid the (inevitably costly) incidents which provoke the crisis intervention.

There is an example of this within Relate services. From monitoring of our clients, we know that relationship problems cause days to be missed off work, use of alcohol, tobacco, and illicit drugs to increase, mental health problems, a rise in visits to the doctor, homelessness, and multiple poor outcomes for children – including poor school attainment, and attendance, drug use, crime, and anti-social behaviour. Based on these answers, and in an evaluation of the efficacy of our services, researchers estimated that each Relate intervention saves the nation £16,800. Although people coming to Relate consider themselves to be in 'crisis', it is not a 'crisis intervention'.

Their impact of life chances would be that by preventing children from reaching a first 'crisis' point (e.g. taken into care, heavy drug use, arrest etc) you significantly decrease the chances of their ever reaching one. It is far harder to 'narrow the gap' between the life chances of a relatively privileged child, and a disadvantaged one, after the first 'crisis' has occurred.

What evidence is there of major barriers to developing a preventative system? Are there examples where you have overcome these barriers?

Anecdotally, a major barrier to developing services which reach the most excluded is the fact that these services are often 'state'- branded. Excluded families – particularly male members – will often only have had negative experiences, and perceptions, of the state: unhappy school days, involvements with the police and CJS, the CSA etc. This is perhaps one reason why Sure Start has not had total success in reaching out to those who would benefit the most,

while the groups above them, who have more positive expectations of the state, have embraced it.

Working with the voluntary sector offers opportunities here. Below is a case study, drawn from a project we did in Nottingham, working with the parents of young offenders. As is evident, the mother interviewed had negative perceptions of the state:

'I was brought up in care and resented being told what to do. But I tell you...I love these people. Even the counsellor was fantastic. She was down to earth, not like 'you're a bad mother'. I learned how to speak to people, how to get people to listen to me. With children...if you start with 'I' they just can't help but listen.

The skills that we learnt should be on the school curriculum. Then we'd know! My son (now 15) was doing car crime, driving while disqualified. I had the police at my door every night for five years. Now he hasn't been in trouble for four months, touch wood.'

It is evident here that the intervention, which worked on her relationship with her son, and her parenting skills, was effective. It is also the case that the brand 'Relate' is seen as a mainstream, 'respectable' service, used by all social classes, and carrying no stigma of being 'for bad parents', or 'for poor people'. Through fair contracting with voluntary sector agencies which have a strong track record, the negative connotations of state intervention in families can be avoided.

What interventions here and abroad have been shown to work in reducing the harm caused by these families, and supporting them to exit the cycle of low achievement?

Our 'Measuring Outcomes' programme is at an early stage, but we are encouraged by initial results, and believe they bode well for further evaluation of relationship counselling, which relies on systemic, psychodynamic, and cognitive behavioural models. Whether working with a couple, a young person, or a family, Relate counselling allows people the chance to understand their relationships and make *sustainable behavioural change* for the future. Below is a selection of results from our initial monitoring of 1000 clients who came for couple counselling. All completed questionnaires both before and after counselling.

25% said that their children were missing days off school before they began working with us. Over 80% said that their children's attainment and attendance at school had improved following our support.

187 clients told us that drugs were a particular problem with their children. 95% of them said that Relate's help had a positive effect on their children's use of drugs and 91% said we had a positive effect on their antisocial behaviour.

30% of clients were drinking more than usual before coming to see us, and 48% of these clients were drinking less as a result of our support.

74% of those clients who told us that the issue they had come to Relate about was affecting their use of prescription drugs said that they had reduced their need for prescription drugs after our support.

There was a 40% decrease in visits to the doctor after our intervention

77% of those who had told us that their ability to stay living in the family home was in danger said that they were now able to stay at home.

80% of those people who felt that they may soon be homeless when they first came to us now feel that they are unlikely to soon be homeless.

These results show that counseling – whether for couples, families, or individuals – has considerable potential. It should be noted that counseling is not lengthy – six would be the average maximum of sessions attended, and some families need less. Poor family relationships, resulting in homes where conflict is high and supportiveness low, are a leading cause of enduring behavioural problems. These relationships must be addressed if the problems are to be addressed. Counseling 'blends' well with, and actually supports, other programmes, such as residential interventions, parenting support, and education, by showing people how their behaviour affects others. It also helps people work through traumatic previous events, which both adults and young people in 'problem families' are highly likely to have experienced.