

The Wellbeing Value of Reducing Parental Conflict

A cost-benefit analysis of Mentalization-Based
Therapy for Parenting under Pressure



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Summary

This report assesses the economic value of Mentalization Based Therapy for Parenting under Pressure, which supports parents experiencing relationship difficulties and high levels of conflict.

MBT is delivered by Tavistock Relationships as part of the Reducing Parental Conflict (RPC) programme. Evaluation evidence shows significant improvements in relationship quality and mental health, two of the most important factors determining overall life satisfaction.

In practice, cost-benefit analysis (CBA) often leaves out the inherent benefits of relationships, instead focussing on the “productive” economy: GDP, income, and expenditure. On the eve of the Spending Review, H.M. Treasury published its Wellbeing Guidance for Appraisal (MacLennan, Little and Stead, 2021), offering a step-by-step guide to incorporate wellbeing science, at all stages of the policy cycle.

We use the Treasury’s recommended metric, a wellbeing-adjusted life year (WELLBY): this represents a one-point change in overall life satisfaction, on a scale of 0-10, for one year. We estimate wellbeing gains for parents who move out of a clinical state of mental illness, by the end of MBT intervention. Treasury recommend a monetary value of between £10,000 and £16,000 per WELLBY, which allows wellbeing effects to be compared directly to the costs of investment.

The report considers a range of scenarios, reflecting uncertainty in our assumptions: these scenarios indicate that one pound invested in MBT could generate a return of £4 to £17. Our Central scenario would see a £10 return, per pound invested.¹

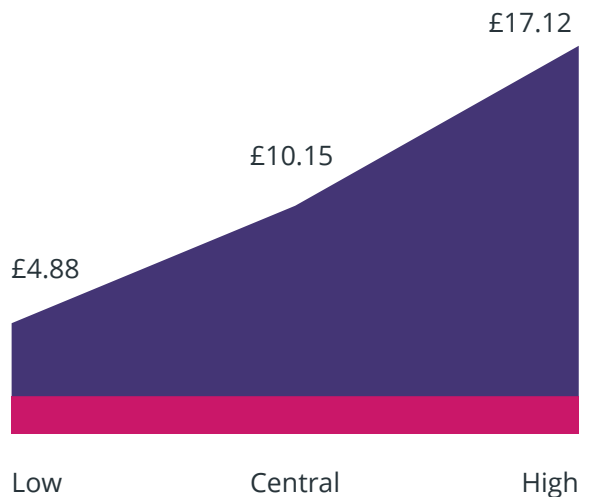
Around 95% of these returns are associated with improved life satisfaction, with the remaining 5% associated with reductions in the public cost of mental health services. This illustrates how narrower forms of CBA – limited to fiscal savings – undervalue investments to reduce parental conflict.

Benefit Cost Ratio

Scenarios based on observable reductions in diagnosable mental illnesses, amongst PARENTS.

Key

■ Benefit:Cost ratio ■ Breakeven (BCR=1:1)



¹ Scenarios assume a ten-year appraisal period, grounded in evidence that MBT has sustained impacts on depression, and that depression has lasting effects on subjective wellbeing. Estimates include a 25% downward adjustment for optimism bias. Sensitivity tests provide confidence that the wellbeing benefits outweigh the cost of intervention, based on more stringent assumptions and shorter appraisal periods (1-2 years). All estimates are in present values and 2022/23 prices, H.M. Treasury’s preferred price year for the Spending Review in 2021. We apply a 1.5% discount rate to wellbeing benefits, and a 3.5% discount rate to public cost savings, in line with H.M. Treasury (2020) guidance.

² The costs of delivery are based on 579 parents, who have an estimated 383 children between them.

Our estimates are a first approximation, with scope to improve the analysis. The report evidences wider benefits, which cannot be monetised at present. Tavistock Relationships plan to include the Office for National Statistics' direct measures of life satisfaction in future programme evaluations – these measures could identify for more extensive wellbeing effects.

Further, the CBA does not account for improved outcomes for children. Half of parents (53%) reported that their children/child's wellbeing had increased, by the end

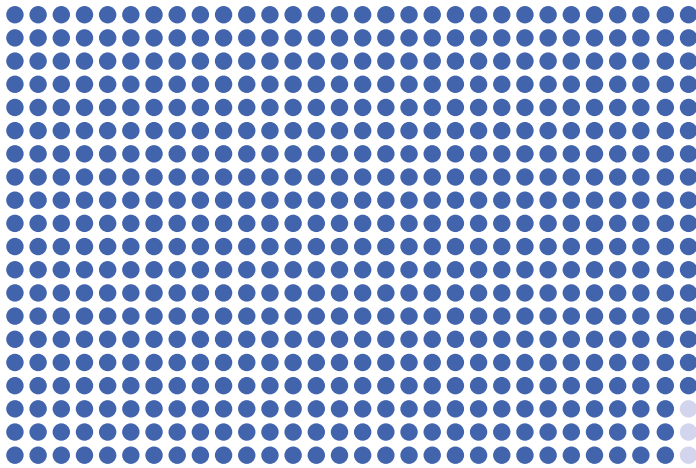
of the intervention. We don't know by how much children's wellbeing improved, but we can explore its potential contribution to the programme's overall value.

Indicatively, the long-term cost of mental health difficulties in childhood are upwards of £260,000, over one child's lifetime (Pro Bono Economics, 2020). Reducing mental health disorders in five children could offset the £1.2m cost of delivering the MBT intervention: this represents 1.2% of the children who stood to gain from the intervention.²

Breakeven point

Based on potential reductions in diagnosable mental illness, amongst CHILDREN.

597 parents



£1.2m to run MBT for **597 parents** in Hertfordshire

4.7 children



Equivalent to the **£260k benefit per child** associated with a reduction in diagnosable mental illness **x 4.7 children**

Our report provides the first practice example of wellbeing appraisal, since the publication of the Government's new wellbeing guidance. It offers insight into the role that wellbeing economics could play in value-for-money assessments, across the public and charitable sectors. The approach is particularly well-suited to the assessment of relationship support and family functioning.

1. Introduction

1.1. The intervention

The Reducing Parental Conflict (RPC) programme includes a package of interventions, funded centrally by the Department for Work and Pensions. The programme is delivered by several organisations, including Tavistock Relationships.

Tavistock Relationships wished to assess the value of Mentalization Based Therapy for Parenting under Pressure (MBT) in the Hertfordshire Contract Package Areas.³ MBT helps couples/parents experiencing relationship difficulties and high levels of inter-parental conflict to:

- Focus on, and think about, not only the feelings and emotions they are experiencing, but those of their children, learning to modify their behaviour as a result.
- To appreciate that their partner's thoughts and feelings may be different to their own, and that their partner may have a different perspective than they do.
- To be curious about possible differences between themselves and their partner, especially about the reasons why people may behave as they do.
- To consider each person's involvement in, and contribution to, the problems of the co-parenting relationship and develop a better appreciation of what their children need.
- To promote awareness of their own and their partner's mental states, feelings, and emotions, with a view to making choices that are in the best interests of children.
- To practice skills of mentalizing, communication and problem solving, particularly in relation to parenting and choice-making around alcohol use.

Outcomes of the MBT intervention were evaluated in the Hertfordshire Contract Package Area, over the past two

years (2019-2021). The evaluation used established psychometric measures of mental health, couple communication and conflict. The contribution of this report is to estimate the economic value of these outcomes, enabling comparison to the costs of intervention.

1.2. Wellbeing Economics

Several leading economists advocate for a wellbeing approach to policy appraisal, notably those associated with the Centre for Economic Performance, at the London School of Economics.⁴ The All Party Parliamentary Group on Wellbeing Economics called for wellbeing to be at the heart of the Spending Review in 2020.⁵ Similarly, Pro Bono Economics recommend the wellbeing approach for the charitable sector.⁶ They all note that the aim of Government is to improve people's lives, and so we need to put this objective at the heart of decision-making. Wellbeing economics can help to quantify outcomes that are otherwise difficult to assess, in value-for-money terms.

On the eve of the Comprehensive Spending Review, H.M. Treasury published its Wellbeing Guidance for Appraisal (MacLennan, Little and Stead, 2021). It offers a step-by-step method to incorporate wellbeing evidence at all stages of the policy cycle, including in cost-benefit analysis. The guide is a supplementary to the "Green Book" (HM Treasury, 2020), the UK Government's guide to policy appraisal and evaluation.

The wellbeing approach is not new and so the guide's main contribution is a practical one. It recognises that practitioners – across the public and charitable sectors – face barriers in applying wellbeing analysis in decision making. Policy assessments draw on primary sources of evidence, specific to the intervention; they also use secondary

sources, to make plausible assumptions about its impacts. There has been extensive wellbeing research over the last 30 years, but this is fragmented and difficult to access. The guide aims to make the evidence more accessible, offering advice on its consistent application.

For example, the guide recommends on how one might measure, and then monetise, changes in wellbeing. This does not settle the debate on the “value” of wellbeing – or, indeed, whether wellbeing ought to be monetised at all – but it does allow practitioners to apply the approach with more confidence. Section 3 discusses the method in more detail.

1.3. Relationships and mental health, in the pandemic

During the pandemic, elevated levels of psychological distress were associated with having children at home, and having a pre-existing health condition (Shevlin et al., 2020). Financial and food insecurity, increased time spent on childcare, and home schooling were all associated with worsening mental health among parents (Public Health England, 2021a).

Children’s wellbeing has also been impacted by the pandemic, linked closely to their parent’s wellbeing and to family conflict. Some young people (aged 11 to 16) reported having closer relationships with their parents, and less severe symptoms of mental health difficulties (Public Health England, 2021b). However, those with a probable mental disorder were more likely to have a parent with

a higher level of psychological distress – these levels are higher in the pandemic, compared to similar data collected in 2017 (Skripkauskaite et al. 2021),

1.4. “Levelling Up” and relationships

There are disparities in the problems described above. During the pandemic, children in financially disadvantaged families reported poorer mental health, including anxiety and loneliness. Parents/ carers from households with lower annual incomes reported their children having higher levels of symptoms of behavioural, emotional, and attentional difficulties than those with higher annual incomes (Public Health England, 2021b).

As lockdown progressed, between February and March 2021, parents from higher income households reported decreases in these symptoms, whereas there was relatively little change for those from lower income households. There is evidence that children with a probable mental health disorder were more likely to live in a household that had fallen behind with payments (Public Health England, 2021b).

In sum, the size of the “problem” – which the RPC programme seeks to address – has grown, unequally, during the pandemic. These disparities compound the challenge to “level-up” economic and social outcomes. It is important that economics also provides clear insight into the fundamental policy goals relating to recovery from the pandemic, and the levelling-up agenda. A wellbeing approach can be instructive in this regard.

³ MBT is the main intervention in two of the four Contract Package Areas, Hertfordshire and the North East of England. The other two Contract Package Areas are Westminster and Dorset. The “Hertfordshire” Contract Package Area also covers some areas in Kent, Essex, Buckinghamshire, and Cambridgeshire. “Hertfordshire” is used as shorthand in the programme: we adopt this shorthand in the report.

⁴ See, for example, Frijters, P. and Krekel, C. (2021). and Clark et al (2018)

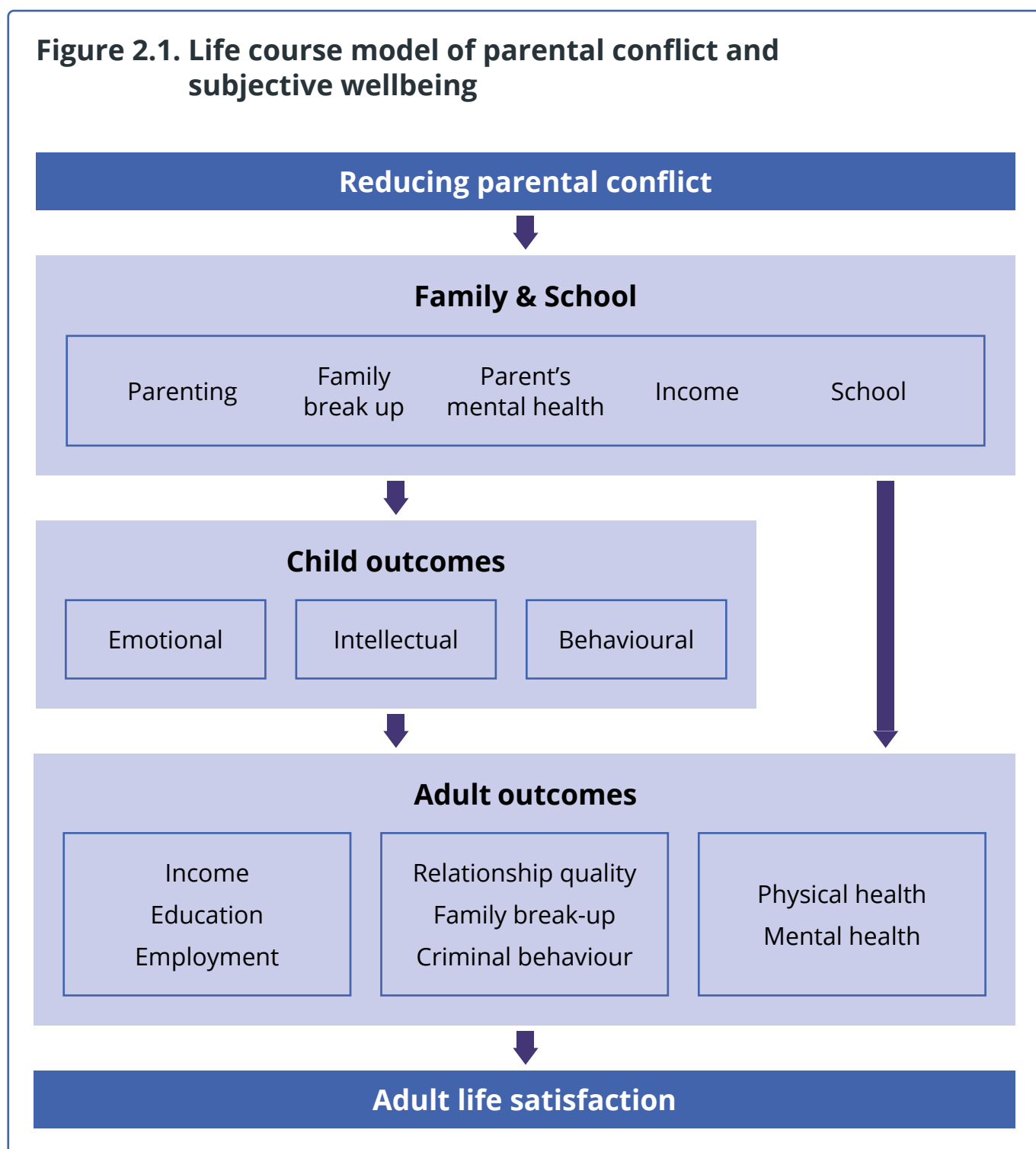
⁵ Layard (2019) and What Works Centre for Wellbeing (2020)

⁶ Franklin and Kenward (2020)

2. Theory of change

2.1. Logic model

A useful starting point is to consider a logic model, linking reduced parental conflict with overall changes in life satisfaction. Figure 2.1 shows how effects on wellbeing are mediated through child and adult outcomes.⁷ The aim is not capture complex interactions between each outcome, rather to provide a frame of reference, from which we can consider two questions: which of these outcomes matter most in determining our wellbeing; and to what extent might inter-parental relationships affect those outcomes?





2.2. Which outcomes matter most to our wellbeing?

We can draw insights from a large body of wellbeing research, summarised in Clarke et al. (2018):

- The most important internal factors are our mental and physical health. Indeed, mental health is the biggest single predictor of subjective wellbeing.
- The most important external aspect of life is the quality of our human relationships – above all, with family and loved ones.⁸
- Children’s emotional health at age 16 is the most important predictor of a satisfying adult life, more so than educational attainment at all ages.
- Above a level to meet basic needs, differences in income explain only 1% of the variation in life satisfaction, other things equal.

2.3. Can reducing parental conflict influence these outcomes?

Evidence on the effectiveness of interventions to reduce parental conflict is summarised by the Early Intervention Foundation (2018; 2020) and the Relationships Alliance (2020): when family conflict is frequent, intense, and poorly resolved, it has negative impacts on relationship quality and mental health. Children exposed to destructive conflict are more likely to: experience depression or anxiety; have physical health problems; develop behaviour problems; and do worse at school.

This suggests that reducing parental conflict could have a sizeable effect on overall life satisfaction. Next, we require a bespoke framework, to assess the costs and benefits of the MBT intervention.

⁷ This model was developed by the Centre for Economic Performance (see Clark et al., 2018). It is adapted slightly in this report.

⁸ See also Powdthavee (2008), who details the role that family relationships play in subjective wellbeing.

3. Cost-benefit framework

3.1. Wellbeing-adjusted Life Years (WELLBYs)

The Office for National Statistics (ONS) uses four survey questions to measure personal wellbeing, known as the ONS4. The first of these questions asks “Overall, how satisfied are you with your life nowadays?”. People respond on a scale from 0 to 10, where 0 is “not at all” and 10 is “completely”. The recommended wellbeing metric for economic appraisal is a wellbeing-adjusted life year, or WELLBY: this represents a one-point change on the ONS’ life satisfaction scale, for one year.⁹

Broadly, there are two ways to assess value for money using WELLBYs:

- Cost Effectiveness Analysis (CEA): one could assess all policy effects in WELLBYs, then compare these impacts to the net public cost of intervention. The relative value of each policy would then be measured by their cost-per-WELLBY.
- Cost Benefit Analysis (CBA): WELLBYs could be translated into monetary values, alongside other monetisable policy effects. Policies can then be compared on standard Green Book metrics, typically their Net Present Social Value (NPSV) or Benefit Cost Ratio (BCR).

Both methods are valid “Green Book” practice (see HM Treasury, 2020). We adopt a CBA framework, in this report, because this will be in widespread use by all Government departments, during the Spending Review in 2021. Hence CBA allows the value of MBT to be compared with a wider suite of spending proposals. Wellbeing CEA is – at present – less common.

In CBA, we need to translate WELLBYs into monetary values. HM Treasury recommend a standard value of £13,000 per WELLBY, ranging from £10,000 to £16,000 (MacLennan, Little and Stead, 2021).¹⁰ This range seeks to:

1. Achieve approximate consistency with existing government values used within CBA, e.g., the Value of a Statistical Life Year (SLY) and the value of a Quality Adjusted Life Year (QALY).
2. Be consistent with studies on the link between wellbeing and income.
3. Be reasonably straightforward to adopt.
4. Avoid any unintended consequences or disadvantage for certain groups.

The lower bound (£10,000) is set to be as consistent as possible with the existing Green Book recommended QALY value, while the upper bound (£16,000) is based on direct academic evidence on the estimated willingness to pay for changes in life satisfaction (MacLennan and Stead, 2021).

The recommended approach is to use a linear conversion from wellbeing to money, and to use the full range of values rather than a single point estimate. These values are in 2019/20 prices and so we update to 2022/23 prices, HM Treasury’s preferred price year for all economic appraisals in this year’s Spending Review.¹¹

Table 3.1. Monetary Value of a WELLBY

	Price base year	
	2019/20	2022/23
Low	£10,000	£10,445
Central	£13,000	£13,579
High	£16,000	£16,712

Table 3.2. Value of a reduction in clinical depression (2022/23 prices)

	WELLBYs	
	1.0	1.5
Low	£10,445	£15,668
Central	£13,579	£20,368
High	£16,712	£20,568

3.2. The WELLBY impact of diagnosable mental illness

Layard et al. (2020) quantify the WELLBY impact associated with diagnosable mental illness, an estimate which we adopt in our cost-benefit framework. Layard et al. (2020) originally proposed this framework to assess the Government’s ‘lockdown’ measures. It recognises that WELLBYs offer a common unit that would allow mental health impacts to be taken into balance, alongside physical health effects (e.g. from contracting COVID-19), and recessionary impacts on the economy.

Layard et al. (2020) initially quantified mental health impacts using a different unit of measurement, a Quality-Adjusted Life-Year (QALY). QALYs

are well-established in health economics, to evaluate various health treatments on a common scale: they are evaluated on a scale of 0-1, where 0 means that life is not worth living and 1 represents one year of life spent in full health. One year lived in a diagnosable state of mental illness is estimated to reduce QALYs by 0.2 units.¹² QALYs can be translated in WELLBYs, noting that average life satisfaction in the UK is approximately 7.5.^{13,14} Hence, one year lived in depression roughly equates to a loss of 1.5 WELLBYs (= 0.2 QALYs x 7.5).

Based on MacLennan, Little and Stead (2021), above, we can value 1.5 WELLBYs at £15,668 to £25,068 (Table 3.2).

⁹ See H.M. Treasury (2021) and Clark et al. (2018)

¹⁰ See MacLennan and Stead (2021) for a review.

¹¹ We uprate by 4.45% based on the June 2021 GDP Deflator Series.

<https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-june-2021-quarterly-national-accounts>

¹² Layard et al (2020) note that there are 12 million adults and 1 million children in the UK who suffer from diagnosable mental illnesses. On average NICE classify these 12 million people as experiencing only 0.8 QALYs per year of life rather than 1.0 QALY for those who are well.

¹³ <https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/personalwellbeingintheukquarterly/april2011toseptember2020>

¹⁴ MacLennan and Stead (2021) also use average life satisfaction to convert between QALYs and WELLBYs. They used an average value of 7, rather than 7.5 in Layard et al (2020). They round-up to an average value of 8, then subtract 1 unit. The subtraction accounts for evidence that Life Satisfaction scores of 0-2 are difficult for people to imagine. Hence a QALY value of 0 could be more akin to a LS score of 1. Given that we are adopting the Layard et al. (2020) model in this report, we use 7.5 for consistency. The alternative estimate is, however, accounted for in the range of monetary valuations that we subsequently place on a WELLBY, noting that MacLennan and Stead’s estimate underpins the lower end of this range, £10,000 per WELLBY in 2019/20 prices.

4. Benefits and costs of MBT

4.1. WELLBY value of reduced mental illness

MBT was evaluated in the Hertfordshire Contract Package Area, between July 2019 and May 2021, using two psychometric measures:

- Clinical Outcomes in Routine Evaluation (CORE), a 34-item measure for psychological distress, used widely in the evaluation of therapeutic interventions; and
- Couple Communication Questionnaire (CCQ), which measures communication, conflict and violent problem solving.

There are statistically significant improvements in CORE scores and on all dimensions of the CCQ. We focus on CORE, given that we have established a framework to value reductions in clinical depression. Post-intervention questionnaires were collected from 258 parents. 82 parents were in a clinical state of distress before the intervention and, of this group, 51 (62%) scored below the clinical threshold, after the intervention.¹⁵

There is missing data for 321 parents who completed the pre-intervention questionnaire but not the post-intervention questionnaire. In the CBA, we need to make assumptions about the change in mental health status for all 579 parents. We assume that the number of parents, benefiting from a reduction in clinical depression, ranges from:

- **51 parents** in our “low” scenario: this assumes no improvement in mental health, for parents with missing data.
- **114 parents** in our “high” scenario: this assumes the same rate of improvement for all 579 participants, as we observe for the 258 parents with complete data.¹⁶

There may be unobservable differences between parents who don't complete the survey, compared to those who do. Plausibly, one might assume some positive outcomes for some parents with missing data, but we might anticipate a lower rate of improvement. Hence our “central” scenario splits the difference between the low/high bounds (83 parents).

Next, we estimate wellbeing value associated with reductions in depression, in each scenario. We estimate that the intervention in Hertfordshire has a wellbeing value of at least £0.8m to £2.9m per year. The range accounts for two uncertainties: missing data; and the value of a WELLBY (above).

¹⁵CORE scores can be converted to the Beck Depression Inventory. The BDI categorises a range of depression, anxiety, and related disorders into four states of psychological distress: minimal, mild, moderate, and severe. Those in moderate/severe distress are in clinically diagnosable state of mental illness.

¹⁶ $51 / 258 = 19.77\%$. This discounts any positive programme outcomes for the majority ($177 = 258 - 81$) participants who enter the programme without ‘moderate/severe’ depression. This group may nevertheless see improvements in their mental health, or in other outcomes that lead to improved wellbeing.

¹⁷Note that GMCA also recommend a total economic benefit of reducing the number of adults suffering from depression and/or anxiety disorders – the estimate is £5,018 per person per year in 2022/23 prices. However, we do not use this higher valuation in our estimate. Whereas the WELLBY and fiscal cost do not overlap, there is potential for ‘double counting’ WELLBY and wider economic benefits, some of which accrue to the individual sufferer.

Table 4.1. Wellbeing value of MBT, per year (2022/23 prices)

	Reduction in depression (no. parents)	Cost saving per parent (£ p.a.)	Total benefit (£ p.a.)
Low	51	£15,668	£799,058
Central	83	£20,368	£1,684,989
High	114	£25,068	£2,869,174

Table 4.2. Public cost saving of MBT, per year (2022/23 prices)

	Reduction in depression (no. parents)	Cost saving per parent (£ p.a.)	Total cost saving (£ p.a.)
Low	51	£1,084	£55,284
Central	83	£1,084	£89,676
High	114	£1,084	£124,068

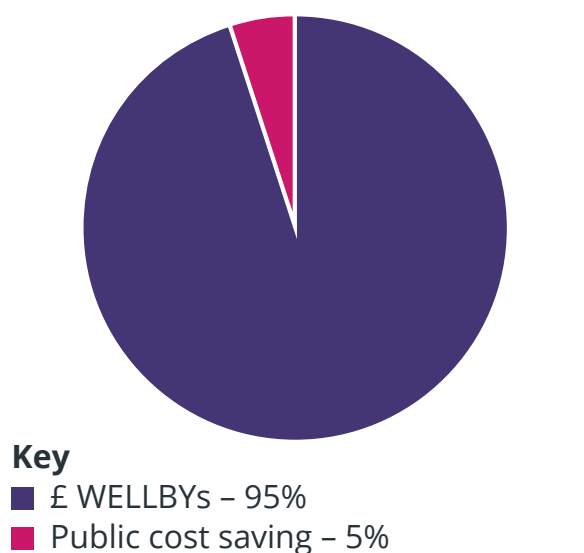
4.2. Public cost savings

The Greater Manchester Combined Authority’s Unit Cost Database (UCD) provides an estimate of the average cost of service provision, for adults suffering from depression and/or anxiety disorders. The UCD is a leading source of cost-benefit data for local authorities and the charitable sector. The UCD recommends a value of £1,084 representing the average annual public cost of clinical mental illness.¹⁷ For 51 to 114 parents this might represent a cost saving of £55k to £124k per year.

Figure 4.1 shows that the wellbeing benefits (for parents) are much larger than the fiscal savings (for Government). Parents in better mental health are likely to be more productive, which could generate personal income, benefits to employers, increased taxes and reduced welfare payments. Even if we accounted for impacts in the productive economy, they are unlikely to outweigh the intrinsic value of better mental health. There would also be a risk of “double-counting” wellbeing and

productivity benefits, as these overlap, to some degree: e.g., improved life satisfaction, associated with reduced depression, may in part derive from employment.

Figure 4.1. Percentage of benefits, derived from WELLBYs and public cost savings



4.3. Cost of intervention

Tavistock Relationships estimate that it will cost £2,113 per parent, to deliver MBT in the upcoming Spending Review period. On this basis, we estimate a ~£1.2 million total cost of delivery, for 579 parents.¹⁸ Scaling to 579 parents allows us to compare the benefits and costs of the intervention, based on the evaluation in Hertfordshire.

Table 4.3. Cost of delivery

Cost per parent (2022/23 prices)	£2,113
Total cost (579 participants)	£1,223,427

4.4. Appraisal period

We cannot observe the duration of improvements in mental health, in the period following the post-intervention questionnaire. Appendix A provides a review of secondary evidence, indicating that improvements in mental health, following effective relationship support, is be sustained over many years. This review is consistent with general evidence relating to effects of depression on life satisfaction. In reviewing how best to apply evidence of mental health improvements in a wellbeing CBA, MacLennan et al. (2021) concluded that:

“Mental health conditions show permanent effect on wellbeing, [with] little evidence of a peak.”¹⁹

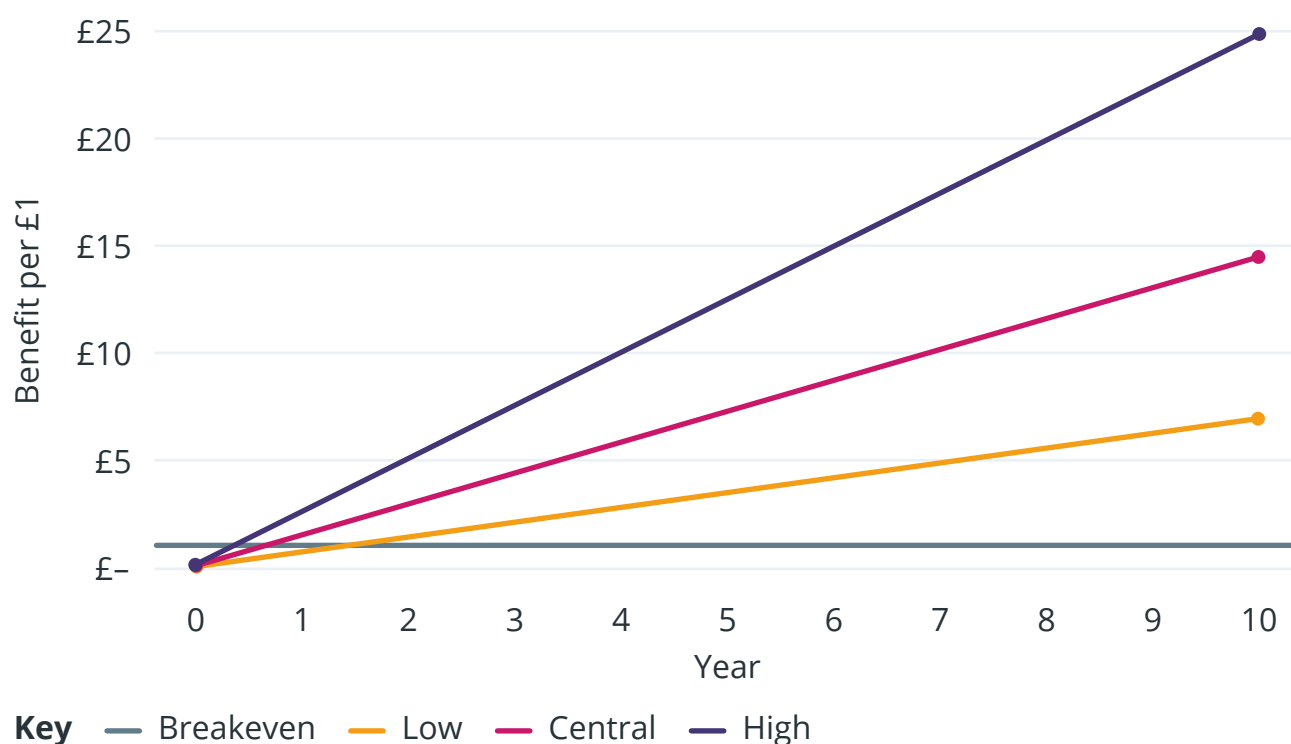
Table 4.4 summarises, based on the full 10-year appraisal period.²⁰ Ten years is the default appraisal period, recommended in the Green Book for programme funding (H.M. Treasury, 2020). This period corresponds to evidence from Randomised Control Trials on couple relationship interventions, which observe sustained improvements in mental health outcomes over at least ten years (Appendix A).

Recognising uncertainty, we conduct some sensitivity testing. Figure 4.2 shows the BCRs in years 1 to 10, respectively. Under our Central and High scenarios, benefits outweigh the costs within the first twelve months; under the Low scenario, the intervention breaks even by year 2. This gives some confidence that the returns will be positive, even if the duration of improved mental health was relatively short.

Table 4.4. Cost Benefit Analysis based on sustained improvements in mental health over a 10-year appraisal period

	PV benefit	PV cost	Net present value (NVP)	Benefit:Cost ratio (BCR)
Low	£7,955,000	£1,223,000	£6,732,000	6.50
Central	£16,544,000	£1,223,000	£15,321,000	13.53
High	£27,925,000	£1,223,000	£26,702,000	22.83

Figure 4.2. Sensitivity analysis on the duration of improved mental health



4.5. Optimism bias

The high and low range in Table 4.4 accounts for known uncertainties with our assumptions, specifically: how many parents benefit from reductions in mental illness; and the value associated with life satisfaction. We apply a downward adjustment to account for “optimism bias” (OB), the systemic tendency for project appraisers to overvalue of their own proposals (see H.M. Treasury, 2020). If our range reflects known uncertainties, then OB adjustment accounts unknown uncertainties.

While OB adjustment is mandatory Green Book practice, there is no prescribed level of adjustment. This requires judgement, based on the available evidence. We adopt an approach recommended in the Greater Manchester Combined Authority (GMCA) CBA framework, in which we can objectively grade our confidence in the underlying evidence, supporting our estimated benefits.

¹⁸These costs represent the financial cost of delivery for prospective funders: we have not established a robust method do account for social and economic costs of the programme. This might include netting off transfer payments (e.g., VAT), which typically reduce the economic costs. On the other hand, we do not place a value on unfunded opportunity costs, e.g., the value of time, to travel and participate in therapy sessions.

¹⁹MacLennan, Little and Stead’s (2021) conclusion is based on summaries of the wellbeing impact associated with improved mental health, reported in Frijters and Mervin (2014) and Frijters and Krekel (2020).

²⁰In line with H.M. Treasury (2020) guidance, we apply a 1.5% discount rate on WELLBY benefits, and a 3.5% discount rate to fiscal benefits, to estimate the Net Present Value. 3.5% is the standard Green Book discount rate (HMT, 2020). Changes in wellbeing, which occur in future years should be discounted using the Green Book ‘health’ discount rate which starts at 1.5% (years 0-30) and declines gradually thereafter. This is because the ‘wealth effect’, or real per capita consumption growth element of the discount rate, is excluded, preserving constant a utility value per point change in life satisfaction in future years. The 1.5% estimate is recommended in MacLennan, Little and Stead (2021). The rationale for the health discount rate is in the Appendix A6 of the Green Book (HMT, 2020).

Table 4.5. Confidence Grades for Economic Benefits (GMCA assessment framework)

Confidence grade / colour	Population / Cohort data	Evidence base (management / impact)	Age of data / analytics	Known data error	Optimism bias correction
1	Figures taken from agency data systems	Randomised control trial in UK	Current data (<1 year old)	+/-2%	0%
2	Figures derived from local stats	International randomised control trial	1-2 years old	+/-5%	-5%
3	Figures based on national analysis based in similar areas	Independent monitoring of outcomes with a robust evaluation plan	2-3 years old	+/-10%	-10%
4	Figures based on generic national analysis	Practitioner monitoring of outcomes with a robust evaluation plan	3-4 years old	+/-15%	-15%
5	Figures based on international analysis	Secondary evidence from a similar type of intervention	4-5 years old	+/-20%	-25%
6	Uncorroborated expert judgement	Uncorroborated expert judgement	>5 years old	+/-25%	-40%

We score the MBT economic evaluation as follows:

- Population/Cohort Data, grades 1-2:** Figures are taken from agency data collected by Tavistock Relationships, graded 1. This is derived from local data from the evaluation in Hertfordshire but may be applied in spending proposals for other areas (grade 2).
- Evidence base, grade 3-5:** The MBT represents experienced practitioner monitoring, using robust psychometric measures. The main limitations relate to the before-and-after evaluation design, with no control group. Evidence on duration of impact is partly drawn from Tavistock Relationships practice evidence, but also from secondary evidence, from in national and international research on similar interventions.
- Age of data / analysis, grade 1-2:** MBT was evaluated in Hertfordshire, between July 2019 and May 2021.
- Known data error, grade 1:** There are no known errors.

Table 4.6. Cost Benefit Analysis with adjustment for Optimism Bias

	Net present value (NPV)	Benefit cost ratio (BCR)
0% optimism bias		
Low	£6,732,000	£6.50
Central	£15,321,000	£13.53
High	£26,707,000	£22.83
25% optimism bias		
Low	£5,049,000	£4.88
Central	£11,491,000	£10.15
High	£20,027,000	£14.12

Overall, the quality of the evidence suggests a wide set of gradings between 1 to 5, implying correction of between 0% and 25%. Our preferred scenarios apply the full 25% adjustment, indicating a return of around £10 for every £1 invested, and in a range from £5 to £17. In the Hertfordshire Contract Area, for 579 parents, this would represent a net benefit of approximately £5m to £20m, based on an investment of £1.2m.

4.6. Additionality and deadweight

The 25% adjustment for Optimism Bias includes adjustment for issues relating to the causal inference, given that the evaluation in Hertfordshire uses a before-and-after design.

Without treatment, depression does not, on the whole, get better. Depression does not typically occur as a one-off event, which then remits. For example,

patients with a history of depression are eight times more likely to be currently depressed than those without such a history (Coyne et al. 1999).

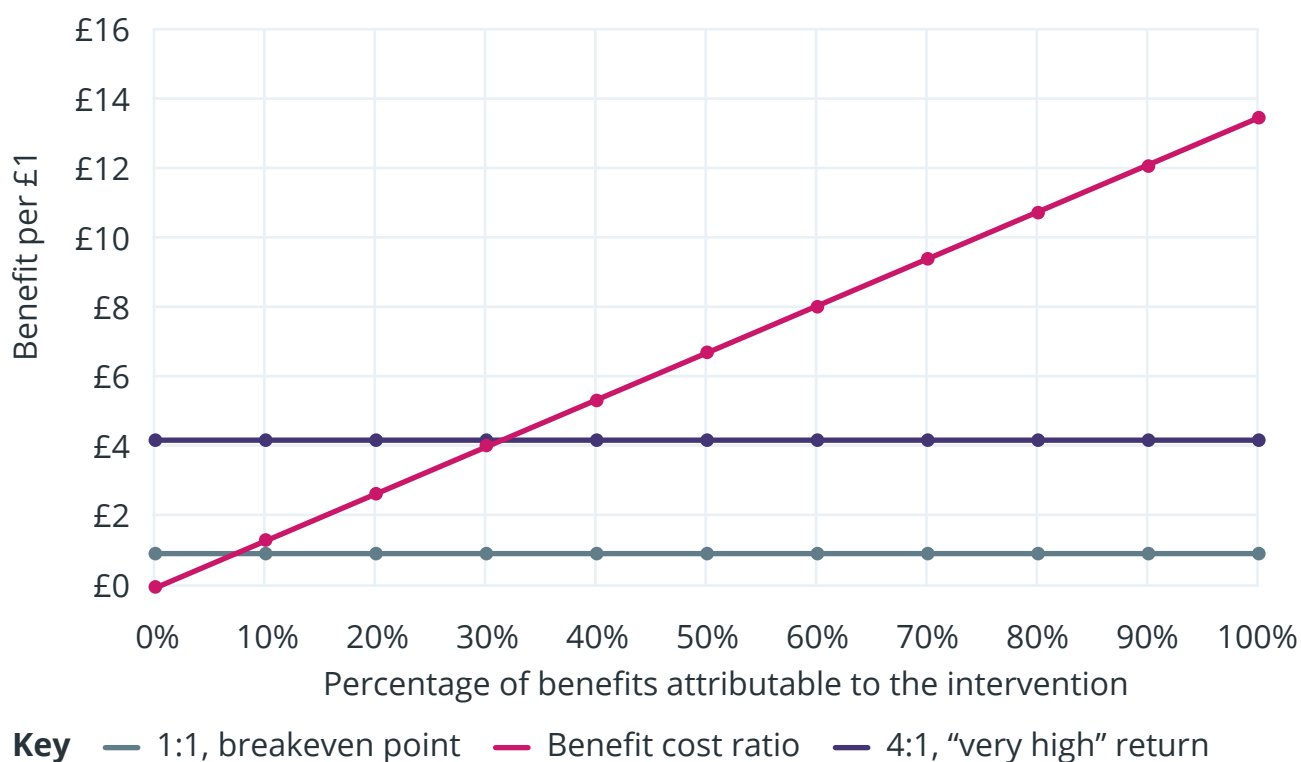
The link between intervention, at the level of the couple relationship, and individual depression, is also well-grounded in research evidence. The strong associations between relationship conflict and depression have led many researchers to see relationship conflict as a causal factor in depression.²¹ Research indicates that untreated control groups of distressed couples tend to show no improvement, and even get worse (Baucom, Hahlweg, and Kuschel, 2003).

Whilst well-controlled Randomized Controlled Trials (RCT's) remain the 'gold standard' of outcome research, they are not without their limitations, in their application to couple and family therapy. Hotopf et al. (1999) point out that patients, clinicians, and decision-makers need to know how treatment works in the real world, and to what extent it is effective under routine conditions. Similarly, Pinsof et al. (1996) indicate that high-efficacy, controlled studies of couple therapy do not always reflect the real clinical situation on the ground. Tavistock Relationships took a view that before-and-after studies are a pragmatic, more naturalistic evaluation of the intervention, as it is delivered in a standard setting.

It is also important to note that there is no established 'treatment as usual' that couples in the MBT programme would otherwise have received – the implicit comparison here is with no therapeutic treatment for parent conflict. Parents may of course be accessing standard treatments for depression, e.g., those available through the National Health Service.

²¹See Beach et al. (1990) and Fincham et al. (1997).

Figure 4.3. Percentage of the total benefits attributable to MBT, required to achieve a given Benefit Cost Ratio



This gives grounds for using the evaluation results as indicative of the effectiveness of the intervention, in improving couple functioning and mental health. Using Green Book (H.M. Treasury, 2020) terminology, we would expect high additionality and low deadweight, associated with any observed changes in parent's outcomes.

Nevertheless – in the absence of a control group – we cannot categorically state that parent's mental health would have either stayed the same or got worse, in Hertfordshire. There may be some remittance in clinical levels of mental illness, particularly when we consider impacts over a ten-year period, and assuming some standard mental health treatments over that period.

A useful form of sensitivity analysis is to identify switching points. This asks: what proportion of the observed outcomes would need to be causally linked to the intervention, to achieve a given benefit-cost ratio? Figure 4.3 illustrates two

switching points, based on a BCR of 1:1 (the breakeven point) and 4:1. For investments in transport infrastructure, the Government considers that benefits greater than £4, for every £1 invested, indicate "Very High" value. Around 10% of transport spending falls into the "Very High" category (DfT, 2020).

Figure 4.3 indicates that the intervention could breakeven, if just 7% of the observed reduction in mental health disorders were attributable to the intervention. To achieve a BCR of 4:1 would require 30% of the benefits to be attributable to the intervention.

There is no set bar for public investment, as these decisions cannot be determined solely by cost-benefit metrics. Yet, the sensitivity analysis above gives some confidence that investing in reducing parent conflict can achieve relatively high value returns, compared to other public investments. Again, relative measures of value for money would look different, in an appraisal that left out key impacts on wellbeing.

5. Non-monetary effects

5.1. Decisive non-monetary outcomes

Monetary benefits relate to a subset of parents who move out of clinical depression by the end of the intervention. The Green Book (H.M. Treasury, 2020) recommends that practitioners also take non-monetary impacts into balance. Table 5.1 recalls that the monetary values, in the CBA, represent two routes to impact: the wellbeing value of diagnosable reductions

in mental illness for parents, and some associated public cost savings. Other non-monetary benefits can be observed in the evaluation, including: non-diagnosable mental health improvements (using the CORE measure); improved couple communication, reduced conflict about children and violent problem solving (using the CCQ measure).

Table 5.1. Impacts that we can quantify (tick) and monetise (star)

Outcomes for parents		
Direct effects on life satisfaction	x	
Diagnosable effects on mental illness	✓★	Do not measure life satisfaction directly. Can measure wellbeing indirectly, for a subset of parents who cross clinical threshold.
Non-diagnosable effects on mental health	✓	
Physical health effects	x	
Relationship quality	✓	Measurable in the MBT evaluation but not monetised directly, only through reduction in clinical depression.
Family break-up	x	
Conflict and violent problem solving	✓	
Income	x	
Education	x	
Employment	x	
Outcomes for children		
Wellbeing	x	Qualitatively, parents report improved child wellbeing, but we cannot quantify the extent of the effect. Breakeven analysis considers potential value of a reduction in children's diagnosable mental health.
Diagnosable changes in mental health	x	
Non-diagnosable changes in mental health	x	
Intellectual	x	
Behavioural	x	
Outcomes for Government and society		
Public cost of mental health support	★	We place a monetary value on public savings associated with the average costs of mental health services. CBA does not capture "external" benefits of the intervention for wider society
Other fiscal savings	x	
Wider family/friends	x	
Employers	x	
Wider economy/society	x	

It is generally more difficult to model outcomes for wider society and the economy: this would require a “general equilibrium” model, to simulate impacts across the whole population. Measuring the direct impact on parent’s life satisfaction would be the single most useful improvement in evaluations, such as the MBT. This would capture the combined effects of improved relationships, mental and physical health, as well as improved education and labour market outcomes. Tavistock have committed to using the ONS life satisfaction question in future.

5.2. Children’s mental health: a breakeven analysis

The positive impacts on children’s wellbeing are perhaps the most important omission from the CBA. Over half of parents responding to the post-intervention survey reported that child/ children’s wellbeing had improved. We cannot establish by how much child wellbeing improved, to include in the CBA, but we can explore its potential impact on the overall value of the intervention.

As an alternative, we consider a breakeven analysis, to assess the contribution that child outcomes could make in the overall case for investment.

Pro Bono Economics (2020) reviewed estimates of the total lifetime costs to the UK economy, from childhood mental health difficulties: based on three studies, they report a range of £260,000 – £295,000, per child.²² These values are variously attributed to the cost of the criminal justice system, costs to society from higher rates of smoking, the use of mental health treatments and losses in lifetime earnings. In Table 5.2 we assume that the lifetime cost of poor children’s mental health is £260,000, taking the lower end of this range.

Table 5.2. Breakeven analysis

Lifetime cost of children’s mental health	£260,000
MBT-PP cost	£1,223,000
Reduction in childhood disorders to breakeven	4.7

We conclude that a reduction in mental health disorders, for just five children, would be sufficient to offset the £1.2m cost of running the MBT intervention in Hertfordshire. There were 579 parents, estimated to have 383 children between them. Positive outcomes for just five children represent just 1.2% of those children who stand to gain from the intervention.²³

If fifty children benefited from reduced mental health problems, the BCR in our central scenario would double, implying a £20 return per £1 invested, rather than the £10 return, associated with the benefits for parents.

In this analysis, the £260k lifetime cost per child is based on a more traditional economic appraisal of public service costs and changes in income. Equally, one could take £260k to represent the value of 20 WELLBYs (at roughly £13k per WELLBY). It is plausible to assume that a child that grows up in a household with significantly lower levels of conflict, could gain 20 WELLBYs over their lifetime.

²²Pro Bono Economics (2020) adjust to 2017/18 prices. We have not updated these values, given that the breakeven analysis is indicative.

²³383 children is a rough estimate using Management Information, collected by Tavistock Relationships. There were 1268 referrals in the Hertfordshire Contract Package Areas from July 2019 – a total of 1679 children were associated with these referrals. Assuming that each referral represents two parents, then the ratio would be 0.66 children per parent (= 1679 children / 2536 parents). We apply this ratio to the 579 parents in the evaluation, estimating that they would have 383 children between them (=579 x 0.66).

6. Conclusion

We find a quantifiable return of around £10 for every £1 invested, the central value in a range of scenarios, with a £5 and £17 return. Economic returns are difficult to pinpoint in any CBA. We consider uncertainties relating to missing data; the monetary value placed on wellbeing; the duration of impact; and causal inference. Benefit-cost ratios also include a 25% downward adjustment for optimism bias.

Monetary returns are based on observed improvements in mental health, for a subset of parents who entered the programme with clinical levels of psychological distress. We estimate effects on life satisfaction, alongside some smaller public cost savings.

Additionally, MBT has measurable impacts on couple communication, violent problem solving, and conflict about children. This suggests wider benefits associated with the intrinsic value of relationships, for parents, children, other family members and society. Whilst there is no robust way to quantify these wider outcomes in the CBA, these ought to be taken into balance, when assessing the case for investment. Impacts on children's wellbeing can have sizeable economic benefits. We show that a reduction in mental health disorders, in just five children, might be sufficient to offset the £1.2m cost of delivering MBT in Hertfordshire.



Appendix A: Cost Benefit Analysis estimates

Table A1. Cost Benefit Analysis (£ millions)

Year	1	2	3	4	5	6	7	8	9	10	Total
Wellbeing benefits (undiscounted)											
Low	£0.80	£0.80	£0.80	£0.80	£0.80	£0.80	£0.80	£0.80	£0.80	£0.80	£7.99
Central	£1.68	£1.68	£1.68	£1.68	£1.68	£1.68	£1.68	£1.68	£1.68	£1.68	£16.85
High	£2.87	£2.87	£2.87	£2.87	£2.87	£2.87	£2.87	£2.87	£2.87	£2.87	£28.69
Wellbeing benefits (present value, 1.5% discount rate)											
Discount factor	1.000	0.985	0.971	0.956	0.942	0.928	0.915	0.901	0.888	0.875	
Low	£0.80	£0.79	£0.78	£0.76	£0.75	£0.74	£0.73	£0.72	£0.71	£0.70	£7.48
Central	£1.68	£1.66	£1.64	£1.61	£1.59	£1.56	£1.54	£1.52	£1.50	£1.47	£15.77
High	£2.87	£2.83	£2.78	£2.74	£2.70	£2.66	£2.62	£2.59	£2.55	£2.51	£26.86
Fiscal benefits (undiscounted)											
Low	£0.06	£0.06	£0.06	£0.06	£0.06	£0.06	£0.06	£0.06	£0.06	£0.06	£0.55
Central	£0.09	£0.09	£0.09	£0.09	£0.09	£0.09	£0.09	£0.09	£0.09	£0.09	£0.90
High	£0.12	£0.12	£0.12	£0.12	£0.12	£0.12	£0.12	£0.12	£0.12	£0.12	£1.24
Fiscal benefits (present value, 3.5% discount rate)											
Discount factor	1.000	0.966	0.934	0.902	0.871	0.842	0.814	0.786	0.759	0.734	
Low	£0.06	£0.05	£0.05	£0.05	£0.05	£0.05	£0.04	£0.04	£0.04	£0.04	£0.48
Central	£0.09	£0.09	£0.08	£0.08	£0.08	£0.08	£0.07	£0.07	£0.07	£0.07	£0.77
High	£0.12	£0.12	£0.12	£0.11	£0.11	£0.10	£0.10	£0.10	£0.09	£0.09	£1.07
Present value benefits, in each year											
Low	£0.85	£0.84	£0.83	£0.81	£0.80	£0.79	£0.78	£0.76	£0.75	£0.74	£7.96
Central	£1.77	£1.75	£1.72	£1.69	£1.67	£1.64	£1.61	£1.59	£1.56	£1.54	£16.54
High	£2.99	£2.95	£2.90	£2.86	£2.81	£2.77	£2.72	£2.68	£2.64	£2.60	£27.92
Present value benefits, cumulative											
Low	£0.85	£1.70	£2.52	£3.34	£4.14	£4.93	£5.70	£6.46	£7.22	£7.96	
Central	£1.77	£3.52	£5.24	£6.93	£8.60	£10.24	£11.85	£13.44	£15.00	£16.54	
High	£2.99	£5.94	£8.84	£11.70	£14.51	£17.28	£20.00	£22.68	£25.32	£27.92	
Present value costs											
	£1.22	-	-	-	-	-	-	-	-	-	
Net present value (= PV benefits minus PV costs)											
Low	-£0.37	£0.47	£1.30	£2.11	£2.91	£3.70	£4.48	£5.24	£5.99		£6.73
Central	£0.55	£2.30	£4.02	£5.71	£7.38	£9.01	£10.63	£12.22	£13.78		£15.32
High	£1.77	£4.72	£7.62	£10.47	£13.28	£16.05	£18.78	£21.46	£24.10		£26.70
Benefit: Cost ratio (=PV benefits / PV costs)											
Low	0.7	1.4	2.1	2.7	3.4	4.0	4.7	5.3	5.9		6.5
Central	1.5	2.9	4.3	5.7	7.0	8.4	9.7	11.0	12.3		13.5
High	2.4	4.9	7.2	9.6	11.9	14.1	16.3	18.5	20.7		22.8
Benefit:Cost ratio (25% optimism bias)											
Low	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.4		4.9
Central	1.1	2.2	3.2	4.3	5.3	6.3	7.3	8.2	9.2		10.1
High	1.8	3.6	5.4	7.2	8.9	10.6	12.3	13.9	15.5		17.1

Notes: All costs and benefits are in present values and 2022/23 prices. Wellbeing benefits are discounted at 1.5% and fiscal benefits at 3.5%, the recommended H.M. Treasury (2020) rates. Public cost savings are represented as fiscal "benefit" in this ratio, rather than a net reduction in the "cost" of investment.

Appendix B: MBT evaluation

Responses from two psychometric measures were collected for this project: Clinical Outcomes in Routine Evaluation (CORE), which evaluated psychological wellbeing; and Couple Communication questionnaire (CCQ), which measured couple communication, conflict and violent problem solving. Both questionnaires were collected by the practitioners from each parent during the initial assessment session and the last session, to measure the CORE and CCQ at pre-intervention and post-intervention.

In total, questionnaires from 579 individuals at pre-intervention and 258 individuals at post-intervention received Mentalization-Based Therapy for Parenting under Pressure (MBT-PP) intervention. More data is being collected as the project is ongoing. All these parents exhibited intense problems with their partner/co-parent at intake. Among the parents who completed the questionnaires at pre-intervention: 53% were females and 47% were males; and 48% were intact parents and 52% were separated parents.

453 parents indicated their age group: 18-24 (4%), 25-34 (30%), 35-44 (40%), 45-54 (23%), and 55-64 (3%). 455 parents indicated their relationship status: Married (30%), Civil partnership (1%), Cohabiting (18%), Non-Cohabiting (3%), and Separated/divorced (49%).

Analysis of pre- and post-intervention CORE

The CORE is a 34-item measure for psychological distress, and the mean scores fall between 0 and 4. The mean scores were then multiplied by 10 to generate final scores. Scores above 10 indicate clinically significant level of psychological distress.

At the pre-intervention stage, 51% (n=579) of the parents scored 10 or more on the CORE which indicates clinically significant level of psychological distress. The post intervention scores were compared with the pre-intervention scores, and Table 1 shows the change in the CORE scores before and after the intervention for those who provided data at both time points.

Table A2. Summary of pre- and post-intervention CORE scores with standard deviations in the parentheses

Relationship status	Pre-intervention	Range of CORE (pre)	Post-intervention	Range of CORE (post)	Difference	t	p
All (n= 227)	11.01 (6.38)	0-28.53	7.39 (5.33)	0 -21.47	3.61***	9.31	<0.0001
Intact (n=111)	12.32 (6.31)	1.47-28.52	8.16 (4.99)	0 -20.29	4.16***	6.89	<0.0001
Separated (n=115)	9.64 (6.15)	0-23.82	6.53 (5.40)	0 -21.47	3.11***	6.28	<0.0001

Note: *** p <.0001, indicating statistical significance

Table A2 shows significant improvement in psychological distress (see Figure 2). When converted the CORE scores to the Beck Depression Inventory scores, for the 82 participants who have completed the post-intervention CORE and showed moderate/severe depression at pre-intervention, 51 (62%) have reduced to minimal/mild.

Analysis of pre- and post intervention CCQ

The CCQ measures levels of conflict between parents, levels of violent problem solving, and conflict in co-parenting the children. The changes in these three aspects before and after the intervention are shown in Table A3.

The above shows significant reductions in: a) conflict between parents in intact relationships and separated relationships; b) violent problem solving for all parents, for parents in intact relationships, and for parents in separated relationships; and c) conflict about the children for all parents, for parents in intact relationships, and for parents in separated relationships.

Qualitative evaluation

In addition to the CORE and CCQ measures, 203 participants responded to the following three questions after completing the MBT intervention.

- a) "Conflict in my couple relationship has": 67% "decreased", 31% "stayed the same", and 2% "increased".
- b) "Communication with my partner has": 62% "increased", 32% "stayed the same", and 7% "decreased".
- c) "My child's wellbeing has": 53% "increased", 42% "stayed the same", and 4% "decreased".

This shows that for over half of the participants, conflict in their relationship has decreased, communication with their co-parent has increased, and their child/children's wellbeing has improved after the intervention.

Table A3 Summary of pre- and post-intervention CCQ with standard deviations in the parentheses

Relationship status	Pre-intervention	Post-intervention	Difference	t	p
Conflict					
Intact (n=98)	31.52 (14.24)	21.96 (13.75)	9.56***	6.70	<0.0001
Separated (n=91)	23.83 (15.21)	13.66 (11.43)	10.17***	6.54	<0.0001
Violent problem solving					
All (n=209)	2.15 (1.49)	1.02 (1.20)	1.13***	10.35	<0.0001
Intact (n=95)	2.70 (1.46)	1.15 (1.30)	1.56***	9.04	<0.0001
Separated (n=85)	1.30 (1.01)	.62 (.75)	.68***	5.34	<0.0001
Conflict about the children					
All (n=209)	6.46 (3.99)	3.74 (3.27)	2.72***	10.25	<0.0001
Intact (n=97)	6.93 (3.69)	3.85 (2.69)	3.07***	8.02	<0.0001
Separated (n=96)	6.21 (4.20)	3.72 (3.62)	2.49***	6.15	<0.0001

Note: *** p <.0001, which means significant difference

Appendix C: Literature review concerning assumptions on duration of impact and attribution

Our cost-benefit metrics are sensitive to assumptions regarding the duration of improved mental health outcomes for parents, and attribution to the intervention. Duration is not measured directly in the MBT evaluation for Hertfordshire, and the evaluation uses a before-and-after evaluation design. We therefore need to consider secondary evidence, drawn from closely related studies, to corroborate both a causal relationship between intervention and improved outcomes, and how long these outcomes might be sustained.

Evidence on the effectiveness of Mentalisation-Based Therapy

The following review generally points to long-term impacts of MBT in relation to couple conflict, social functioning and depression.

Anthony Bateman, a leading researcher into MBT recently published a paper outlining results at 8-year follow-up of a study of MBT (Bateman et al., 2021). Although participants in this study were experiencing borderline personality disorder, eight years after the intervention participants treated with MBT showed better functional outcomes in terms of being more likely to be engaged in purposeful activity and reporting less use of professional support services and social care interventions (74% v 51%).

Tavistock's clinical experience has demonstrated that couples who are in high states of conflict (i.e., those assessed in the RPC as needing a high intensity intervention) are in many ways not dissimilar to those being treated with MBT for borderline personality disorder – the similarities mainly being around a relative inability to think and reflect, rather than act out their emotions and frustrations. Hertzmann and Nyberg's chapter in

Engaging Couples (Hertzmann, 2018) explored the links between these two cohorts of patients. It was this similarity of presentation which first prompted Tavistock Relationships to start using MBT, to work with couples in highly dysregulated emotional states. Hence there are reasonable grounds to consider that the beneficial impacts of MBT – delivered through the Reducing Parental Conflict programme – are also likely to be maintained in the longer-term.

Roddy et al.'s (2020) recent meta-analysis reported that: "couple therapy has large effects on key relationship domains and gains are generally maintained over short- and long-term follow-up". Again, it is reasonable to have some degree of confidence that a couple-focused approach to MBT will therefore result in sustained improvements in couple functioning and reduced conflict.

Longitudinal outcomes, gathered in RCTs with a 10-year follow-up period, show that programmes which focus on couple relationship quality – as opposed to those which focus only on parenting issues – result in long-term improvements in relationship quality; adult mental health; and child mental health (Cowan et al., 2005; Cowan et al., 2009, Cowan et al., 2011).

Barbato's (2020) meta-analysis explored the association between depressive symptoms and distressed intimate relationships: they find that couple therapy improved depressive symptoms at end of treatment, and after 6 months or longer. Couple therapy was more than effective than individual psychotherapy in reducing couple distress.

Literature on the effectiveness of MBT for the treatment of depression also finds sustained over the longer-term. For example, patients with personality disorder demonstrated that the Beck Depression Inventory score significantly reduced for the MBT treatment group, at the end of the intervention (duration of treatment being 18 months), whereas the BDI stayed the same for the treatment as usual group, for 18 months (Bateman & Fonagy, 1999). The follow-up data from 18 months to 36 months for this same cohort showed that the treatment group's BDI continued to reduce and was significantly different from the control group at each time point (Bateman & Fonagy, 2001).

The Tavistock Adult Depression study shows improvements in CORE scores are sustained for two years, while CORE scores for a control group continued to be high for over 3 years (Fonagy et al., 2018).

In our analysis, we note that parents with depression may go into remission, i.e., may have recovered without intervention. Whiteford et al. (2012) reported evidence of "spontaneous remission from major depression", estimating that 23% of prevalent cases of untreated depression will remit within 3 months, 32% within 6 months and 53% within 12 months.²⁵ However, Whiteford et al. (2012) consider evidence for depression in general, i.e., not relating specifically to parents suffering from relationship conflict. In the main analysis, we also note that parent's depression might be expected to get worse, left untreated, potentially counterbalancing the potential effects of remission.

In sum, while there is robust secondary evidence for a causal and lasting effect of MBT, we conduct sensitivity tests on assumptions relating to duration and attribution, recognising uncertainty.

Wellbeing research on depression and relationships

We go a stage further than the observed effect of MBT on depression and relationship quality – our scenarios predict subsequent effects on measures of subjective wellbeing. Adaptation is a key concept in the wellbeing research. Wellbeing evidence shows that people adapt to many life events and changes so that wellbeing impacts can diminish over time.²⁶ In the context of this report, we need to consider whether parents could acclimatise to relationship conflict and/or mental illness. In that case, the RPC programme might temporarily influence wellbeing, because parents would adapt to their situation.

Importantly, adaptation does not apply to all aspects of life: studies that have followed the same participants over time show that wellbeing can change significantly over the long term (e.g., Fujita and Diener, 2005). When people are in a stable partnership, their wellbeing ratings are higher than those of people not in such relationships; they also stay higher (Lucas et al., 2003).²⁷ Positive interventions, such as cognitive-behavioural therapy, for people with moderate to mild depression, has also been shown to have a lasting impact on wellbeing (Butler et al., 2006).

We conclude with some confidence that the wellbeing effect – associated with sustained improvements in relationship quality and mental health – will not fade out.

²⁵Whiteford et al. (2012) investigated whether remission rates vary by disorder severity, for adults, children and adolescents. We report their estimates for the adult sample, as a closer approximation to parents in the MBT-PP. The analysis draws on observations from 19 studies, using a regression model to estimate remission rates.

²⁶See Riis et al., (2005) on adaptation to requiring regular medical treatment, and Lucas (2005) for adaptation to becoming divorced.

²⁷Although the wellbeing 'boost' of marriage is short lived (Lucas et al., 2003)

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Dr Allan Little has written this report (the Report) in a personal capacity, as a consultant to Tavistock Relationships (the Client), based on information provided to him by the Client. Dr Little is acting only for those entities and persons identified as the Client. Recipients of the report are recommended to seek their own financial and other advice and should rely solely on their own judgment, review, and analysis of the Report.

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We research, develop, pilot and raise awareness of best practice, providing services to couples and families, and disseminating our learning through academic and policy activities.

Our training programmes in couple and sex therapy range from introductory up to clinical qualification level and are accredited by bodies including The British Association of Counselling and Psychotherapy and The British Psychoanalytic Council. Our London-based, national and international online clinical services offer affordable counselling and psychotherapy to people facing difficulties in their relationships and parenting. Our evidence-based, innovative projects such as Living Together with Dementia, Parents as Partners, Building Relationships for Stronger Families and Adopting Together have supported and improved the quality of relationships when most challenged.

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