**Submission by Professor Jeff Borland and Dr Yi-Ping Tseng (University of Melbourne)**

Our submission relates to discussion in the Draft Report of early intervention programs – and in particular, programs intended to improve outcomes for children who experience extreme adversity (Volume 2, page 662; see Appendix for the excerpt from the Draft Report to which our submission relates). We are both members of the research team evaluating the Early Years Education Program (EYEP) referred to in the Draft Report.

Our comments are made with specific reference to children who at early ages experience extreme adversity: that is, prolonged exposure to multiple sources of adversity (see for example, Hughes et al., 2017 and Fergusson and Horwood, 2003). It is known that children who experience extreme adversity will constitute a disproportionate share of adults with serious economic, health and social problems, and of the associated budgetary cost of government health and welfare programs (see for example, Caspi et al., 2016). To our knowledge, the incidence of extreme adversity at early ages in Australia is not established. As one guide, however, in 2016-17 there were 53,277 pre-school children receiving child protection services (Australian Institute of Health and Welfare, 2018, table S3). Hence, this group might be seen as sizable in absolute magnitude; but a relatively small proportion of the overall population of pre-school children.

Our first comment relates to the section of the Draft Report which states:
'While not providing a universal solution, strengthening the ability of all ECEC staff to recognise factors that may put children at risk of a mental illness, as well as offering additional support to all ECEC services (draft recommendations 17.2 and 17.3) are likely to aid an improvement in social and emotional wellbeing for vulnerable children.'

We question this conclusion as far as it relates to children who experience extreme adversity. We believe that our research suggests a contrary conclusion – that the only appropriate method to improve outcomes for children who experience extreme adversity is via a targeted service such as EYEP; and that a universal program is likely to have little positive and potentially a negative impact on those children.

Our conclusion is based on several findings from the trial of EYEP. First, it proved to be a major undertaking to engage and maintain day-to-day participation of children experiencing extreme adversity with EYEP. This is due to the high levels of stress and external pressures faced by these families. Without sufficient resources being dedicated to children's orientation and on-going participation with a program, it is unlikely that participation will commence or be sustained – and these problems are likely to be exacerbated in universal programs where children who experience extreme adversity may be stigmatised. Second, to have a positive impact on children who experience extreme adversity, a program must address brain development and be long-term. As the Harvard educationalist Jack Shonkoff has written (2011, p.982), what is needed is to link 'high-quality pedagogy to interventions that prevent, reduce, or mitigate the disruptive effects of toxic stress on the developing brain'.

Furthermore, out experience with EYEP is that after 12 months of participation by children, only a small impact was observed – but after 24 months much larger impacts on a wider range of outcomes were found (and noting that EYEP is a program that runs 50 weeks and 25 hours per week each year). Thus, only a program that is designed to address the specific problems of children who experience extreme adversity and that is sufficiently intensive is likely to cause any change in outcomes for those children. Third, a program for children who experience extreme adversity must be able to deal with complexity. It needs to be broad enough to encompass children with many different sources of and responses to adversity, and flexible enough to meet their differing needs.

Our second comment relates to the section of the Draft Report which states:
Scaling such programs to substantially increase the number of children attending is a very challenging task, due to funding shortages, a lack of services, limited coordination, poor tailoring of service provision to local circumstances and other problems.

We question this conclusion – again as far as it relates to children who experience extreme adversity. First, as we have noted, the number of children involved is large, but not prohibitive for scaling up. Second, if it is accepted that programs such as EYEP are the only way to improve outcomes for children who experience extreme adversity, there is no alternative to scaling up intensive programs targeted at those children. Third, we believe that the new science of scalability is providing a solid framework for knowing how to roll out progams in order to replicate impacts from the initial trials of those programs (see for example, Al-Ubaydli et al., 2019 and Davis et al., 2017). Examples of issues that require attention are ensuring fidelity to the program design, having a workforce (in this case early years educators) of the same quality as the initial trial and being aware of mediating factors that may affect take-up of a scaled-up program.

**References**

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Shonkoff, J.P. (2011), 'Protecting brains, not simply stimulating minds', *Science*, 333(6045), 982-83.

**Appendix: Productivity Commission (2019), Mental Health: Draft Report Volume 2, p.662.**

Some of these risk factors can be ameliorated through early intervention. Over many years, and in many developed countries, studies and trials have shown that early intervention for vulnerable children significantly improves outcomes. Early intervention usually takes the form of integrated education and therapeutic services, delivered by highly skilled staff. For example, one such program in Victoria for preschool children employs experienced educators, an infant mental health consultant and family support workers (Jordan et al. 2014). An evaluation of the program has shown positive outcomes for both child and parental mental health (Tseng et al. 2019).

Scaling such programs to substantially increase the number of children attending is a very challenging task, due to funding shortages, a lack of services, limited coordination, poor tailoring of service provision to local circumstances and other problems. As a result, some children and families receive services that are much less intensive than what is needed (Emerging Minds, sub. 455). More commonly, however, at risk children, and in particular infants and young children, access no health services at all (Guy et al. 2016).

Nonetheless, vulnerable children are increasingly attending ECEC services and preschools. For some groups, rates of attendance are higher than the rest of the population (SCRGSP 2019h). While not providing a universal solution, strengthening the ability of all ECEC staff to recognise factors that may put children at risk of a mental illness, as well as offering additional support to all ECEC services (draft recommendations 17.2 and 17.3) are likely to aid an improvement in social and emotional wellbeing for vulnerable children.