SUBMISSION ON THE PRODUCTIVITY COMMISSION'S DRAFT REPORT: MENTAL HEALTH IN AUSTRALIA

Triple P International commends the Productivity Commission for their ongoing comprehensive investigation into Mental Health in Australia, and welcomes the opportunity to comment on the Draft Report, released in October 2019.

Please consider this submission in parallel to the remarks and Q&A from TPI's appearance at the Rockhampton public hearing, on 2 December, 2019[1].

This submission will cover in brief:

- The Triple P System, and Triple P International.
- Impact of evidence-based parenting/carer support in relation to key areas from the Draft Report, in particular:
    - Part IV – early intervention and prevention
        - DR 17.2 – social and emotional development in preschool children
        - DR 17.3 – social and emotional learning programs in the education system
        - DR 17.4 – educational support for children with mental illness
        - DR 17.5 – wellbeing leaders in schools
        - DR 17.6 – data on child social and emotional wellbeing
- Key reference to Australian rollout examples.
- Reference to independent cost effectiveness evaluations.

Introduction

The Triple P – Positive Parenting Program® is an Australian researched and developed program that has been operating around the world for over 40 years, and is delivered in over 28 countries. There are now more than 340 evaluation papers on Triple P for families across different cultures, socio-economic groups and structures.

Triple P International (TPI) is the sole license holder (licensed through UniQuest) responsible for disseminating and implementing the Triple P system in Australia and around the world. Draft recommendation 26.4 notes that effective implementation is key to realising the benefits of reform. This sentiment is as true for individual programs as it is for national policy change, and TPI's understanding of this can account for the scale of effective implementation to date.

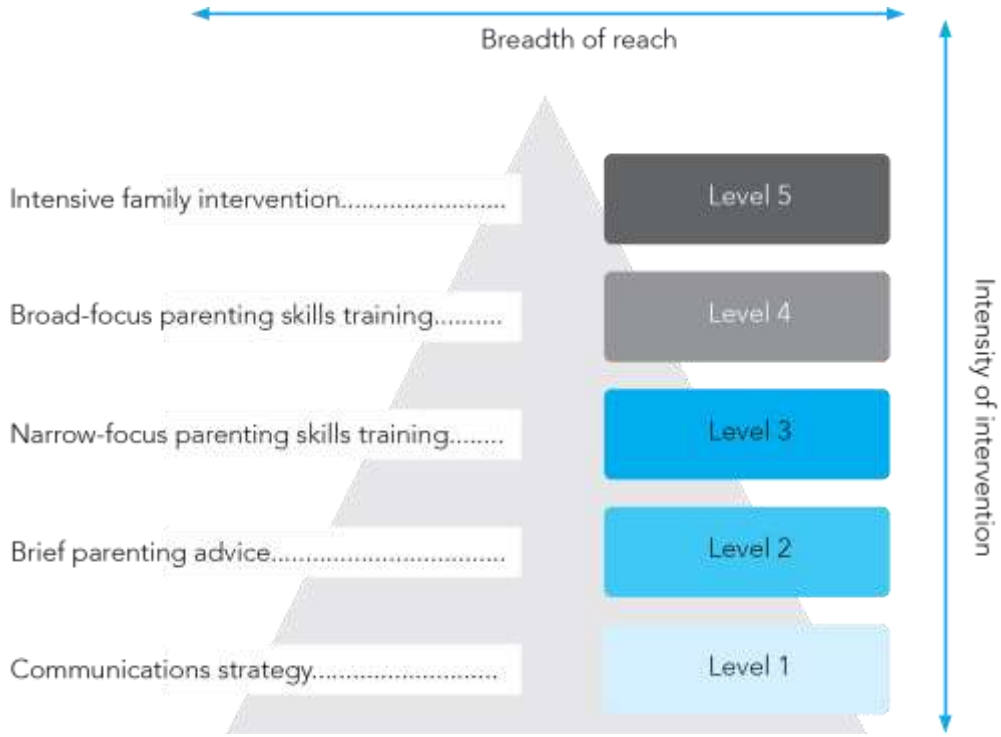
The Triple P system

The Triple P – Positive Parenting Program® isn't a single program, but rather a suite of interventions of increasing intensity for parents of children birth–16 years.

Within each level, there is also a choice of delivery methods. This ensures Triple P is flexible enough to meet the needs of individual and specific communities. It is designed to give parents as much help as they need – but not too much – to prevent over-servicing and encourage self-sufficiency.

As shown in Figure 1, this multi-level system, provides a 'proportionate universalism' approach, rather than 'one size fits all'. It means there is some level of support for all, but more for those with greatest need.

Figure 1. The Triple P system



Impact of evidence-based parenting/carer support in relation to key areas from the Draft Report Part IV – early intervention and prevention

As noted extensively in the draft report, preventing multiple adverse childhood experiences is key to generational change in mental health outcomes, and avoiding costs associated with their long-term impacts.

The seminal Adverse Childhood Experiences (ACE) survey highlighted that a person who has experienced four or more ACEs is:

- 12x more likely to attempt suicide.
- 10x more likely to use intravenous drugs.
- 7x more likely to experience alcoholism.
- 5x more likely to experience depression.[2]

Harsh and coercive parenting increases the risk of child maltreatment and the development of serious social, emotional and behavioural problems in childhood and later in life. Inconsistent parenting increases the risk of children developing conduct problems, depression and anxiety. It also increases the risk of engaging in juvenile crime and in dangerous behaviours such as drug and alcohol abuse and risky sexual behaviour.

Child and youth mental health and wellbeing initiatives targeted at the individual are of course important, but also crucial is the home/living environment, and addressing risk and protective factors there, by improving the competence and confidence of parents to raise resilient and mentally healthy children. Part of this is embedding capacity in the workforces most in touch with children and youth (early childhood educators, health services, primary school teachers, high school teachers, school counsellors and the proposed wellbeing leaders), to ensure those workforces are confident in holding consultation with parents around social, emotional and behavioural development.

The evidence provided further down applies to the suite of Draft Recommendations listed in bold below. In particular, TPI highlights the importance of early childhood intervention, and workforce capacity building for professions primarily dealing with children.

- DR 17.2 – social and emotional development in preschool children.
- DR 17.3 – social and emotional learning programs in the education system.
- DR 17.4 – educational support for children with mental illness.
- DR 17.5 – wellbeing leaders in schools.

- DR 17.6 – data on child social and emotional wellbeing.

TPI *strongly endorses* the recommendation (17.2) to expand early childhood health checks, so that they assess children's social and emotional development before they enter pre-school, however, this must be accompanied by embedded support to address lagging social and emotional development.

As discussed during the Rockhampton hearing, the expansion of early childhood health checks will likely highlight considerable unmet need at that crucial pre-school age. Triple P's population health approach, that works with embedding capacity in existing workforces to accredit those in most regular contact with particular cohorts – could be used to address this unmet need. For instance, 86% of 4-year-olds were enrolled in preschool programs in 2018, so there is potential to have great impact on social and emotional development, and longer-term impacts, by embedding capacity in this workforce.[3]

Triple P has an extensive evidence base demonstrating effectiveness at addressing social and emotional development. Some examples below of intervention effects:

- **Midlands, Ireland:**[4] after 3 years, a community-wide rollout out of multiple levels of Triple P found the number of children with borderline to clinically elevated social, emotional and behavioural difficulties was reduced by 37.5% in the Triple P counties, while in the non-Triple P counties, the rate increased by 8.6% (demonstrating a prevention and treatment effect on children's mental health outcomes). In addition to the research paper attached, a Briefing Report is available here http://www.cccw.ie/wp-content/uploads/2014/04/Triple-P-Briefing-Report.pdf

- **Preparing for Life, Ireland:**[5] an enhanced home-visiting program incorporating Triple P for families in an impoverished area of Dublin, commencing in pregnancy through to the child's 4th birthday found improved school readiness across five domains (cognitive development, language development, approaches to learning, social & emotional development, and physical wellbeing & motor development). Notably only 2% were at risk of behavioural problems at 48months, compared to 17% of children in the comparison group. At school entry, only 25%of children in the enhanced group were not on track in social competence, compared to 43% of low-treatment children.

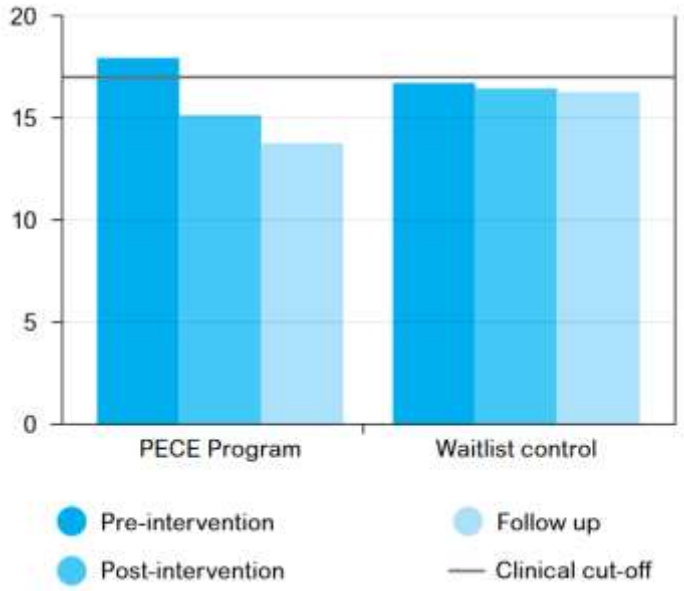
- **South Carolina, USA:**[6] Prinz, Sanders, Shapiro, Whitaker, and Lutzker (2009) demonstrated community-wide reductions in child maltreatment prevalence rates, using a place-based randomised design to implement the multi-level Triple P system. Eighteen counties in South Carolina, USA, were randomly assigned to either the Triple P system or a care-as-usual control group. Two years later, the Triple P counties observed significantly lower rates of founded cases of child maltreatment (*d* = 1.09; 16% lower than comparison counties, slowing the growth of cases), hospitalisations and injuries due to maltreatment (*d* = 1.14; 22% lower than comparison counties), and out-of-home placements due to

maltreatment (*d* = 1.22; 17% lower than comparison counties). Reanalysis of this data almost a decade later strengthened most of the research findings showing 31 per cent fewer substantiated cases of child maltreatment, 12 per cent fewer hospital-treated child maltreatment injuries and 21 per cent fewer child out-of-home placements.

Alongside the flagship Triple P system – which provides positive parenting support direct to parents and carers, sits more recently developed and evaluated Positive Early Childhood Education (PECE) Program for professional development program of early childhood educators. A PECE Program RCT included a major focus on program effectiveness and fidelity in implementation, which is critical for seeing the benefits of interventions in early childhood. This particular study included 96 early childhood educators and 12 child care centre directors. Findings include:

- Pre-intervention, many early childhood educators identified lack of skills or supports regarding addressing challenging behaviour as the main influence reducing workplace satisfaction.
- As well as significantly improved child behaviour towards adults, educators reported feeling less stressed at work, communicating better with each other and supporting each other more.
- They also said they felt more prepared and supported to meet complex child needs and challenging behaviour.
- They also reported increased work satisfaction.
- When educators could complete PECE Online during the workday, there was a 100% program completion rate.
- Educators also reported that they felt less stressed because of improvements in communication and support within their team, and centre directors reported increases in personal problem-solving rather than a reliance on education leaders or external supports.
- They also had a greater sense of job control (a marker of work stress relating to how much control one has over the circumstances and conditions of their job), in areas such as dealing with children's behaviour, working with parents and daily activities and routines.
- Pre- to post-intervention scores on the measure of difficulty of challenging child behaviours can be found at Figure 2.

Figure 2. Lower total difficulty scores assessed via the Strengths and Difficulties Questionnaire (SDQ). Scores above the clinical cut-off line indicate significant problems that need intervention.



The Draft Report, in relation to DR 17.6, notes that:

> *'schools invest a lot of effort in improving social and emotional learning each year and are faced with choosing from a crowded and overlapping list of programs. Little is known about the effectiveness of many of these programs. Schools would provide better and more cost-effective social and emotional wellbeing programs once these programs are accredited to ensure their quality'.*

TPI agrees that accreditation for programs based on the rigour of evidence should be encouraged across Australian jurisdictions.

This should be available to early education providers and social services as well as schools. An example of an attempt to this end at a federal level in Australia is the Communities for Children Facilitating Partners Evidence-based programme profiles guidebook. The idea of this resource is good in theory, but in reality, this list does not have sufficient rigour to determine best practice procurement. Although the programs – as suggested by the title – are listed as evidence based, many are in fact only evidence-informed, or the quality of evidence has not been assessed. There is considerable distinction in the rigour behind these categories.

For schools, early education providers and social service providers, an improvement on this would be to provide a rating system (i.e. 1-5 star or 0-10) which highlights the quality of evidence. Strong evidence should

be a minimum requirement for selecting a program, but it does not represent the whole picture when it comes to appropriate program selection and implementation. Our recommendation is to create a clearinghouse that is rigorous and explicit about the quality of evidence behind programs, but also helps users to understand the appropriateness of that program for other aspects important to effective implementation. The clearinghouse would help schools, organisations and providers to make good decisions based on the quality of evidence, readiness for dissemination and the appropriateness of the program to their context. We know of a group in Scotland (Psychology of Parenting Project at NHS Education for Scotland) that is currently setting up a local clearinghouse based on these important features for successful implementation. An example of a rigorous clearinghouse focused on evidence and readiness for dissemination is the Blueprints for Healthy Youth Development in the USA.

Victoria's School Readiness Funding initiative also endeavours to the goal of providing accredited providers, but again, quality of evidence is not sufficiently measured or shown – making it difficult for providers to determine differences, and make the best-informed choices to deliver improved outcomes.

Australian rollout examples

Triple P's population health approach is implemented in a range of community settings, including schools. A population approach is critical for a number of reasons. Destigmatising and normalising accessing parenting support in the broader population reduces barriers to help-seeking of families who are particularly struggling. Provided below are some examples of Australian jurisdiction rollouts.

Queensland

Using a universal delivery system to reach vulnerable families is a central tenet of Triple P's population health approach to parenting support. In Queensland, an estimated 336,000+ parents and carers accessed the program in the first four years of the government's Universal Parenting Program initiative. This includes 54,000 opting to access digital interventions, available online 24/7.

Inclusion of digital interventions together with a state-wide communications strategy promoting the availability and benefits of face-to-face and online programs, allowed the rollout to reach vulnerable sectors of the community at levels close to or exceeding state-wide representation in Queensland. This included low-income families, single-parent families, culturally and linguistically diverse families and Aboriginal and Torres Strait Islander families, many of whom accessed the program through community seminars or online.

Table 1 below shows proportionate reach based on web sign-up to seminars and programs, and responses to the opt-in cohort questions.

Table 2 shows proportionate reach based on data gathered from the online delivery, Triple P Online, which is equivalent in target and effectiveness as a Level 4 Triple P intervention.

Table 1. Reaching diverse families in Queensland

Profile (N = 14,259*)	Target proportion (%)	Proportion reached (%)
Low income (Health Care Card)	20.0	29.6
Aboriginal or Torres Strait Islander	3.6	4.3
Culturally and Linguistically Diverse (LOTE)	7.0	14.5
Single parent	16.1	24.2
Metropolitan	62.2	73.8
Regional	34.9	25.2
Remote	2.9	1.0

*Based on data provided from web-based registrations for Triple P programs in the period September 2017 and September 2019.

Table 2. Going online to support vulnerable families

Profile (n = 23,382*)	Target proportion (%)	Proportion reached (%)
Low income (Health Care Card)	20.0	27.9
Aboriginal or Torres Strait Islander	3.6	3.4
Culturally and Linguistically Diverse (LOTE)	7.0	12.9
Single parent	16.1	22.0
Metropolitan	62.2	73.9
Regional	34.9	24.8
Remote	2.9	1.3

*Based on data provided from web-based registrations for Triple P programs in the period August 2015 to December 2018.

The Queensland model shows the success of integrating service delivery around a central website and the need for a dedicated communications strategy to enable parents to find out what is available and where to access help. After an initial investment of $6.6 million over two years, the Queensland Government committed another $5.35 million over three years (September 2017 to June 2020) to continue to make Triple P freely available across the state.

The data in Table 2 has important implications for cost effectiveness – and reach into vulnerable sectors of the community. As above, many of the cohorts who are often identified as vulnerable or at risk, are *overrepresented* compared to state averages of their populations.

This means that families with health care cards, single mothers, Indigenous families, and others who may experience additional stressors, are actively engaging in assistance that is flexible to their day-to-day life's demands. For families under pressure, Triple P Online can be done at home in their own time, saving transport and childcare costs.

Research has found that 79% of parents are already accessing parenting advice online[7], so it is important that this information is effective and safe and that evidence-based advice is made available to parents in the places they are seeking it. Online delivery has been identified by parents as a preferred method of accessing parenting advice[8].

Additionally, Figure 3 below highlights the impact the Queensland rollout has had on parents' confidence in dealing with concerns. The graph shows the pre and post confidence scores for parents who completed Triple P Online.

Figure 3. Queensland parents' reported confidence in dealing with concerns

Western Australia

Beginning in Western Australia in 1996, a large scale (n = >800), regionally based universal program of eight-week group Triple P was trialled, and targeted towards at-risk families (trial was not randomised due to the 'at-risk' target cohorts, but did have a control arm) with a child between 3 and 4 years of age.

A first study[9] measured outcomes immediately, 12 months and 24 months post intervention and found:

- Significant reductions in parent-reported levels of dysfunctional parenting and parent-reported levels of child behaviour problems.
- Moderate to large effect sizes on child behaviour problems.
- Significant and positive effects observed in parent mental health, marital adjustment, and levels of child rearing conflict.

A second longitudinal study[10] on this same cohort, looked at up to 15 years' worth of administrative records from WA Departments of Education, Health, and Corrective Services, conducted by the Telethon Kids Institute found:

- Triple P was associated with a 15.9% reduction in the rate of ED admissions across childhood/adolescence, with the strongest effects observed for presentations with a diagnosis 'conditions due to external causes' and when a child was aged 10-15 years.
- A lasting, long-term positive effect on literacy and numeracy achievement (as measured in primary school), and school attendance (as measured in secondary school)
    - Higher reading achievement over the ages of seven to 12 years.
    - Consistently higher numeracy achievement up to the age of 12 years.
    - 22.9% fewer days absent from upper secondary school.

Rollout

Triple P is now (as of July 2018) offered universally through Education as a part of a transition to school (for kindergarten aged children-same age range as the cohort in the above study), and transition to high school initiative of the Western Australian Government.

In the first six months of this initiative (July-December 2018), 3, 529 parents across WA attended a Triple P session delivered by the Department of Education.

In keeping with the principles of population health, this makes parenting support as normal as enrolment, destigmatising the point of entry for families.

New South Wales

A Nexus evaluation report[11] highlights the impact of a NSW rollout of Triple P. From 2007-2010 (evaluation period), the NSW government aimed to make Triple P Levels 2 and 4 to all NSW families with children aged between three and eight years, by:

- Funding Triple P International (TPI) to train approximately 1, 180 practitioners from government and non-government agencies between 2008 and 2010 and to provide Triple P resources for families and practitioners

- Supporting each accredited practitioner to deliver two Seminar Series and two Groups per year on an ongoing basis.

By the end of 2010, 1,027 practitioners had been trained in Triple P.

The Nexus evaluation found:

For Level 2 (Seminars):

- The Triple P group showed significant improvement in SDQ scores from pre-intervention to the six-month follow-up (the change for the comparison group was not statistically significant), and this result was present in both boys and girls.
- This improvement equated to a net reduction of 9.7% in the proportion of children in the clinical range on the SDQ.

For Level 4 (Group Triple P, Self-Directed Triple P, Indigenous Triple P):

- Significant reported improvements in parenting behaviours (over-reactivity, laxness, hostility, parenting scale total score).
- Significant perceived improvements in child behaviours on SDQ scores (emotional symptoms, conduct problems, hyperactivity, peer problems, social scale) and the aggregated SDQ total problem score.
- Those improvements resulted in a reduction of children in the clinical range from 35.3% to 24.8%: a net reduction in children in the clinical range of 10.5%.

Additional data from structured interviews with parents found:

- 82% had noticed changes in their child's behaviour.
- 91% felt that their child's behaviour had improved.
- 75% felt that their child was getting on better with them and their siblings and friends.
- 87% indicated they were doing things differently when their child misbehaved.
- 93% felt more confident in their parenting.

In general, the perceived improvements were most marked for those who completed Level 4 Group Triple P.

The Nexus report also included an economic evaluation which found that following a direct investment of around $5 million, Families New South Wales leveraged $8 million value through Triple P implementation. However, this benefit is likely much larger as the evaluation only covers the initial stages of implementation, which carry the highest cost-burden, and do not include the longer-term social benefits.

This NSW implementation is estimated to have shifted a net 1,150 children from the clinical to the non-clinical range on the SDQ.

Cost effectiveness evaluations of Triple P

Table 3. Cost-effectiveness analyses of Triple P

Study	Features	Cost/benefit	Study type
Positive Family Functioning – Deloitte Access Economics (2010) report for Department of Families, Housing, Community Services and Indigenous Affairs. Pages 56-62 Outline the Triple P cost-benefit analysis[12]	Study analysed various Triple P studies, mostly Australian, for the calculation. This included but was not limited to: • a large scale (n = 3,000) controlled evaluation of all five stages of Triple P for four to seven-year olds[13] • a meta-analysis of a Level 4 Triple P intervention[14] • a community-based Level 4 Triple intervention in Western Australia (n = >800), where the intervention was targeted towards at-risk families[15]	Benefit cost ratio calculated to be 13.83, suggesting a 1,283% return on investment from Triple P.	RCT Meta-analysis Controlled Other Economic modelling
Population cost-effectiveness of the Triple P parenting programme for the treatment of conduct disorder: an economic modelling study (2018)[16]	A population-based multiple cohort decision analytic model was developed to estimate the cost per disability-adjusted life year (DALY) averted of Triple P compared with 'no intervention' scenario, using a health sector perspective.	*Group format* Very cost effective – threshold of $50,000AUD per DALY averted compared to no intervention Incremental cost effectiveness ratio (ICER) = $1,013 per DALY averted *Individual format* Also cost effective	Economic modelling

		ICER = $20,498 per DALY averted	
Washington State Institute for Public Policy (2018)[17]	Children's Mental Health Under the category 'Disruptive Behaviour' Triple P (Individual and Group) were measured for cost effectiveness.	Benefits minus costs: Triple P – Level 4 – Individual $4, 800 Triple P – Level 4 – Group $3,589	Economic modelling
Institute of Health Economics Return on Investment for Mental Health Promotion: Parenting Programs and Early Childhood Development (2012)	In this study, prepared with the support of the Public Health Agency of Canada, the authors reviewed the economic evidence regarding early childhood interventions. Using this data, and data supplied by the Triple P program, an economic model was developed to determine the return on investment if Alberta introduced the program to a birth cohort of 52,000 children.	Results indicated that if the Triple P program reduced conduct disorder by 6%, then there would be a positive return on investment. Current evidence indicates that the actual return on investment is far greater than 6%, with a study reporting Triple P has the potential to avert at least 26% of conduct disorder cases in children.[18]	Economic modelling

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