Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Health Inequalities: Triple P Project

7 November 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Ms Maeve McLaughlin

Witnesses:

Mr Eamonn Farrell	Health Service Executive
Mr Conor Owens	Health Service Executive
Mr Joseph Ruane	Health Service Executive

The Chairperson: On behalf of the Committee, thanks very much for coming and for your briefing paper. Joseph, I will hand over to you to introduce your team and make your presentation, after which there will be questions and comments from members.

Mr Joseph Ruane (Health Service Executive): First, I would like to acknowledge the invitation and thank you for giving us the opportunity to be here. About 12 years ago, I assisted this Committee as a trainee manager, and it is great to be back here after so long.

I am the integrated services area manager for the midlands, which covers Longford/Westmeath, Laois and Offaly. I took up that role in 2007. One of the projects that was running at that time and had a potential that excited me was the Triple P positive parenting programme. Thankfully, we have been able to keep it going five years later. Conor Owens is the director of the project, and Eamonn Farrell is the family support service manager in the midlands. They will be able to go into further detail on the project.

I have four key messages. First, we face significant challenges in resources and staffing in the health service in the South, and we need to challenge how we are using those resources so that we use them as effectively and efficiently as possible to the benefit of the population. Second is the importance of partnership and working with local communities and families to build up resilience and add synergies. Thirdly, whatever we are doing must be evidence based. Fourthly, the project must satisfy those three headings.

Mr Conor Owens (Health Service Executive): Thank you very much for giving us this opportunity to present to you. I will outline what I hope to cover in the presentation and talk about why parenting

should be looked at and dealt with as a public health issue. I will present evidence to support that based on biology, economics and equality, so that the strategy targets specifically areas of inequality and strategies that work for early years. After that, I will give a quick overview of the project that we are running in Longford/Westmeath, which is a universal access parenting programme for all parents with children who are seven or younger.

Longford/Westmeath is in the midlands. It has a semi-rural population of 130,000. Like all areas, it has been significantly hit by the recession over the past few years. Over that period, the unemployment rate has risen from 4% to 14%. It has actually gone past 14% — the paper you have, unfortunately, is out of date in that respect. The prevalence of social and emotional behavioural problems for children is quite high; it is approximately 20% overall. In specific areas, such as conduct disorder, you are looking at even higher levels. Approximately 40% of the population in Longford/Westmeath are in receipt of a medical card. Overall, the problem that we identified is that a disturbingly large number of children develop significant social and emotional behavioural problems. The concerning thing is that the vast majority of them are preventable. It is not that we just have to learn how to cope with them; we can prevent them. I will come back to the traditional argument of a distinction between prevention and intervention.

Mr Eamonn Farrell (Health Service Executive): Do you want to explain why you mention the medical card?

Mr Wells: Everybody has a medical card up here.

Mr Owens: Apologies. I mentioned the medical card because we use it as an indicator of family income. If you are below a certain threshold, you will qualify for a medical card, which means that you are entitled to free GP visits. It is used as an indicator of financial income.

It is interesting how many economists have come to this work and provided quite a lot of insights. The economist James Heckman said:

> *"Investing early allows us to shape the future; investing later chains us to fixing the missed opportunities of the past."*

Roughly translated, we have the evidence that prevention works. We have the evidence that intervening later, when there is conduct disorder or behavioural problems like that, results in huge financial costs.

We traditionally talk about how the environment, neighbourhoods and parenting affect children and how they come with a biological investment or reservoir from birth. The research shows us now really clearly that the home environment alters the biology. If parenting is aggressive or if there are significant problems around aggression, violence and inconsistencies in the home, that will change the structure of an infant or young child's brain. That means that, afterwards, you are dealing with much more significant and established problems. Remediation is then very difficult. Intervening early with evidence-based parenting strategies means that you do not necessarily have to go down that route. You are looking at the brain adapting towards self-regulation instead of impulsiveness.

Research was done in this area in the States. Interestingly, it was initially done by a for-profit private insurance company called Kaiser Permanente. It wanted to find out how it could make more profit. It looked at the areas in which big insurance claims were coming in. The first area that it looked at was obesity. It tracked 3,000 families over 50 years. It discovered that the adults who had what are called adverse childhood experiences in their early years had a significantly higher risk of developing obesity. It then used the same methodology for other areas, like ischaemic heart disease, depression and alcoholism. It found that there is a far higher likelihood of an adult suffering from those or engaging in those types of behaviours if they had those adverse childhood experiences (ACEs). Adverse childhood experiences are things like exposure to violence, exposure to trauma, separation, a parent having addiction issues or a parent being in trouble and perhaps being in prison. Those things are not that uncommon.

This slide is about depression. You can see quite clearly that the more ACEs you are exposed to, the higher the likelihood that you will be depressed as an adult. Remember, that research was done on a population in America who could afford health insurance and who could retain it over a long period. So it was an advantaged population. The figures are even higher for a disadvantaged population.

You can see that heart disease, when controlled for other factors, was still highly linked to childhood experiences. What early childhood experiences do is expose a child to toxic stress, which alters the development of the brain and increases the likelihood of engaging in risky types of behaviours, leading to depression, heart disease, drug addiction and such behaviours. What the research clearly shows is that early supportive relationships from parents are a protective factor and can counteract those events. Such relationships can push a child's trajectory back up to health. I just wanted to go over those to show how important early relationships are and how those right the child's brain and development.

Support for population-level parenting with young children has come from multiple sources, such as the Institute of Medicine in America, the Council of Europe, the UN report, the World Health Organization, the National Institute for Health and Clinical Excellence guidelines, and the National Academy for Parenting Practitioners. All those authoritative groups have said quite clearly that the evidence, on an effectiveness and financial efficiency basis, is that we need to look at that area.

As a result, we set up our programme in Longford/Westmeath. We decided that we wanted to work at a population level but to have access for all parents. We did that using — I think you have this in your 'Fit and Well' document — the idea of progressive universalism. It is not that we offer it straight off to everybody, but there is access for everybody. However, there are some groups that we dedicate more resources to than others. It is like a scale: those with a higher level of need will receive more, but those without an identified high level of need will still have access. I will come to that point in a second. Traditionally, a lot of our services have been geared towards lower socio-economic groupings, because we are clear on the types of problems that are there. I will show evidence now that if you want to improve the quality of life for children and their families, you need to go outside those groups, because the majority of children are in the other socio-economic groups.

The first argument against a public health approach is that we are in a time of recession, with limited resources, so although it would be really nice to do take the universal approach, we cannot afford it. I believe that the universal approach would save significant amounts of money, and I will quote some evidence to show that. To take a public health approach, the problem needs to be really common. We have at least a 20% prevalence rate in the community. From a survey we did in the Republic, we found that 30% of children with social and emotional behavioural problems, identified by the parents, were from the lower socio-economic group. So 70% were not. Therefore, if you want to change or improve the quality of life for children in your population and you do a fantastic job for the parents in the lower socio-economic group, we can guarantee that you will fail to achieve a population effect. The caveat is that, although 30% of the children with social and emotional behavioural problems are in the lower socio-economic group, life is much tougher in that group. The reason why it is 30% is that, population wise, it is a small group. There is a higher density and more prevalence of problems in that group, but if you look at the real numbers across the population, you see that the majority of children with those problems are not in the lower socio-economic group. That is why we argue for the population approach, because it goes right across.

Any of you who have done any work with targeted groups will know that it is difficult to engage a targeted group. It does not automatically appeal to anyone to feel as though they are in a targeted group. If I came to any of you who are parents and said that I had a fantastic parenting programme that I think that you would really like, your first reaction would be, "Why are you saying that to me? What does that say about your expectation of my abilities?" So, ironically, by offering it across the population, you actually get quicker access to the targeted population because they see that it is not specifically about them. It is something for everybody, so that makes it more palatable for them to become engaged. There is less stigmatisation.

A really interesting piece of research was done by a guy called Steve Aos from the Washington State Institute for Public Policy in America. Some of you are familiar with him. Basically, he does the 'Which?'-type reports on the effectiveness of evidence-based programmes. In his analysis, he showed that the Triple P universal programme had a return of $6.06 for every dollar that was invested. The interesting thing about that was that its return was higher than that of targeted parenting delivery to clinical groups. The reason behind that is: by doing a universal programme, you pick up many children who have not been identified by the system. You stop them having to come into the system. You start to have a preventative effect. That is what the population piece does; it combines prevention and intervention at the same time. Therefore, it is not two services or funding streams. It happens at the same intervention.

The remarkable thing about that figure of $6.06, which was way ahead of the figure for any of the other specific parenting interventions, is that they measured that only on out-of-home placements,

accident and emergency services and child residential places. They did not take into account the figures for reduced conduct disorder, reduced parental depression or improvement in ability for school readiness. They did not take any of those factors into account. So that figure is a very conservative estimate of the saving that could be achieved when you use the public health approach.

I have a cartoon that I use on most of the times I talk about this issue. I think that it is particularly important. *[Laughter.]* When I first saw it, I thought, "Poor Lassie. What is Lassie doing?" However, when you think about the services that we are all connected with, you realise that it is actually a bit more complicated than that. With regard to help-seeking behaviour, the person who is shown drowning there is just asking for help. They have not been informed about the specific type of help that they want to get or what they actually need to access. Lassie is doing what Lassie does best; she has gone to get help. The guy on the right who is helping Lassie is doing his best. He is probably really good at what he is doing. However, what he is doing is not what Lassie needs. That man's manager has someone who works really hard. However, he has not directed him specifically to what he should be doing. This is where the argument for evidence-based work comes from. You need to have normalising of the issues and promote help-seeking behaviour. The service that is offered needs to be immediate, effective and exactly what the person needs. Leadership for the man who is sitting there needs to be really clear about what needs to be done and achieved.

At the start, I mentioned the rationale for population piece. The 'Every Family' study was done in Brisbane in Australia. It was the first population parenting programme that was done anywhere in the world. Its survey found that 16% of children with social and emotional behavioural problems were from the lower-class category. The rest were not. So, if you want to improve quality of life for children and families, and have a good early years strategy and promote reductions in inequalities, you need to go across the spectrum. You need to offer a broader service.

When some people see that, one of their first reactions could be that each of those social categories will have a different way of evaluating their children's behaviour. There might be more laxness in one particular group than in another. That is a fair argument. However, when we look at the way parents cope with difficulties in parenting, this is what they found in the survey. There is a remarkable similarity in the strategies used by parents across the different socio-economic groupings. Whether it is threatening, shouting or hitting, most parents react in the same way.

Traditionally, when we talk about parenting, people think of a group. That would hugely over service need and be hugely expensive. So Triple P is a multi-level intervention that requires different levels of resources for each of the five levels. The first level is about parent information, so it requires very little resources. You are looking at websites, podcasts, newspaper articles and things like that. I hope that some of you received the 'tip paper' that we sent up.

The next level is concerned with brief advice. We do that in schools with an hour-and-a-half talk. Again, that is evidence-based and has been shown to work.

The next level is a two-hour stand-alone intervention into common problems. Again, it conducts surveys based on the problems that parents face. So, in the small discussion groups the topics are: dealing with disobedience, managing and fighting aggression, sleep routines, and hassle-free shopping. Those were the four topics identified in surveys as being really important. We missed the boat on hassle-free shopping. Everyone smiled when we offered a way to address the problem and most of them said, "No, we do not really want to do it. We do our shopping online" or "We go on our own". So we have missed the boat on that. Parents have given up on that one.

There are some concerns that we came across when we started to deliver. I will go through them quickly, as they seemed to come up quite commonly. One was that parenting is a soft issue and is not core business. Parenting is generally seen as a piece in itself. However, we are approaching it by asking what some of the best proven interventions are for children with attention deficit and hyperactivity disorder, children with conduct disorder, children with mild levels of behavioural and emotional problems, children at risk of depression, parents with depression and parents with impulsiveness. There is one common theme in all of those: parenting. No one would argue that those issues are not the core business of a health service. So one of the really good things about parenting is that it reaches so many different core pieces of a health service's work. You deal with multiple problems at one time.

A really common concern was that the programme would not work here. We have the evidence from Longford/Westmeath to show that it does. The common line is, "That works fine in Australia, I am sure, but they do not know our parents." That is not true. Parenting principles are just the same.

Another common line was, "Irish parents do not do groups. We will moan to ourselves and keep our problems quiet." That is not true. The level in which we have had the highest recruitment has been the groups. So parents do participate in groups. It is also said, "It is a nice idea, but it is poor timing and expensive." Again, if you look at the Steve Aos stuff on financial returns, they will be delivered within a two-year time frame. This is not about services for the future; it is about immediate measures. When people traditionally talk about prevention, they think about a saving that will accrue to justice in 10 to 15 years. The evidence shows that that is true, but there is more to it than that. You will have savings accruing pretty much straight away.

In answer to the concern about poor timing, in your line of work, you meet people every day. How many parents do you meet that are under pressure? With the recession, what levels of depression and stress are you seeing in parents? When the work that we are replicating was done in Australia, there was a 26% decrease in maternal depression rates. That is huge. You see on the doorsteps the impact that depression can have within a family. It can be devastating.

The last concern we came across was, "We do not have money. We need to be focusing on treatment. Wait until we have money for prevention." Treatment and prevention can be the same thing. We have parents coming to groups who are doing OK but want to learn more tips on protecting their children in the future. We have parents in the same groups whose children are in the clinical range, which is great because it means that you do not have to stigmatise through screening. One of the key lessons that we learned is that parents like the programme. Word of mouth is spreading, and, in fact, our highest source of referrals is through word of mouth. Partnership is essential. No one organisation is totally acceptable to the population. Each organisation has skills and contacts that can be exploited. Marketing is really important. Staff selection is crucial. When we talk about evidence-based work, some people say that we do not have money to add another service. My query would be whether those people have evidence that all the services being provided are working. For those that are not working, there should perhaps be a reorientation of their resources to services that are working.

This has been unsolicited, unedited feedback that we received from parents who went through parenting groups. We took their comments and put them into a word cloud, and that is what they are saying about their experience of going through the programme. To date, approximately 3,000 parents have self-referred into the programme.

Thank you very much. That was a whirlwind, so apologies.

The Chairperson: Thanks very much. Your presentation was very interesting. Some of us have been involved for a number of years with children and young people. Professor Heckman has been here before, and we have listened to him. He makes a lot of sense. Sometimes, we are afraid to spend money, even though we know that it will save us money in the long term, but that is the way we are today. I agree with you: the old African proverb about it taking a whole village to raise a child is very important.

We are the Health Committee; we are here to scrutinise the work of the Department of Health, Social Services and Public Safety (DHSSPS). However, there are times when other Departments have a responsibility for health inequalities. It just so happens that our Department has to deal with the illness that is associated with health inequalities. You mentioned a partnership approach a few times. How do you get people to adopt that genuine partnership approach when every Department here is chasing the one pound and has its own priorities as well?

The Office of the First Minister and deputy First Minister plays a central role for children and young people. I am talking about targeting poverty and the 10-year strategy around children and young people. Those fall outside our remit. We are trying to tackle health inequalities and the stuff that you mentioned based on what other Departments should or should not do. We are in a coalition Executive, and that probably makes it a wee bit harder as well.

I do not know whether you heard me earlier referring to two Departments. In fairness, we are still waiting on responses from other Departments. We wrote to them all to ask whether they have any health inequality strategy. They replied no. There is an issue about mindset. Although the Department of Finance and Personnel may not have a specific strategy to tackle health inequalities, it is doing a lot of work by funding stuff, such as funding the Department of Enterprise, Trade and Investment around job regeneration and all that stuff. I agree with you on the universal population approach to the constituency, and I agree with you on the whole issue of all being able to avail themselves of it in the constituency. We have a sizeable percentage of people who are working poor.

They suffer the same things, but they are still working poor. How did you go about convincing people that a genuine partnership approach from the constituency, the voluntary sector, the community sector and the statutory agencies is needed?

Mr J Ruane: When we started this, which was around six or seven years ago, it was contained. It is like what we were saying about here: it was in a particular Department or section in our own health services. The first point was selling the programme in that sector and, in doing that, pulling all the separate Departments together to look at it in the context of what it could offer to each of them. It was important to have that piece in there to work on. We had to sell it to people in our own Department first to get them on board. Without that support, we would not get anywhere. It is about trying to find the leadership that exists to put this in place. That was key.

It took time to pull different sectors and Departments together. Within health, you have, for example, psychology and public health nursing. Each element looks at its own sector, but there was benefit for everyone in this, as Conor showed in the slides, whether in mental health or education. It is about bringing that message to people to pull them together.

Getting that piece in there is what we were working to achieve first. We said that health services could not deliver it on their own, either because of the stigma of approaching them or because people do not want to be associated with them. It is about engaging the external agencies that have access to the communities that we want to reach. We want to reach the community and every parent out there whom we can support and help, wherever they are.

Working to bring in the external agencies, such as the community representatives and organisations, was probably a lesser task than the initial task inside the Department. It was about bringing all those people together to show them that they had the majority role to play in reaching the communities that we were trying to get to engage in the project. Even though we, as a health service, are a very big organisation, without the component parts coming together it would not go anywhere.

A certain number of people took up that offer and a certain number said, "No thanks; that is not ours." We had to leave it with them and hope that, at some stage, they would see the benefit of it and ask to join in. That did happen over time, and we got a growing number of partners. When we started, we were looking at one, two or three community groupings that were responsible for delivering local development initiatives, which is nothing to do with parenting. We told them that what they do has a lot to do with it and that this project could help with that work.

That piece of work was about identifying people with leadership qualities in those communities, bringing them on board and developing the work. We started with Health Service Executive (HSE) services only and then had perhaps two or three external agencies, some of which we looked to deliberately, because we knew of their involvement in the community. Currently, we have 10 different organisations and are oversubscribed with partnerships.

The Chairperson: How do you get other Departments to buy into it? I will give you two examples: in the previous mandate, there was a battle in this Assembly between DHSSPS and the Department of Education to see who was going to fund breakfast clubs and after-school clubs. That is what it boiled down to. There was a great project in my constituency called the integrated services for children and young people programme. The junior Ministers said that they would love to roll it out in their constituencies, but it is down to a battle over who will fund it. It is about the statutory role of genuine partnership approach.

Mr J Ruane: We were lucky at the time, in that the Health Service Executive covered the entirety from childhood to adulthood. It was the responsibility of one Department in the main, although obviously there were linkages with education. There was a strategy for children's services committees, which was the coming together in specific counties of the local council, the guards, the education authorities and health providers. There was a framework there with which we could engage.

We are, however, now entering challenging times. Where there was one Department dealing with children, encompassing everything to do with health services, we are now moving towards the separation of the child and family services into a separate Department, the Department of Children and Youth Affairs, under Minister Frances Fitzgerald. There will be a challenge, and our focus will be on ensuring that the work continues that has been done between the two Departments on health and the new developments on children and families. If we are not focused on the importance of that, we

could end up saying that there is a child and families agenda, and we should let that Department look after that. There was a benefit at the start.

Conor emphasised that, ultimately, when money is being spent in whatever Department, we have to ask whether it is being spent as efficiently and effectively as possible. For example, with the children's services committee in the midlands — in Longford/Westmeath — we found out that the health service and councils were giving money to some voluntary groups. Suddenly, groups were receiving money, and we did not realise the total money given. We were able to look at that and say whether one group was good and should continue over another one. Therefore, there was focus.

The key thing that has been there and has to continue is transparency, both in the HSE and with the staff. Eamonn is understating the challenges that existed internally in the system. People said that it was the social worker's job; the child and adolescent mental health service's job; or the public health nurse's job. Ultimately, we were forced to say, "Look, this makes sense. It is evidence-based. We will take the leadership call. We need to do this." The other thing is that we had support locally in the community. Local public representatives, families and educationalists viewed that as positive.

Mr Owens: I will add a little bit to that. The work that we did started in local areas and moved up to the policymakers. If the Minister were to look at an idea like that, one really important thing is scale and to have all Departments looking at not a large piece but a small manageable area, because systems are very good at surviving as they are. It is very difficult to change a system. If you introduce an evidence-based programme into a system, it is very difficult.

What we achieved through the local management and leadership was that a number of people became a core team and delivered the programme. It was almost like a spur on the side of the main system to get established and get buy-in from the local community for people to see that the programme is what people want and is helpful. We are now entering the phase in which that programme moves back to being aligned with the major systems. Therefore, I would look not at the idea of starting such a programme in an established service but at having it slightly on the side so that people get a remit to do the work and to build up expertise in it. As such, the programme gets a reputation for actually working.

The immediacy of positive feedback from parents has helped us enormously. So many arguments are dissolved when people hear someone say that they attended the programme and that it was good. Even though they are very difficult systems to change, people in those systems all respond to hearing that something was good, that parents liked it and that it changed something for children.

At that level, where things such as the 'tip paper' come in, it is about promoting local ownership and showing people that this is something that our service is delivering of which we can be proud. The aim of a public health piece such as this is that the community takes ownership of it. Again, you do that through partnership. The community wants it and drives it. However, there are difficulties in trying to get co-ordination. You will hear an awful lot of talk about effectiveness and efficiencies. An effective and efficient programme will not ensure that the piece that has to go with that survives. You have to have strong leadership and a good implementation plan. That is where the work of political leadership and local leadership comes into play: to pick specific sides and to give something a chance to prove that it works and is useful. If it does not work, stop doing it. It is the same for existing services. Eamonn and another colleague, Joe Whelan, did a survey. We found that there were 17 different parenting programmes.

Mr Farrell: There were 17 on offer prior to our commencing this piece of work to find out what was happening out there. People had been trained in 17 different programmes. However, even though substantial resources had gone into them, very few were being delivered or being delivered effectively.

Mr Owens: All of that was out there. Parents want to know that it is something that works. When we started the evidence-based programme, parents responded to it very quickly. We were training people in one programme, not 17 programmes. When you have that focus, you get people to deliver a lot more, and frequently, and then you get a critical mass.

Mr Beggs: First, I declare an interest as a member of Horizon Sure Start in Carrickfergus and as a member of the Carrickfergus locality group, which deals with some of these sorts of issues.

Fascinatingly, you talked about James Heckman, who has been well known for a long time and is a Nobel laureate economist. We tabled a motion on the issue four or five years ago. Steve Aos was

also in this Building. One name that you did not mention was Harry Burns, who is the Chief Medical Officer for Scotland. Four years ago, he delivered a presentation to the Northern Investing for Health Partnership. Two days previous, he delivered the same presentation to the entire Scottish Executive. He was trying to reduce health inequalities in Scotland, and he came to the conclusion, exactly as you did by using evidence-based, scientific programmes, that it was about early years investment. That is very relevant, and I hope that our Chief Medical Officer takes a similar position.

You mentioned the medical card. I would be interested to know what level of salary that takes in.

Mr J Ruane: Around €30,000 or €40,000.

Mr Owens: It is also related to the number of children that you have.

Mr Farrell: Generally speaking, it is under €35,000, give or take. It is means-tested.

Mr Beggs: You mentioned that your programme is for nought to seven years. Interestingly, in Northern Ireland, the investment is in nought to four years old. Will you explain why you think it is important for that older age group to be included?

Mr Owens: Originally, we started with three to seven years old. The rationale being that there is a major transition then, because children are preparing to go to school and are becoming established in school. We thought all the research pointed to the fact that that is a really important, critical phase with lifetime consequences. However, we got such buy-in from other sections that we brought our age range down. We are preparing to start delivering in another two counties, and, again, the age range there is nought to seven. Again, we widened the range from four to seven to cover that transition into school, because school readiness is incredibly important. The more work that we can do around that, the more that teachers will be able to teach, rather than having to tell John or Mary to sit down, concentrate, play in a reciprocal manner, or whatever. All those skills are built up through parenting, and that is why that time is so important.

You mentioned Harry Burns. I remember that he said that we know what works but that we just do not do it. He was talking about early years and parenting. In Glasgow, he has supported and been involved in setting up the same kind of work that we do, expect that he does it for nought to 16 years, while we do it for nought to seven years. That is being run at population level right across the city of Glasgow.

Mr Beggs: I fully support what you are doing. It is great.

What about outcomes? How long has your programme been running? What savings are you achieving? At the end of the day, you need to convince people to pool resources. Do you need more and ongoing resources to get better outcomes? You said that you are making, if I picked you up right, 20% savings. What cash flows are required to fund that, kick it off and enable it to happen?

Mr Owens: We started in September 2011. We have had one interim report, and our final report will come out in June next year. Our interim report — it was interim, so there is a health warning attached to all its results — showed was that our outcomes were in line with, if not slightly ahead of, international research.

Mr Beggs: You started in two thousand and —

Mr Owens: In 2011 — sorry, in 2010. We have been up and running for just over two years , so it was 2010. The project will run for two and half years, and the evaluation will continue to roll out after that.

As to outcomes, what we are showing is that, with parents who have children in the clinical range, for those who attend the group, over 50% are no longer in the clinical range as a result of going through a parenting group. We are not working directly with the children; we are working just with the parents.

Mr Beggs: Is money starting to flow from other parts of the health service to widen out the service elsewhere?

Mr Owens: We are expanding into a further two counties, so we will then be delivering in over four counties.

Mr J Ruane: And we will have a doubling of the population brief.

Mr Beggs: What was the initial investment made to kick this off? What was the annual investment to service 130,000 people?

Mr Owens: The majority of the investment is in staff. The HSE reoriented a number of posts, and I think that that is key to sustainability. You cannot be inventing new posts, so there is a reorientation based on evidence, need and interpretations. We are lucky in that we attracted some money from the Department of Children and Youth Affairs and got some money from Atlantic Philanthropies to cover the research and evaluation.

As to the whole overall pot, I do not have the answer for that yet. We will have it come June. What we have discovered is that we have got a lot smarter in the way in which we deliver. We will have an economic evaluation piece on the next two counties. We have learnt ways to increase efficiencies enormously. One of the ways to do that is through partnerships, where partner organisations free up staff. We have a core team, whose job is to deliver, train and mentor full-time. We have other organisations that release staff. We have an agreement for 110 hours a year, and we supervise and mentor those staff, and they deliver. Therefore, we are not using just the HSE resources but are getting community resources, and getting the savings from that.

I think that it will be a while before we see savings in referrals, simply because services do not reach everyone who needs them. We hope to show savings, and believe that we will. We carried out a population survey at the start, so we know the prevalence rates for different behavioural problems, levels of concern, levels of parental stress and depression, and quality of relationships. We have those for Longford/Westmeath and for matched controlled areas. We will be carrying out that survey again in February of next year, and that will hopefully show a decrease in prevalence rates. That is where the major savings will be.

Australia, as I said, showed a decrease of 26% in maternal depression rates, which I thought was startling. Think about it: if you had an economist who could cost that in possible work days lost, visits to GPs and medication, the figures would be huge.

Mr Wells: I have three questions. First, you mentioned the feedback from the parents group. Let me give you an example: I am a vegetarian, and vegetarians live seven years longer than meat eaters. That is an absolute fact. It is utterly meaningless, because vegetarians tend to be exercise freaks, do not drink or smoke and do not do a lot of things that affect life expectancy. Therefore, vegetarianism may have nothing to do with life expectancy; rather vegetarians are just that type of people.

Similarly, there is a bit of self-selection here. Obviously, the people who have the drive and impetus voluntarily to register for the programme are probably the people who will have an active interest in making it work, and therefore are likely to keep at it and get that type of result. What is happening to the people out there who have not the motivation to register?

Mr Owens: This is great, because I have an answer for this one. *[Laughter.]* There is a strange thing called the law of diffusion of innovations. It states that 16% of people are early adapters to anything. They are the people who will sign up very quickly. They will come along, and they are self-starters, motivated and want the best. We reckon that, based on our stats, we got that percentage 13 months ago. After that, we are working on people who are not early adapters.

However, we have to change the message in order to recruit those people and get them interested in coming forward and self-selecting. This is where the marketing piece is so important. The early adapters respond to fliers and opportunity. They will take it. Then there are others who, after that, responded to word of mouth. We discovered that that was the driver for recruitment — not fliers, posters, podcasts or anything like that. We needed to change our recruitment strategy to try to get people who had gone through programmes to start talking to other people about those programmes. That is what people are doing now, which increases our reach into those areas.

With the progressive universalism piece, there are geographical areas where we know there is a higher level of need than there is in other areas, and we dedicate more resources to those areas. We find out what services are available, whether it is a community mothers group or whatever. Wherever

people have a good connection, we go in and talk to those people. We get them involved in observing and taking part in programmes. They then talk to people whom they know.

Therefore, there is a group that is easy to recruit, and there is a group that is harder to recruit. If you are taking the public health approach, you have to recruit from the different groups and not just take the people who come to your door. One of the arguments that we have heard is that we are running groups that are not full. There might be a group that has eight parents in it but could take 12 parents. Some people will ask why we do not expand our age range so that we can get more parents in. Our answer has been no. Although we know we will get more parents in if we expand our age range, we will only ever deliver to the parents who are quick to self-select and will never develop the skills and recruitment skills for the populations that require that bit more effort or convincing or that are that bit more wary of services and authority structures.

We have stuck to our age group, and that has made life a bit harder for us, because we have had to figure out ways of recruiting those harder-to-reach groups. We conducted a survey at the start, the results of which were really interesting. I am not sure of the exact figure, but the vast majority of parents said, "Of course we want evidence-based programmes to be readily available to everybody. They are fantastic. We have to have them." Then, when they were asked whether they would attend one, the answer was no. They said that they were for other people, not for them. If you go back to the Lassie cartoon in the slides, there is a piece about normalising everyday problems in parenting that stresses that they are not a sign of incompetence or of not being able to do something. That is just the way that parenting is. At times it is fantastic, while at other times it is stressful.

The next piece is about promoting help-seeking behaviour and evidence-based parenting. Then, there is the opportunity with Triple P. There are a lot of steps involved. It is not just a case of offering the parenting programme; rather, there is a whole strategy that needs to go in beforehand, and there is a strategy for different populations as well.

Mr Wells: That is an interesting response. I was surprised at your graph. If you ask me where the problems lie, in my constituency they are in the sink estates, which contain the difficult, hard-core, poor and vulnerable communities. You are saying that if you went to the leafy suburbs of Blackrock or Dublin 4, you have as high a level of —

Mr Owens: In real numbers. There are fewer sink estates than there are other estates. In sink estates, you will have a higher density of problems. For example, of 10 people, a high number of them will have the problems that we are talking about. However, you might have 100 people in the other estates and 15 children with social, emotional and behavioural problems. When you add up the numbers, there is a higher level, but we are not talking about the percentages.

Mr Wells: It is more of a problem in the sink estates.

Mr Owens: Absolutely. Life is much harder in those estates. It is just that, overall, fewer children come from such estates.

Mr Wells: It is surprising that you are identifying high instances of problems in what we would call middle-class, leafy suburbia. You are seeing people in those areas who have problems parenting.

Mr Owens: Think of people whom you know.

Mr Wells: I do not know any such people with those problems. I just wonder whether the breakdown of the standard family unit, which is clearly affecting all parts of the community, is the explanation. Is that the issue that is causing a lot of difficulties? Obviously, it is much more difficult to provide parenting if you have been through a bitter divorce or separation. Is that the common factor? The common factor cannot be economic, because many areas that are quite affluent are still showing instances of very poor parenting.

Mr Owens: We got the answers so that we could categorise people into different socio-economic groupings. We also asked people about their ability to pay bills and what pressures they were under financially. A lot of people in the leafy suburbs are, behind closed doors, struggling. That would be a huge stress. I agree with you: if you have resources, life is going to be a lot easier, and there is a greater likelihood that you are going to be able to do higher-quality parenting, but it is not guaranteed.

There are people with great levels of resources who are very poor at handling stress or who just find the whole idea of the relationship around parenting difficult.

Mr Wells: This is a common theme. We have heard some dramatic presentations on this issue. We had an incredible one in June from a lady from Dundee with a Polish name, which I cannot pronounce, so I am not going to attempt it, but she gave very dramatic statistics as to the importance of early intervention. The point that she made is the same as yours: that we have to do this or we will be storing up huge problems that society will have to pay for at a later stage.

The problem we face here is that we are firefighting now. We are trying to pay the bills that keep the cancer wards open and keep the Fire Service going and pay the social workers. We are told that if we invest an awful lot of money now, there will be a payback, but there are a few problems with that. First of all, that payback could be a very long time, and we are trying to pay the bills now. Secondly, much of the payback would be to budgets that we do not control. We have a different system to the Republic, and much of our social welfare is paid directly from London and does not come out of our grant at all. You have a unified system in Longford and Westmeath. To be purely mercenary about it, how many years do you think it would take to get a return on this expenditure?

Mr Owens: The great thing about Heckman's work is that it has come purely from that economic model. I hope that you got the document. On page 10, it goes into the impacts in South Carolina. They rolled out the service across 18 counties, and each county had a population of between 100,000 and 120,000 people. They found that, within two years, on a purely economic level, they made back all their financial investment. That was not a long-term thing. That needs to be qualified. Where they made most of that back was in a decrease in the number of children needing to be taken into residential care. The cost of a child going into residential care is significant, and they were able to decrease the number of children going into residential care.

Mr Wells: We would not see some of what would come back. London would save it, because of the system that we have. It would be a saving to the UK but not a saving to Northern Ireland. However, two years strikes me as very optimistic.

Mr Owens: It is remarkable. It is so remarkable that the study was funded by the Centers for Disease Control and Prevention in America. It is now funding a replication of it on a much larger scale. If this continues to hold, this is quite dramatic.

Mr Wells: The other question is, of course — I do not think I have been to Longford or Westmeath that often, but it is a largely rural area in the midlands —

Mr Owens: It is semi-rural.

Mr Wells: Would the same model apply to inner Limerick, Dublin or Belfast?

Mr Owens: It goes back to the common concerns that it does not work here. It is in Glasgow, and it is being used in Brisbane. It is used in city populations, but we are not using it in city populations. Our evidence base is going to be semi-rural, but there are 127 independent studies on Triple P. A significant number of those are city populations.

The Chairperson: At the minute, I just have Gordon, so —

Mr Farrell: I am conscious that Roy asked a question earlier about costs. I am not saying that it is of any huge benefit, but when we budgeted for the research component three years ago, our budget for the delivery, roll out and everything was somewhere short of €2 million. We have come in under budget, and a huge percentage of that budget was allocated towards the research component. It was not new moneys. It was reorientation of resources from Department members and the people — *[Inaudible.]*

The Chairperson: At the minute, I have Gordon and Maeve. Do any other Members want to come in? We just need to be careful of the time.

Mr Dunne: Thanks very much for your presentation. You are very welcome. Would it be fair to say that it is basically a case of prevention rather than cure? Obviously, it is prevention and investment at a very early stage. How do you justify the funding? Is it an issue to justify it? We are certainly under

pressure. Acute services are always in demand, and cancer care is growing in demand. How can you justify funding the project in that regard?

The other thing — this has been touched on — is parents. In many cases, there are single-parent families. Is that a priority? The commitment of both parents is probably a big issue of time and effort to get involved in the programmes. Maybe we could get some more information on how they are worked out locally. Do GPs have a role? Health visitors? We would like more information on how it goes out into the community.

Mr J Ruane: If this had developed 10 years ago in Longford/Westmeath, business cases would have been done by the Department of Health seeking additional staff. It would have said that it could not be done without another 10 staff. That was the method and model; we did our business, and that was it. There has been a reality check over the past five years. There is no more money coming down; you have what you have, and you decide whether to continue it as it is or to rejig it. We made the call over the past number of years. Arguably, we jumped; we took a leap of faith. When I say "leap of faith", it was based on evidence that has already been gathered elsewhere.

We absolutely accept all of the concerns that Conor outlined about whether it will work in Ireland. Initial work went on, and it proved positive. Social workers, public health nurses and various colleagues with a psychology background were doing clinical work. We made the call to say, "Well, actually, you were doing that full time. Now I want you to do half time on this." That creates tension and anxieties in the system. The immediate thing is, well, we absolutely needed Conor or Eamonn full time, and he is going to go away. That has to be managed. The reality in the system in the South at the moment is that we lost about 3,500 staff a number of years back through early redundancy. Our figure for the health service has to go from about 101,000 staff down to 95,000 staff. The same arguments are going to be there; staff are going to go, what are you going to do? The fundamental question is whether it is important and evidence based. Once you take those things, you then have to prioritise, knowing that the work that we previously did must stop, or the way in which we did work in the past, having reviewed it, can be done more efficiently and effectively. That is where the resources have happened. Had it been done and developed in the boom times, it may not have got off. That is the irony.

Mr Owens: In order to take a decision on services now, it is really scrutinised and thought through. The public health nurses are really central to the work that we do.

Mr Farrell: They are the equivalent, I think, to your health visitors.

Mr Owens: Yes. We have a number of them trained up, and we have dedicated Triple P clinic time. The public health nurses became involved. When they were doing developmental checks, the parents were saying, "That child is fine, but the four-year-old over there is driving me mad and I cannot stop him hitting his sister." Those concerns came up again and again. The public health nurses found themselves spending time addressing those topics with the parents. They were trading off what they had read or what their colleagues had told them, or their own hard-earned experience. They did not have an evidence-based practice, and an evidence base was really important.

In some cases, it was not that we were asking them to do more work; it was that time was being filtered off to deal with those requests. We are now offering them a structured way in which that can be done. It can be done through groups as well; the public health nurses run small-group discussions around dealing with disobedience and night-time routines. Many parents or mothers were coming to a public health nurse and saying, "I am going back to work in six weeks' time, and the child is still not sleeping. What am I going to do?" It is about things like that. The topics that we talk about in it are ordinary, everyday things, like what you do when you are on the phone and the child comes pulling at your trouser leg, saying "I want a biscuit." Or, children are in the back of the car and they kick off when you are driving somewhere. Things like that. They sound ordinary and mundane; they are really common. However, these are the things that start to build up and can lead to problems. That can be the time when a parent can turn around and give a child a clout or shout something at them, and 10 minutes later be going, "Oh my God. Why did I say that?" Or not, maybe.

However, we are not going for the dramatic. It is the ordinary; and we are trying to get it across to every parent, using the existing services and the public health nurses. The GPs get regular updates from us, and they promote the programme. So, again, it is community ownership; as much promotion as possible. The GPs are going to be really important to us in the New Year, because there is an

addition to what we are doing. We are starting a childhood obesity programme, and we are doing that through parenting, rather than directly through the child.

Mr Dunne: It is a big issue. It is connected to lack of exercise and sports.

Mr Owens: Absolutely huge.

What we are finding is that there are all these strategies around healthy eating and exercise for children, but children are used to getting their treats or food in a certain way. So the parents need additional skills, at times, to help them to cope with that. Our target is really the ordinary, and we believe that that will decrease the clinical.

As I said earlier, the prevention and the clinical mix in the same groups. If you had a group referred from a community psychiatric team, you might decide to keep that as a closed group, depending on the levels of their problems. Generally, we have open groups. We have found that in some particular geographical areas that parents have said, "Yes, we want to do this, but we do not want anyone from outside our area to be part of it." And that is fine.

The Chairperson: Can I just remind members that we need to finish this in 10 or 15 minutes, but we are going to continue it over the lunchtime break. Other members want to come in on this particular part.

Mr Dunne: That is grand. Thanks very much. It was very interesting.

Ms Maeve McLaughlin: Thank you for your informative presentation. I believe that this is about redirecting and reprofiling resources. We have to do that within a current policy context as well. Increasingly, I find that there is a general shift in health, at senior policy level, to more community primary-based health programmes. Within that, and central to it, is early intervention and early years. One of the things that struck me — the economic impact is a critical tool for us to have the information. The thing that struck me was that representatives of the Institute of Public Health in Ireland were here a number of weeks ago, and they gave a very detailed presentation, but specifically — and I am looking for clarification on this — they talked about the Scottish model. They said £5·6 million had been saved in the Scottish economy as a result of early intervention. They also talked of the American model, 15:1 or 16:1, and about research that had been done in the Twenty-six Counties of an investment of 7:1. So I think it critically important. I will go further: we need an island-wide figure that allows us to make the case which does not exist currently. Maybe you could clarify that. Where are the differentials in the information that we are receiving?

Mr Owens: I think that you have put your finger on something critical. The Steve Aos figure that I quoted was from April of this year. If you go back to his previous figure for the same type of work, you will find that they are hugely higher. He rejigged his methodology, and there are basic assumptions made in cost-benefit analysis. People use different assumptions, and they can make enormous differences on those investment ratio figures, whether it is 6:1, 70:1. It needs an economist to compare the assumptions or to try to get the raw data to have the same assumption. I will tell you the reason why I was particularly taken with Steve Aos. I was a bit disappointed when I saw $6 for $1, compared with some of the other ones that I have I read about. However, he applied the same methodology to lots of different evidence-based programmes so that you could compare not the headline figure but the relationship between the figures for different programmes, and the one for universal Triple P was way ahead of the vast majority of other programmes. So, from that, I took it that, whatever your economic assumptions are, there was a higher return for universal access to Triple P than there was for the majority of other programmes.

Ms Maeve McLaughlin: That is useful to know. It is important that we have that tool, so that we can lobby collectively.

Mr Owens: We wanted to do an economic analysis when we started ours, but there was nothing to compare it against. So we were concerned about coming up with a figure that might look very high and about the fact that we would have nothing to compare it against.

Ms Maeve McLaughlin: It is a shift from early years to 0-7. I have looked at some of the information on the whole issue of brain formation, the impact and the stages and all that — technical, but incredibly important. What obstacles, if any, were there, because I have found locally in my

constituency that there are some obstacles to differences between early years and going at it from 0-7? It is a shift. People looked at early years, and it was three, the going into school age group. This is a change, so have there been any obstacles, and how did you overcome those?

Mr Owens: The obstacle that we came across was a repeated request for an expansion of the age and a repeated pressure for the teen version. There was pressure from public health nurses for the pre-birth period. I do not think there is an ideal age range. I think that it needs to be based on a common definition and a common rationale for why you are picking an age. We picked that age because it is a key transition time between home and school, but I think that any range is fine as long as it is within early years. With 0-4, I think that you miss some of the transition into school. I am not sure of the age of entry to school. For us, the child has to go between the ages of four and six. We carried it up to seven to get it established there. As long as it is within that kind of time frame of under seven or under six, I think that that is where you will get the highest returns and where you will get the prevention piece. It may not quickly reduce your waiting lists. The reason behind that is that there are so many hidden hurdles to getting on a waiting list. You have to want to be on a waiting list. With the public health approach, you are providing universal access, so you are getting people who may not have been on your waiting list.

Ms Maeve McLaughlin: Finally, I know that part of the learning, again back to constituency but in terms of regeneration, was that early intervention is viewed as a catalyst. It is interesting that is has actually been platformed through the City of Culture events next year, which are critically important as well, in respect of the learning about targeting resources to where they are most needed and the huge debates about the word itself. The whole concept there that you are talking about — progressive universalisation — is an interesting one. How are the outcomes measured? I will give you an example of why I am asking that. Over the past year and a half, in some of the programmes in part of the constituency that I represent, which is an area of high social need, the teenage birth rate has dropped by 50%. That shocked everybody in the sector. They were going, "How did that happen?" One of the obstacles, I find, is that people say, "You cannot really measure those outcomes, because there are all sorts of outside factors that may impact a person and their family. So how do you do that?" This is a critical piece of work that we can demonstrate. We hear clearly what you are saying, but it is important that we look at models for how we measure those outcomes, particularly in that sector.

Mr Owens: I think that we have to put our hands up and say that we were extremely fortunate to get external funding for a robust evaluation. Part of our work now is to say that we will not have those resources available to us in the future. So, when we look at the next two counties, we are thinking about the minimum data set that we will need, based on our experience. What systems will we need in order to streamline it as much as possible? You cannot operate on a really good, continuous, solid evaluation. You have to shrink it down over time in order to make it manageable and make it part of ordinary work and practice. That is the only way that it stands a chance of going to scale. The last thing that you want is a really good project that has not evolved to the point where we can fit it back into mainstream systems. We have to shrink elements like that and pick out what is core. What is the data set? What information will be enough for managers and political people to say that it is worth continuing?

Mr Farrell: In the context of measurement tools, the range that we have used is all recognised clinically and internationally. So, nothing is being used that is not a recognised measurement tool in the context of pre- and post- or measuring outcomes through general health questionnaires, strengths and difficulties questionnaires, relationship indexes and all of those things. They are all recognised tools.

Mr Owens: We are shrinking the data set and putting into it only three questionnaires.

Mr McCarthy: That is exactly what I was going to ask. I think that you said that you have been on the go since 2010. You have obviously done excellent work. Is there a cut-off point? Will the programme continue for a couple or three years, or what?

Mr Farrell: The cut-off point for the research component — the collection and measuring of data — is the end of 2012. However, the programme will continue. We had always factored in a sustainability element, which was the partnership approach in terms of having resources and that they would continue to deliver. So, the programme will continue. Not only will it continue, but it is expanding into these other two counties as well. A few new elements are being added into it. There is commitment to that.

Mr McCarthy: Finally, what will your role be when the programme is finished? Will you be looking over their shoulders to see whether they are carrying on the good work that you started?

Mr Farrell: If it is successful, we will be in the background. Its sustainability should not depend on any of us to be there at all. Our hope and aim is to do ourselves out of a piece of work if it is successful.

Mr Owens: Currently, our next piece of work is to produce implementation manuals, so that it is not reliant on individuals. We will come up with those manuals because you have to have leadership, an evidence-based programme and economic analysis. They all come under the heading of implementation. Lots of people here in the North are developing quite an expertise in implementation, such as the Centre for Effective Services, Barnardo's and the Parenting Forum Northern Ireland. Those groups are already doing that kind of work.

Mr McCarthy: Thanks very much.

The Chairperson: We will continue this over the lunch break. Formally, for the record, I want to take this opportunity to thank you for coming today and delivering your presentation. The more presentations that we get on this issue, the more it starts to set in that, as a Health Committee, we have a duty to look at health inequalities, not necessarily outcomes. It is our responsibility. In fairness to the Minister, he has agreed to hold off the publication of his strategy until we have finished our report. That in itself is a good sign that there is a genuine partnership approach at that level between the Department, the Minister and the Committee. As I have said, we will continue this discussion. I will suspend this part of the meeting. We will head to the Members' private dining room, where we can discuss the issue further. Thank you.